AN EXPLORATION OF FAMILY HEALTH ASSESSMENT IN COMMUNITY PRACTICE FRAMED WITHIN A FAMILY NURSING APPROACH

A CONSTRUCTIONIST ENQUIRY USING COMPARATIVE MULTI-CASE STUDY

DOROTHEE J.H. O’SULLIVAN BURCHARD

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ABSTRACT

At international and national level the family is recognised as an indispensable partner for promoting health, and community nurses are seen as well placed to advance family health care. Little is known about how these nurses accommodate families’ needs or whether such an assessment is theoretically informed. This study aimed to gain an in-depth understanding of family health assessment, the perceptions, experiences and interactions of those involved, and the usefulness of a family-derived theoretical assessment framework.

The novel integration of a symbolic interactionist and family systems perspective grounded within a constructionist methodology made it possible to arrive at a fusion of these theoretical orientations, achieved using comparative multi-case study design. Each of the four cases included a community nurse and a family. Sampling was purposeful and for maximum variation. Sequential data collection involved interviews, observations and documents that were thematically analysed. A thematic, conversation-analytical approach to speech exchanges was applied to audio-recordings of home visits. The development of an innovative, theoretically-grounded, analytical framework achieved a robust and in-depth analysis within and across cases. Triangulation and a broad inferential scheme were applied to the data. Comparison across cases extended the exploratory design and added explanatory power.

There was a striking alignment in the meaning given to ‘family’ by both the community nurses and family members. Family health assessment was seen as an inclusive, multi-layered experience of being in the equation. The community nurses promoted solidarity by taking a family orientated approach, which involved balancing the intrusion into family life with the families’ need for privacy. The families experienced the home visits as a therapeutic encounter with a trusted nurse; they did not view the visits as an assessment but rather as ongoing conversations that were highly valued for the continuity of care provided by the community nurses. Interactions between the community nurses and family members indicated that a sophisticated ‘relational inquiry’ had taken place. In the assessment practice of the health visitor, the community children’s nurse, the family health nurse and the district nurse, conversational sequences showed four distinct circular interaction patterns from which an explanatory model of family health assessment was constructed. The community nurses’ recorded case notes did not mirror the depth and breadth of the shared assessment information and the thread of relationship that was embedded in nurse-family interactions. A family-derived theoretical assessment framework helped with the mutual exploration of health needs and concerns.

Key Words: family health assessment, community nurse, family nursing, constructionist methodology, multi-case study, circular interaction patterns
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AUTHOR'S DECLARATION

This thesis, and the research on which it reports, is my own original work and has not been submitted elsewhere in fulfilment of the requirement of this or any other award.

Signature:...........................................................................................................................................................................

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1 INTRODUCTION TO THE THESIS

INTRODUCTION
The following work describes a qualitative enquiry into family health assessment in different fields of community nursing practice. The enquiry examines the process of interaction during home visits. It also explores nurse and family perceptions and experiences of these visits. The design is a comparative multi-case study using a constructionist methodology.

My experience in working with families stimulated my interest in this enquiry. In children’s nursing a family-centred approach is fundamental in care. In my clinical work, I learned that family-centred care is more than a global descriptor for practice. To understand and meet the needs of a child, other family members also have need of nursing care. My clinical experience shaped my belief in the importance of families and the promotion of family health care.

In my postgraduate studies I was introduced to family nursing literature. Family nursing originated in the nursing communities of North America as a body of knowledge that offered nurses a range of integrated conceptual family frameworks for clinical practice, education and research (Friedemann, 1995; Wright & Leahey, 2000; Hanson & Kaakinen, 2001; Friedman et al., 2003; Denham, 2003; Bomar, 2004). The utility of these frameworks was seen by Whyte (1994; 1997a) who introduced family nursing to nurses working in clinical practice and education (Whyte et al., 1998; Claveirole et al., 2001; O’Sullivan Burchard et al., 2004).

‘Family nursing’ made sense to me and captured my interest. After joining the Family Nursing Network Scotland and moving into nurse education, I led a small-scale study which explored lecturers’ knowledge of family nursing. Its relevance for nurse education was evident in the findings (O’Sullivan Burchard et al., 2002). Ever since, I have been curious about how nurses in practice accommodate a family’s health needs. I regarded the examination of family health
assessment as a useful starting point for this enquiry, since provision of family health care calls for assessment as the foundation of effective care (Bryans & MacIntosh, 2000).

1.1 IMPORTANCE OF THE STUDY
Health care legislation and policy have led to changes in service structures and health care provision. This has created competing demands for the health professions. In such a climate, nursing assessment of health needs is a critical component of care, as it informs decision-making with subsequent resource implications (Cowley et al., 1995; Bryans, 1998; Kennedy McAuley, 2000; Bryans, 2003). Health needs assessment requires management of resource allocations without neglecting caring obligations (Audit Commission, 1999). Assessment of health needs has also become a multi-agency enterprise that should involve families and result in a working partnership for all concerned (Department of Health, 2001a; SEHD, 2005a&b). Therefore, the assessment practice of community nurses has economic-political, socio-ethical, and multi-professional implications.

In the United Kingdom (UK) community nurses in different fields of practice work with individuals, families and communities in a variety of roles, and must take account of their needs and wishes (NMC, 2004). These individuals commonly live in a complex relational network of interdependence and shared experience (Centre for Research on Families and Relationships (CRFR), 2001; Scottish Executive, 2001a; Wasoff and Hill, 2002; Roseneil, 2005; McKie et al., 2005). Professional discourse frequently refers to these individuals as ‘service users’ and ‘carers’ (Nolan et al., 1994; 1996; Jarvis, 2001). Their social network comprises relations and/or friends who may live in the same household but who are also affected by health and illness events (Wasoff & Cunningham-Burley, 2005).

Evidence suggests that nursing work with families and assessment of their health needs is complex and multi-dimensional. It requires skilled communication, a relationship-orientated approach and a broad theoretical-experiential knowledge base (Whyte, 1994; 1997a; Cowley et al., 1995; Nolan et al., 1996; Bryans, 1998; Bryans, 2000a; Bryans, 2000b; Bryans & McIntosh, 2000; Kennedy
Chapter 1 Introduction to the Thesis

McAuley, 2000; Bryans, 2003; Macduff & West, 2003; Nolan et al., 2003). The few studies that examine assessment practice have drawn predominantly on accounts from individual carers (Nolan et al. 1994; Jarvis, 2001; Sedden & Robinson, 2001). There is also a prevalence of individual-focused assessment frameworks (Elkan et al., 2000; Bryans, 2003). Although contributing to knowledge in working with family members, these ‘one-informant’ approaches limit understanding of the inter-related and multi-dimensional nature of health-illness concerns within a family unit. Family members influence interaction and nursing activities, but their contribution is seldom made visible and their needs missed in assessment (Carney et al., 1996; Kennedy McAuley, 2000; Jarvis, 2001). Assessment of family health may be problematic if nurses subscribe to an individualistic perspective, or omit the collective contribution and needs of the family when documenting care interventions. There is a lack of research into such theoretical family frameworks being applied in practice; therefore, there is a requirement to investigate more fully the utility of such frameworks. This is even more pressing since the Government urges nurses to evidence theoretically informed and structured health interventions (SEHD, 2001a).

Family nursing offers integrated conceptual frameworks with different strands, theoretical influences, levels of complexity and interaction, and draws on family social science theories, family therapy theories and nursing theories to inform family health care (Hanson, 2001b). As a theoretical body of knowledge, it can guide practice and research where the focus is on the family as client (Wright & Leahey, 2000; Hanson, 2001a; Friedman et al., 2003; Denham, 2003, Bomar, 2004). The utility of many of these conceptual frameworks, however, has not been evidenced by research, resulting in a family nursing theory-practice gap (Segaric & Hall, 2005). The interchangeable use of and inconsistency in terminology relating to family health care is also notable. Given the expectation on families regarding self-care, it is of paramount importance that a theoretical, family-focused perspective is identified. This perspective may help to inform the assessment practice of community nurses.
Chapter 1 Introduction to the Thesis

1.2 AIMS, OBJECTIVES AND OVERVIEW OF THE STUDY

The study aimed to gain an in-depth understanding of family health assessment, and the perceptions, experiences and interactions of community nurses and families, and the usefulness of a family-derived theoretical assessment framework.

The initial objectives of the study were to

- explore and describe community nurses’ and families’ understanding of family health assessment as experienced during home visits
- analyse and explain the process of interaction between the community nurse and family members and/or carers during home visits in order to inform family health assessment practice
- examine the usefulness of a family-derived theoretical assessment framework in community nursing

One further objective emerged (see Chapter 6, Section 6.8 and Chapter 11, Section 11.3). A qualitative, theoretically orientated, multi-case study with a comparative focus was designed to meet the aims of this enquiry. The methodological approach was grounded in constructionism drawing on symbolic interactionism and family systems theory. Such a methodology promised to provide sufficient scope to take account of different perspectives, diversity of contexts, and multiple voices.

Each of the four cases included a community nurse and a family, and was bounded by events before, during and after several home visits. The focus of each case was the participants’ perceptions and experiences and how these were demonstrated in their interactions. Sampling was purposeful and of maximum variation. The study took place in three health boards in North, East and Central Scotland. These multi-sites gave the opportunity to involve community nurses from different disciplines. Community nurses most likely to work with families were selected: a health visitor, a community children’s nurse, a family health nurse and a district nurse. Each nurse participated in the selection of a family. Data collection and analysis for each case was conducted sequentially. The data sources, including interviews, observation of home visits and nursing
documents, were subjected to thematic analysis. A thematic conversational-analytical approach was used to interpret the audio-recorded nurse-family interactions. The aim of the cross-case analysis was to compare cases, identify patterns and build theoretical explanations. The process of family health assessment was explored and described. Use of a broad inferential scheme made it possible to arrive at an interaction model that explained the family health assessment process.

The methodological decisions and challenges using this approach are discussed with the aim of adding to methodological debate. It is hoped that this will be useful to other researchers. Recommendations for policy, practice, education and further research are suggested, based on a synthesis of findings from the study and the existing literature.

1.3 STRUCTURE OF THE THESIS

This thesis reports on the conception, operation, and conduct of the study and the original contribution it makes to knowledge. An overview of the thesis structure is given below.

Following this introductory chapter, the literature is reviewed within Chapter 2. The health care policy context is briefly examined. Literature focusing on conceptualising approaches to family health care, and current empirical knowledge is then critically reviewed. Key concepts integral to the study are defined. The review contributes to a thorough understanding of the research problem.

The theoretical and methodological issues considered as critical in addressing this research problem are discussed in Chapter 3. This includes ontological and epistemological assumptions and their position within the context of nursing research. Theoretical perspectives to guide the study and those relevant to family research, are also discussed. Finally, limitations and implications of assumptions and perspectives are acknowledged.
Chapter 1 Introduction to the Thesis

In Chapter 4 the study design used to answer the research question is justified. The potential and purpose of case study design is examined followed by a description of how this design strategy will be used and rigour maintained. The pitfalls of case study are identified.

In Chapter 5 planned methods for conducting the research are defended. It begins with a consideration of ethical issues, and access and selection of the research sites followed by an explanation of the sampling strategy, methods of data collection and data preparation. The planned within-case analysis is presented. Procedures for the cross-case analysis are tentatively considered.

An account of the findings is given in Chapters 6, 7, 8 and 9 according to the sequence in which each case study was conducted. A description is given in each chapter of its conduct and procedures followed by case-specific findings and interpretations.

The cross-case analysis and the selected approach are explained within Chapter 10. Following an initial identification of issues, brief narratives of each case bring out the case-specific details, from which the cross-case analytic work then proceeds, culminating in the synthesis of findings.

Chapter 11 offers a final discussion of key findings within the context of the study’s merits and limitations. A critical examination of the methodology, reflections on the study’s theoretical underpinnings and the multi-case study design are presented. The discussion proceeds to focus on the key findings with reference to current knowledge and an updated policy context. There follow recommendations for policy, practice, education and research, and conclusions.
2 THE LITERATURE REVIEW

INTRODUCTION
This chapter builds the justification for the study based on a selective review of the research and descriptive literature. Search strategies are outlined and an overview of developments in health care policy and legislation provides a historical context. The focus narrows to examine policy affecting community nurses and the implications for their role development. The discussion continues by looking critically at conceptualising approaches to family health care, to further contextualise the research phenomenon. Current research relating specifically to assessment in community nursing is reviewed. Key concepts integral to the study, and key points drawn from the literature, are then set out, leading to the formulation of the central research question.

2.1 LITERATURE SEARCH STRATEGIES
A range of search strategies were used, and searches continued for the duration of the study. This included electronic databases using Cumulative Index to Nursing and Allied Health Literature (CINAHL), British Nursing Index (BNI) Medical Literature, Analysis and Retrieval System Online (Medline), PSYCINFO, PRO QUEST HEALTH FOR SPECIAL INFORMATION, SCOTTISH HEALTH ON THE WEB, Cochrane and Index to Theses. Search terms were: family nursing, family nursing assessment, family health, health assessment, family health assessment, holistic nursing, and community nursing assessment. Much of the literature was anecdotal with little primary research. Date limits were not set as it was important to search broadly. Abstracts were retrieved and literature selected for scrutiny. Literature was also retrieved using the ancestry approach (Cooper, 1998). The reference lists of pertinent literature were searched for relevant sources, which promised a further lead into appropriate subject matter. Material was located from the library catalogue of the home institution, other libraries and special collections. Government websites and NHS Evidence-National Library for Public Health were accessed for policy documents and literature on practice developments. The search also included some German-language published texts. Several theses were consulted for their methodological or subject matter interest.
Chapter 2 The Literature Review

To maintain chronological coherence of the thesis, the literature review includes sources up to 2004. Methodological literature was updated according to the development of the study. Material examined after commencement of data collection in 2004 largely informed the discussion chapter.

2.2 THE POLICY CONTEXT

2.2.1 Health Care Legislation and Policy

Over the last two decades a major shift from a medical illness focus to a more holistic approach which emphasises ‘health’ has influenced health care policy. This change included a move to client participation and the targeting of distinct population groups (WHO, 1985; 1998). The ‘healthy family’ was to take centre stage and nurses were singled out as being well placed to achieve such a re-positioning (WHO Regional Office for Europe, 1999; WHO, 2000a).

In health care across the UK, the Government initiated a major re-orientation with the National Health Service and Community Care Act (UK, 1990). The Act introduced a split in health and social care, with informal carers and voluntary groups becoming necessary contributors to care provision. The Act endorsed a health promoting model of care, enabling service users to stay at home, and directed community led services towards inter-professional and integrated working (Tanner, 1998; DoH, 1999a; Stewart et al., 2003).

Collaborative inter-professional and multi-agency working across the health, social work and education sectors was regarded as a necessity in a range of policy documents that focused on meeting the needs of the population throughout the life course (SEHD, 2001b; 2001c; 2002a; 2003a). The concerns of patients, carers, families and communities were to be addressed in government initiatives to redesign health care services (SEHD, 2003a). The Partnership for Care Scotland’s Health White Paper called for health professionals to enhance their communication skills, adopt a patient-focused approach and secure the assessment needs and rights of carers (SEHD, 2003a).
Chapter 2 The Literature Review

Health care reforms during the last 10 years also became inclusive of children’s services with a range of policies targeted at this population (DoH, 1999a; 2004; The Scottish Office, 1999; Scottish Executive, 2001; 2002; 2003). Children and their families were to be placed at the centre of the service network to encourage integration (SEHD, 2000; 2003a; Mackenzie et al., 2004). The White Paper Towards a Healthier Scotland (The Scottish Office, 1999) introduced a range of policy initiatives to improve the health of children aged 0 - five years and strengthen families and communities (Cunningham-Burley et al., 2002; Shucksmith et al., 2003; Bryans & McIntosh, 2004; Wasoff et al., 2004). Embedded in these policy initiatives is the introduction of the family health plan in England and Scotland for vulnerable families (DoH, 2001; SEHD, 2001c). The evaluation in Scotland identified its selective use as potentially stigmatising (Shucksmith et al., 2003). Its introduction as a practice development project confirmed its comprehensive approach to exploring vulnerable families’ health needs (Sanders, 2003).

The rapidly proliferating health care reforms designed to advance integration across care sectors can be interpreted as recognition of the inappropriateness of separating the bio-psycho-social nature of individuals from their social environment. It can also be seen as an attempt to compensate for this separation which had been set in motion with the National Health Service and Community Care Act of 1990. Affirmation of citizens’ ownership in health care maintenance appears to be a major theme across the spectrum of policy reforms; as is the shift towards greater integration of carers, families and communities into health care structures and processes. Within this climate of joint working it seems timely to explore the perceptions of those who can stake a claim in the new assessment enterprise, such as community nurses, patients and their families.

2.2.2 Nurses and Health Care Policy

Public policy reforms have resulted in a re-structuring of primary care organisations in health and social care. These reforms have created instability for professional practice and development across care sectors (Cameron & Masterson, 2000; Wasoff & Hill, 2002). Nurses appear to have been given an influential position for contributing to health care reforms, as is suggested in a number of policies. The need for recognition of their unique professional perspective, their espoused model of holistic health care and their engagement with some of the broader socio-
political factors affecting health and health policy, have been argued elsewhere (Maslin-Prothero & Masterson, 1998; Antrobus & Kitson, 1999).

In response to health care changes, radical modernisation of the public nursing workforce was deemed necessary by Government (DoH, 1999b; SEHD, 2001b; 2001c). The strategy focused on creating new nursing roles for primary care. Nurses were asked to demonstrate their contribution in support of Nursing for Health – A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public’s Health (SEHD, 2001c). The extent to which community nurses were supported to integrate policy changes can be questioned due to the plethora of initiatives which created instability at operational level (Cameron & Masterson, 2000). In a review of district nursing services in England and Wales, the Audit Commission (1999) reported on patients’ concerns about the interaction and the nature of relationships with district nurses. Lack of resources was identified as affecting the performance of district nurses and recommendations were made for improving their assessment practice. Apart from obstacles at operational level, a range of conflicting demands had been empirically identified at a strategic level elsewhere - for example short-term government initiatives, and the imbalance of power between the medical and nursing professions at individual, organisational and policy levels (Cameron & Masterson, 2000).

An example of a short-term government initiative is the Scottish Family Health Nurse Pilot with its introduction of ‘family health nursing’ to the Scottish community nursing arena (Macduff & West, 2003). The new family health nurse (FHN) was part of the WHO European Region Health 21 policy framework and had been “singled out as key to facilitating the healthy family concept” (WHO Regional Office for Europe, 1999: 1). In support of this new role, the WHO (2000b) developed a framework for education. Subsequent guidance followed, issued by the International Council for Nurses (ICN) (Schober & Affara, 2001) and more specifically in Scotland (NHS Education for Scotland, 2004).

The policy pilot initiative introduced the FHN in Scotland (Macduff & West, 2003). By implication, only the FHN practices from a ‘family health nursing’ perspective, i.e. promoting family health in their nursing work. Thus, the assessment of family health became dependent on the FHN role. As
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a new generalist role, it was seen to provide a nurse-led service for community nursing. The initiative raised the question of whether family health care fell into the sphere of one particular role, scope of practice or service as suggested by some (Macduff & West, 2003; NHS Education for Scotland, 2004). Its inception can be interpreted as having created an artificial division in role perceptions between community nurses. From a policy perspective, family health care and its foundational element of a family health assessment appears to have been treated as a novel approach. Yet, from a historical perspective, community nursing practice in different guises involved working with individuals, families and communities, and attended to their needs for centuries (Kelly & Symonds, 2003). Such a focus also reflects a professional obligation (NMC 2004). The study by Daly & Carnwell confirms the confusion and lack of consensus that can be associated with nursing roles, “regarding their meaning, scope of practice, preparation for, and expectations of such roles” (2003: 159). Indeed, community nurses in Scotland identified role difficulties with partnerships and access to resources, and the change processes involved, as barriers to the development of new public health nursing (SEHD, 2003b).

Role developments across all fields of practice in Scotland have been shown by Tolson & West (2001) to go beyond nurse/midwifery-led services. Based on their survey across professional disciplines, Tolson & West conclude that developed roles are an attempt by the profession to encourage “responsive, person-family centred and holistic services” (2001, Section 2.8.3: 9). Tolson & West did not define the meaning of “person-family centred and holistic services”, therefore, it is timely to examine the community nursing practice of those who are engaged in nursing work with families. Indeed, research that seeks to understand families’ needs rather than being preoccupied with role definition and task analysis has been recommended by Goodmann et al. (2003). More specifically, research into service users’ responses and perceptions to theoretically informed and structured health interventions led by nurses has also been suggested (SEHD, 2001a). A closer examination is therefore required of how community nurses in different fields of practice approach the family and assesses their health needs. Such an investigation may contribute to a better understanding of community nursing practice and its effectiveness of care (McIntosh, 2003).
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Policy recommends focusing on the needs of patient and community to develop professional practice and skills, implying that family health care is highly contingent on policy and role development initiatives (SEHD, 2001b; 2001c; 2003a). Individuals in need of health care commonly belong to a social group, network, family or household. Their relational connectedness may thus become the starting point for developing the knowledge, skills and competencies necessary for family focused care. Nurses therefore need to seek information not just about one individual, but should focus on the health care needs of the relational group to which that individual belongs, in order to develop family health care. Although community nurses work with families, little is known about how individual needs are assessed with due regard given to the collective needs of the family. A health visitor practice development initiative includes a new emphasis on ‘family-centred care’ and on the family health plan as a core tool to assess the needs of vulnerable families (DoH, 2001). If community nurses’ unique contribution towards promoting a holistic model of health is to be of benefit for families across the whole spectrum of populations, however, a family-focused assessment requires to be evidenced by theory and research in order to inform family health care practice (SEHD, 2001c; 2002a). This study aims to make a contribution to this evidence.

2.3 CONCEPTUALISING APPROACHES TO FAMILY HEALTH CARE

2.3.1 Defining Holistic Nursing Care

Meleis (1990) notes the centrality of ‘health’ in nursing, with all its diverse definitions and approaches. It is the different levels of meaning given to ‘health’ which define approaches to care. Meleis further argues that ‘health’ may be a personal concern for some, but more often it is a social matter. She questions the implicit “ethnocentric framework for health” in many nursing models that define ‘health’ as a personal matter which makes the individual responsible for their own health, and fails to see families, communities and societies as co-accountable (Meleis, 1990: 107). A broader view of ‘health’ would go beyond an individual focus and include an understanding of social, environmental, societal and political influences.

Levine (1971) gives one of the earliest accounts of the potential merits of holistic nursing largely informed by systems theory. Holistic nursing, according to Levine, means recognition of the individual’s wholeness or integrity, and the interaction between the individual and the
environment. This interaction creates inter-dependence. Family in society is an example of such inter-dependence (Allan & Crow, 2003). It also exists between and among family members, and between family and health (Hayes, 1997; Frude, 2003; Bomar, 2004). Confirmation of this inter-dependence is evident in studies at national and international level (e.g. Whyte, 1994; Denham, 1999; 2003; Hall, 1998; Jarvis, 2001; Kennedy McAuley, 2000; Jansson et al., 2001; Duhamel & Dupuis, 2003; Barberia & Canga, 2004; Smith et al., 2004). The literature suggests that both the definition and the interaction of ‘family’ and ‘family health’ is complex. Mauksch refers to these concepts as interactive forces which need to be understood within a “framework of pluralistic interaction” and accepted in their “complexity, ambiguity and imprecision” (Mauksch, 1974: 526). Therefore, a global reference to ‘holistic nursing’ care may deflect from these complexities. It may ignore the contexts and the multiple dimensions of ‘family’ and ‘family health’ and their socially and culturally constructed nature (Denham, 1995; Hartrick, 1995; Hartrick & Lindsey, 1995).

Holistic nursing care suggests recognition of the interplay and the inter-connectedness of multiple dimensions. As Covington (2003) notes, to generate nursing knowledge holism, inter-subjectivity and contextual meaning have become accepted perspectives in nursing practice and research. Taylor (2004), however, cautions against the complexities involved in practicing holistically and the taken-for-granted notion of a holistic approach as integral to nursing practice. An idea which aims to provide a more integrated approach is ‘family-centred care’.

### 2.3.2 Defining Family-Centred Care

In the UK, ‘family-centred care’ is regarded as the defining approach to care delivery in child health (Nethercott, 1993). Influenced by Bowlby’s research (1953; 1973; 1980; Holmes, 1993), which highlighted the effects of ‘maternal deprivation’ on the child’s psychological and emotional development, the British Government initiated major reviews of practice concerning children in hospital (MHCHCS, 1959; DoHSS, 1976). While health care policy rhetoric has taken hold of ‘family-centred care’ and subsequently informed health care provision at organisational level across fields of practice, professional discourse about ‘family-centred care’ continues to be troublesome.
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‘Family-centred care’ has long been regarded as an ‘ill-defined’ concept (Darbyshire, 1994; Frank & Callery, 2004). Studies examining its multi-dimensional nature identified the problem of parent involvement (Callery & Smith, 1991; Evans, 1994), resources (Callery, 1997), negotiation (Callery & Smith, 1991; Callery & Luker, 1996; Espezel & Canam, 2003), role perceptions (Kawik, 1996) and misperceptions about partnership working (Coyne, 1995a&b). While these studies highlight the interactional nature of the nurse-family relationship, each was carried out in a hospital environment. Based on an ethnographic case study in a community setting, Whyte (1994) recognised the usefulness of a family systems nursing classification as a more systematic theoretical underpinning. In her later work Whyte classified ‘family-centred care’ at a level where the family was acknowledged in the context of the individual (Whyte, 1997a). Despite the empirical evidence cited, it would appear that family-centred care in the United Kingdom remains a construct full of contradictions. It is reasonable to suggest that the term ‘family-centred care’ implies care giving being centred on the family, thus encompassing the individual child, sibling and parent collectively. This would then allow the family to take ‘centre-stage’ in care provision, as suggested by the WHO (WHO Regional Office for Europe, 1999; WHO, 2000a).

A broader focus that goes beyond a dyadic interaction in family health care provision has also been promoted by Nolan et al. (1996; 2003). They offer a typology of family care in which an instrumental approach to care needs to be complemented by the development of an understanding of the carer’s perspective and a multi-dimensional understanding of that care (Nolan et al., 1995). Nolan et al. (1999) regard their partnership approach for supporting family carers as corresponding to a family systems nursing approach as promoted by Whyte (1997a). However, their work is not built on a shared theoretical perspective of systems theory as was advanced by Whyte (1994; 1997a). Nolan et al.’s mutual emphasis on the importance of gaining an insight into family care giving requires an understanding of the nature of the relationships that need to be built with the family. Whilst Nolan et al. (2003: 258) cite the North American Tresolini and the Pew-Fetzer Task Force in 1994 as promoter of ‘relationship-centred care’, North American family nursing scholars also identified the relational dimension as a decisive factor in contributing towards nursing work with families (Robinson, 1996; Hartrick, 1997). In North America, the predicament in nursing work with families was also seen as a lack in consistent terminology by Robinson (1995).
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Denham (2003) notes that ‘family health care’ is a construct full of conceptual vagueness. Given the above review, the same can be said about approaches such as ‘holistic nursing care’ and ‘family-centred care’. Similarly, the concept of ‘family’ is elusive with definitions varying depending on discipline, purpose or policy context (Wasoff & Day, 2000; Bomar, 2004). Therefore, it should not be surprising to find ‘family nursing’ and ‘family health assessment’ as equally imprecise terms which merit further investigation.

2.3.3 Defining Family Nursing

Nursing knowledge and practice has historically included meeting the needs of individuals and their families (Whall, 1986; Hayes, 1997; Kesby, 2000; Kelly & Symmonds, 2003; Bomar, 2004). Directly or indirectly, family members are commonly affected by nurse actions. Conceptual models in nursing have evolved, with some specifically integrating a family focus e.g. Reutter (1984), Frey (1989), Taylor (1989) and Reed (1993). Theoretical developments in family nursing provide conceptualisations from integrated perspectives for understanding families and informing family health care.

According to Denham (2003: 4), the aim of family nursing is “to provide holistic care for individuals and family units”. This implies a practice-orientated approach where the family is seen as the unit of care (Gilliss, 1989a). Friedman et al. (2003) define family nursing practice more comprehensively, referring to it as a perspective focusing on family strengths that is health-orientated, holistic, systemic and interactive. The primary goal of family nursing is viewed by some as the promotion of the health of the family as a whole and of each of its members (Hartrick et al., 1994; Bomar, 2004). Much of family nursing is associated with theoretical developments in the US and Canada (Hayes, 1997). Wright and Leahey (2000) refer to these developments as the nursing of families, the implication being that ‘family nursing’ became the adopted descriptive, interchangeable label in North America. Recent years have seen international advances in practice and research in this field of nursing (Bomar, 2004). According to Bomar (2004: 5) “family nursing is not widely adopted” in the UK. However, Bomar does not mention the work of Whyte, who introduced family nursing and promoted its integration into Scotland’s nursing communities (Whyte, 1994; 1997a; Whyte et al., 1998; Claveirole et al., 2001; O’Sullivan et al., 2004). Whyte saw the merit of family nursing for advanced practice in different fields of nursing. That said, the
use of family nursing as a conceptual framework to guide research continues to be limited in the UK.

The common principles across different schools of family nursing thought were noted by Whall and Fawcett (1991). They regarded these as a consideration of environmental influences on family health; the effects of nurses' actions on behalf of or in partnership with families; incorporation of a holistic perspective of health; and a focus on family well-being instead of pathology. Gilliss (1991) argues that ‘family as context’, as the most common focus in nursing practice, does not constitute ‘family nursing’ because the family group is not consistently addressed throughout assessment, planning, intervention or evaluation. In recent years a degree of consensus has emerged around four approaches which can be used to describe ‘family’. Figure 2.1 below gives a summary of these classifications. It draws on widely held definitions from the literature, with sources listed in the last column of the table.
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<table>
<thead>
<tr>
<th>Approach</th>
<th>Family as Context</th>
<th>Family as Client</th>
<th>Family as System</th>
<th>Family as Component of Society</th>
<th>Family Nursing Scholars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Nursing</td>
<td>Individuals remain focus of care with simultaneous focus on the family as a whole. No distinction between foreground and background.</td>
<td></td>
<td></td>
<td></td>
<td>Hanson (2001a) Friedman et al. (2003) Bomar (2004)</td>
</tr>
</tbody>
</table>

**Figure 2.1: Conceptualisations of ‘family’ in family nursing**

The identified approaches are all referred to as ‘family nursing’ in the North American literature in column one. Columns two to five give the different conceptualisations associated with each approach. These approaches also to a large degree reflect the four models suggested for family nursing practice by the ICN (Schober & Affara, 2001). It should however be acknowledged that within the UK, two of these approaches can be considered common to nursing practice. ‘Family as context’ can be regarded as contemporary nursing practice interchangeably referred to as ‘family-
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centred care’. ‘Family as component of society’ reflects a public health nursing perspective in the UK.

Some scholars propose a three-level (Friedemann, 1989) and a five-level classification (Friedman et al., 2003). These scholars propose to differentiate between inter-personal and systems levels. However, Whyte (1994; 1997a) found some of the differentiation in family definitions too complex to be useful for practice. A clear differentiation was not possible between inter-personal and systems levels and was, therefore, less useful for practice. Whyte distinguishes only between ‘family as context’ and ‘family system’ as the unit of care. Only when assessment and intervention focus on the interaction and reciprocity between and among family members, and the family as a whole, do family nursing scholars speak of family systems nursing (Whyte, 1997a; Wright & Leahey, 2000; Friedman et al. 2003; Denham, 2003; Bomar, 2004). The methodological implication of differentiating family levels within the context of this study will be further discussed in Chapter 3, Section 3.3.3.

Conceptual frameworks in family nursing draw on nursing models, family social science and family therapy. Friedman et al. (2003) argue that while concepts were borrowed from different disciplines, family social science theories are of limited clinical application in nursing compared with family therapy theories that offer a more practice-grounded perspective. Conceptual frameworks in family nursing show an eclectic integration of borrowed theories, with systems theory exerting the greatest influence (Hartrick, 1995). It would appear that family nursing scholars constructed “frameworks of pluralistic interactions” (Mauksch, 1974: 526). This integration of borrowed theories accommodates the “continually interacting forces” within the family, among its members, and within each individual (Mauksch, 1974: 526). Indeed, some scholars (e.g. Hanson & Kaakinen, 2001; Denham, 2003; Friedman et al., 2003) emphasise drawing on more than one theoretical orientation. They argue that a broad knowledge base is required in order to accommodate family diversity, family needs and family health care practice. It is therefore incumbent upon nurses and researchers to select a conceptual framework that can guide both family practice and family research. Furthermore, these underpinning perspectives must be recognised to create coherence in professional values - values that could then shape practice and research.
A selective overview of theoretical influences discussed in the literature is given in Figure 2.2. The second column in Figure 2.2 lists conceptual frameworks in nursing which consider the family either as ‘person’ or ‘environment’ (Fawcett, 2000). A range of social science theories in family social science and family therapy were influential in the development of those integrated approaches to family health care listed in column three.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Conceptual Framework / Theory</th>
<th>Family Nursing Conceptual Framework</th>
<th>Family Nursing Assessment Model</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Framework of Systemic Organizations (Friedemann, 1995)</td>
<td>Family Assessment &amp; Intervention Model (FAIM) i.e. Family Systems Stressor-Strength Model (Hanson &amp; Mischke, 1996; Berkey &amp; Hanson, 1991)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family Health System Model (Anderson, 2000)</td>
<td>Friedman Family Assessment Model (Friedman et al., 2003)</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>Systems theory Cybernetics Information processing theory</td>
<td>Family Health Model (Denham, 2003)</td>
<td>Based on Whyte (1997a); Hanson (2001a); Friedman et al. (2003); Denham (2003) &amp; Bomar (2004)</td>
</tr>
</tbody>
</table>

**Figure 2.2: Selective overview of theoretical orientations in family nursing**

In contrast to family nursing scholars in the US who integrated a broad public health perspective (e.g. Friedemann, 1995; Hanson, 2001b; Friedman et al., 2003; Denham, 2003; Bomar, 2004), some scholars in Canada adopted a family therapy orientation into their assessment and intervention framework (e.g. Wright & Leahey, 1994; 2000) or focused on ‘health’ as the central concept (e.g. Allen & Warner, 2002; Ford-Gilboe, 2002). Their integration of structural-functional, developmental and systems theory is common to the conceptual frameworks listed in column three, albeit with varying emphasis. The combination of these three theoretical orientations offers scope to approach ‘family’ and ‘family health care’ from multiple perspectives. An exception is Allen & Warner (2002) who omitted references to structural-functional theory. From
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a ‘family nursing’ perspective all these conceptual frameworks can be referred to as ‘family-derived’.

The final column in Figure 2.2 identifies family nursing assessment models. Tarko and Reed (2004) differentiate between specific tools designed for formal and standardised processes. The former takes a quantitative approach towards measuring family coping (e.g. the Family Systems Stressor-Strength Inventory (Berkey & Hanson, 1991; Hanson, 2001b), and family assessment frameworks. These frameworks take a more open-ended, qualitative approach (e.g. Whyte, 1997; Wright & Leahey, 2000). Allen & Warner (2002) argue that assessment of family health is an exploratory interactive process between the nurse and family members rather than the measurement which the term may imply. The Calgary Family Assessment Model (C-FAM) exemplifies the exploratory nature of learning about family concerns (Wright & Leahey, 1994; 2000; Wright et al., 1996). Bomar claims as its distinctiveness the integration of “widely understood theories into a practical guide” (2004: 203). Whether the wide range of integrated theories such as general systems theory, cybernetics, communication theory, change theory, Gregory Bateson’s theory of mind, and constructivist and narrative approaches (Friedman et al., 2003), and “larger worldviews of postmodernism, feminism and biology of cognition” (Wright & Leahey, 2000: 16), can be regarded as widely understood by practising nurses is questionable. While “systems thinking”, where “objects are interrelated with one another” (Whitchurch & Constantine, 1993: 325), permeates conceptual frameworks, some reference such as “thinking interactionally” or “thinking family” (Wright & Leahey, 2000: 15) alludes to interactional theory. However, its theoretical roots and influence is rarely made explicit. Each of these theories is full of assumptions; together they combine into an eclectic, relativistic mix that may detract from its main elements. Nevertheless, the C-FAM is grounded in the clinical practice work of the ‘Family Nursing Unit’ at the University of Calgary in Canada (Tapp et al., 1997). By way of self referral, families underwent assessment and intervention for family nursing therapy. Sessions were made available as supervised learning opportunities for nursing students at undergraduate and master’s level (Bell, 2002; 2003; Moules & Tapp, 2003).

Whyte et al. (1998) also reported on the introduction of a modified family systems nursing assessment model that drew on the McGill Model (Gottlieb & Rowat, 1987), the C-FAM (Wright &
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Leahey, 1994), and the Activities of Living (Roper et al., 1996). In an action research project the assessment practice and documentation of a community children’s nursing team in Scotland was initiated. The utility of Whyte’s (1997) empirically grounded Family Systems Nursing Assessment Model (FSNAM) was thus strengthened in clinical practice.

The C-FAM is a multi-dimensional model comprising three main categories and further sub-categories. In common with other systemic and integrated family nursing frameworks it includes an ecological and developmental perspective on family. These are represented in the structural, developmental and functional domains as the main categories. Although its display may suggest the need for detailed information relating to each of these dimensions, Wright and Leahey (2000) emphasise the discretion that must be exercised by the nurse to focus on those relevant to the family situation. A further consideration is to ascertain the meanings and beliefs a family may attribute to a particular health or illness event (Wright et al., 1996). Advocating a therapeutic approach, the C-FAM places the focus on family strengths and resources rather than on deficits (Bomar, 2004). Since Wright and Leahey promote a systems approach to assessment, they recommend tools such as Genogram and Ecomap to help elicit and diagram family information about their health history within an intergenerational context and a social or environmental network of relations. Both tools are designed to illustrate the inter-relations between structural phenomena informed by systems theory. Both tools were first developed by Hartmann (1978) for social work practice and are mentioned in the ecological social work of Germain (1984) and in family therapy literature (Beauchesne et al., 1997; McGoldrick et al., 1999).

Irrespective of which family definition or theoretical orientation is considered, each conceptualisation implies an intention to interact with individual family members and the family as a group. Such intention is influenced by the nurse’s relational stance to family work (Tapp et al. 1997; Tapp, 2000). The centrality of interaction and human relationship, and the circularity in family processes, was identified in an ethnographic case study by Whyte (1994). The study explored the experience of families with a child who had cystic fibrosis. The implications of relationship work with families are echoed by others (e.g. Robinson, 1996; Leahey & Harper-Jaques, 1996; Kirschbaum & Knafi, 1996; Nolan et al., 1996; Hartrick, 1997; Nolan et al., 2003; Bryans, 2003). This relational dimension in the assessment of family health needs therefore
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cannot be ignored. For this reason, Wright & Leahey’s C-FAM was deemed useful in structuring some of the key concepts and multiplicity of factors that are likely to feature in a family health assessment (see below Section 2.4), indicating its utility as an open-ended, exploratory framework within the context of this enquiry.

While theoretical orientations in family nursing provide useful guidance for research, they may encourage an over-theorised approach. Several nursing scholars caution against a systems approach as it may negate the perceived experience from the family perspective (Gilliss & Davis, 1992; Anderson & Tomlinson, 1992; Hartrick, 1995; 1998a; Hall, 1998; Hall & Callery, 2003; Friedman et al., 2003). Some scholars also offer alternative perspectives to systems thinking for nursing work with families (e.g. Hartrick et al., 1994). Gilliss and Davis (1992) argue that the premise that family members exert a systemic influence of change on each other remains an assumption. From the examined family nursing literature it can be concluded that ‘family’ and ‘family nursing’ are concepts full of ambiguity and inconsistencies. In response to these caveats, careful consideration will be given in Chapter 3 to the selection of an appropriate theoretical framework to shape this study’s design. Despite the potential limitations of a specific theoretical approach, Gilliss (1991: 21) regards theoretical and empirical work that addresses nurse and family together as a key factor in contributing to the advancement of the science in ‘family nursing’, a field of practice later termed ‘family health care nursing’ (Hanson, 2001a). This study aims to make a contribution to its advance.

2.4 HEALTH NEEDS ASSESSMENT WITHIN A FAMILY CONTEXT

Anecdotal and theoretical literature abounds on family assessment as shown above. Studies that focused on the assessment of a family’s health as a group of people within a primary health care setting could not be located. The literature search resulted in a substantial range of studies that examined the impact of health needs and care issues on specific family members. This confirms the interdependence and interaction between ‘health’ and ‘illness’ on individuals and other family members. Studies examined predominantly the identification of carer roles, perceptions and experiences. From a survey of self-identified carers, Jarvis (2001) concluded that unacknowledged care given by family members may go unnoticed in assessments. The significant role played by family carers was confirmed by Young (2003) in a study into district nursing practice.
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Studies examining health visiting practice focused on parent perspectives, participation, and exploration of health needs and/or individual family members’ interaction (Kendal, 1993; Carney et al., 1996; Hogg & Worth, 2000; Worth & Hogg, 2000; Peckover, 2002; Mitcheson & Cowley, 2003; Bryans, 2003). Others identified the prevalence of individually-focused models in health visiting practice (Elkan et al., 2000). Bryans (2003: 16) differentiated between a “problem-orientated approach” associated with the “disease model/cultural behavioural” perspective, and the “relationship-centred approach” linked with the “empowerment/client participation” approach. From these studies it can be concluded that assessment based on an individual that fails to include a collective perspective may limit the community nurse’s understanding of family phenomena. A full understanding of the reciprocal interaction between family members and their health may be compromised without conceptual distinction between ‘individual’, ‘client’ or ‘family’. Some regard the insufficient conceptual distinction as placing a limit on methodological developments in nursing research (Moriarty, 1990; Gilliss, 1991; Ganong, 1995; Robinson 1995; Bell et al., 2000; Ganong, 2003). While an individual client may contribute to an understanding of the relational properties between family members, a “one-informant approach” (Uphold & Strickland, 1989: 407) may be insufficient to meet the needs of those who manage long term or palliative care, or disability demands, at home.

Depending on the field of practice, a commonly used term is ‘carer’ and ‘household’ in the UK. These definitions describe family members and their role in a professionally constructed manner as a ‘resource’ or as ‘co-worker’ (e.g. Twigg et al., 1990; Ellis, 1993; Nolan et al., 1994; 1996; 2003; Worth, 1999; Nolan & Lundh, 1999; McGarry & Arthur, 2001; Jarvis, 2001; and Pickard & Glendinning, 2002). Whereas in this body of literature ‘family’ is not specifically defined, the recipient of intervention is a group of people who could be defined “as a unit of care” (Gilliss, 1989b: 7; 1989b). Moreover, from a professional perspective a distinct nursing orientated definition is required within a multi-agency environment. Worth (1999: 249) cautions against “universally similar assessments” such as the ‘Joint Assessment’ as it may devalue each professions’ contribution to holistic needs assessments. Worth highlights the need for, and influence on, research into assessment practice in district nursing. Nolan et al. (1994: 18) consider “holistic” as having to include the ‘carer’ for a comprehensive assessment to be meaningful. Without a suitable conceptual frame, however, ‘carer’ and ‘cared-for’ may not be assessed as an interacting ‘unit’. Their interdependence in family life may not be fully recognised, - despite an
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acknowledgement of their individual needs and that of their wider social network. These networks have been identified as having "structural properties" (Nolan et al., 1994: 27 (bold in original)). Therefore, an assessment framework that helps identify some of these structures is relevant.

Nolan et al. (1994: 3 & 19) highlight the interpersonal nature of assessment as a process that goes beyond a one-off event, with interaction central to its function. Consequently, this calls for the investment in the individual self by both nurse and family members. This engagement involves their beliefs and values. Indeed, the value-orientated nature of assessment was confirmed by Ellis (1993) and in a large scale multi-site study by Grant et al. (1998). Nolan and associates also emphasise the evolving nature of the carer and cared-for relationship. They caution against a chiefly instrumental assessment focus. Developmental transitions that occur within and alongside individual and family life cycles also impact on health and illness experiences, however (Rolland, 1989; McGoldrick & Gerson, 1989; McGoldrick & Carter, 2003).

In a naturalistic multi-method design Bryans (1998; 2000a&b) explored the type of knowledge and use of skills by district nurses in patient assessment. Methods included two simulated patient cases. Within a simulated environment a district nurse’s assessment was audio-recorded, followed by a post-simulation, focused interview. The sample comprised two groups for the two cases – one of twelve nurses, the other of eight. Interactions were video-recorded to ensure consistency of patient simulation. Each case involved construction of a credible scenario simulated by a professional performer. Validity was enhanced by five real-life follow-up visits using a theoretical sample of about a third of the district nurses. Interaction was initially content analysed. Bryans then developed a modified ethnographic, contextually orientated, conversation analytic procedure based on Peräkylä & Silverman (1991). Bryans made possible the sequential and contextual nature of simulated interactions. Emerging patterns were described and explained using comparative case study analysis across multiple data sets. Findings confirmed the presence of both problem-orientated and relationship-centred communications. Bryans argued for this method to be extended to other assessment contexts where more than one visit would enhance transferability of findings. She acknowledged “the ‘one-shot’ simulation method” as a limitation,
as it may not present the full range of knowledge and skills embedded in assessment practice (Bryans, 2000b: 88).

Bryans (2003: viii) used a similar design within health visiting assessment practice. The number of home visits that followed, however, was not reported thus limiting the strength of findings. Bryans used a convenience sample of 15 health visitors. Rigour was supported by triangulation of methods such as multiple sets of simulation data with field data. Illustrative case studies were developed in support of the synthesis of findings. The finding relevant to the context of this study is that effectiveness of home visits is enhanced by a recognition of clients’ psychosocial needs. Bryans confirmed the varied, complex and shifting needs of individuals, and the “reflexive-interactive approaches that weave between different areas of client need”, created a therapeutic effect (Bryans, 2003: viii). She recommended identification of the longer-term implications of reflexive-interactive approaches.

Bryans’ studies contributed to an understanding and explanation of the assessment process of district nurses and health visitors within a largely simulated environment. Given the nurse – patient dyad in the studies, findings may not be relevant to family or household situations with multiple members. Nor did they take account of the dynamics within a family. Interaction processes in family environments are not easily contained; they are lively and unpredictable (Hall, 1998). Examining a family-focused orientation in assessment would provide a different perspective on interaction processes. Such a focus would give a fresh insight into the range of communicative behaviours necessary for assessment practice.

An ethnographic study by Kennedy McAuley (2000) examined the nature and use of community nurses’ knowledge relating to their decision making during a first assessment visit. An exploratory, interpretative approach with a purposeful sample of 11 district nurses was used. Home visits were observed and the nurses’ perceptions were sought directly after each visit and one year later. Data was analysed using the constant comparative method. Kennedy McAuley attempted to apply Friedemann’s (1995) family levels to interpret the district nurses’ assessment focus, and developed an explanatory typology of district nurses’ knowledge. A methodological definition of
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‘family’ was not given, however. The same study is reported as having used a convenience sample of assessment visits which suggests an element of selection bias (Kennedy, 2002). No indication is given of how families were recruited for participation. Although verbal consent was sought at the start of the visit, written consent was gained from “the patient” at the end of the visit (Kennedy, 2002: 714). Although the presence of family members and their impact on interactions is reported, it is not clear whether consent was sought from every household member (Kennedy McAuley, 2000). Inconsistencies in the reporting of this study raise questions about reliability and validity. Despite these limitations, findings are reported to have revealed “the importance of the role and contribution of the family to the care of the patient and the complex family dynamics within which the DN has to work” (Kennedy McAuley, 2000: 244). Kennedy (2002) acknowledged that data collection was restricted to only a first home visit. She recognised this as a limitation.

The studies by Kennedy McAuley (2000), Bryans (2000a&b; 2003) and Kennedy (2002) highlight community nurses’ assessment practice and experience from a professional perspective. But these studies are of a limited usefulness in providing an in-depth understanding of reciprocal interactions from multiple perspectives in nursing work with families.

Sedden & Robinson (2001) conducted a mixed-method, multi-site study on the perspectives of senior managers, case managers undertaking assessments and service users’ experiences of this process. The sample included social workers and health professionals. Methods included telephone interviews with senior managers, 32 semi-structured interviews with case managers and in-depth semi-structured interviews with 64 carers of older people with dementia. Their accounts were not sought immediately after the assessment visits, though, and triangulation of methods is only implied. Latent content analysis was applied to the qualitative data. Access was not given to qualitative data excerpts or to quantitative analytic procedures raising questions about the validity of the findings. Findings cannot be differentiated according to represented professional groups which limits their usefulness as a way to inform community nursing practice. The carers’ experience was based on individuals’ accounts. Given the interdependence between the cared-for person and other family members, a carer experience becomes a family concern with subsequent health implications. Consideration of different family members’ perspectives would further the understanding of family health needs.
Carney et al. (1996) explored methods of needs assessment in health visiting to inform policy requirements for population-based needs assessment. The study identified the problem of defining ‘need’ as a socially constructed phenomenon. Need is seen differently by patient or professional. An assessment may reveal a need, but may not be acted upon because of resource constraints. As Carney et al. (1996) pointed out, it raises expectations which health professionals may be unable to meet. The data revealed health visitors’ professional activities with family members who were not considered as the client. Despite this element of their work, it was not made explicit. The implications of this study are that health visitors’ interactions with family members remained invisible, with interactions lacking in evidential support.

While the above studies investigated the assessment process and experience of nurses/health professional and carers, none attempted to include the perceptions of the family as a whole. The interchangeable use of ‘family carer’, ‘client’ or ‘patient’ limits conceptual understanding and blurs the complexity of the assessment process. Moreover, the lack of a theoretical family-derived framework in these studies hampers the formation of a theoretically informed and structured health assessment, led by nurses and involving family members. The review further identified a serious gap in knowledge namely: how the needs and concerns of the family as a group of interdependent people are taken into account. The studies reviewed above provide a strong rationale for focusing on interaction in the assessment process, and for examining the perceptions and experiences of the community nurse and the family.

### 2.5 KEY CONCEPTS INTEGRAL TO THE STUDY

Informed by the literature, key concepts can now be defined which will be integral to this study.

*Community nurse* referred to “a professional who has a mandate to provide care in the community” (Kelly & Symonds, 2003: 113). Since *community nurses* may have different backgrounds and remits, the following assumptions were made:

- the *community nurse* may have a generalist or specialist role
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- the role may include primary health care assessments and interventions that are time bound
- the community nurse may attend to health care needs associated with illness episodes for previous secondary or tertiary care provision.

*Family* was defined as a whole comprising at least two or more individuals living in a household (Moriarty, 1990; Bengtson et al, 2005) and “joined by affectional bonds, the influence of which may fluctuate with time and circumstances but which persist through the life span. Family membership is mutually defined and includes elements of shared beliefs, emotional, social, physical and economic support.” (Claveirole et al., 2001: 1142).

*Family health assessment* was defined as a process that considers the reciprocal interaction of biopsychosocial and contextual phenomena, and the interrelationship between and among family members, the family group/system and the environment (Hanson, 2001b). It was assumed to involve three central categories identified in Wright & Leahey’s C-FAM (2000) as concerns about family structure, family function and family development.

*Relational stance* referred to intentions and values which were brought into family work that manifesting themselves in communicative behaviours. A relational stance can be defined as an orientation that acknowledges family strengths through purposeful communicative behavior (Tapp, 2000). While commending family members and acknowledging their contribution, it may also confirm their roles and actions and create a growth-promoting climate of interaction (Wright & Leahey, 2000; Walsh, 2003).

*Listening* referred to gaining an understanding about a family’s concerns and discovering valuable information about their health matters. As an empirically grounded concept, listening is a constitutive element of Whyte’s Family Systems Assessment Model (Whyte, 1997a). It is seen as a prerequisite for nursing work with families and is fundamental to assessing their needs. According to Allwood (1976) listening is an actual intention which confirms ‘the other’ in conversation. This listening may or may not be associated with a vocalic behaviour as a sign or signal.
Communicative behaviour such as linear questioning was defined as a way to seek family information (Wright & Leahey, 2000). Linear questioning is a linguistic strategy within and for a given context and purpose and is therefore a communicative transaction relating to pragmatics, a branch of linguistics (Habermas, 1984[1981]; 1987[1981]). Pragmatic here means the behavioural effects of human communication or action (Watzlawick et al., 1967).

It was assumed that family and family health assessment might be conceptualised differently by individuals. Relational stance, strength focus and commendations were defined as intentions and values contributing to the relational dimension that might be part of the assessment process. Relational dimensions were likely to be culturally bound. Listening was assumed to be displayed by the nurse.

Finally, from the start of the study, it was assumed that the community nurse and the family would explore health needs and concerns co-operatively. The community nurse’s concern for the family as a whole was regarded as being their key consideration.

2.6  KEY POINTS DRAWN FROM THE REVIEWED LITERATURE
The policy review has given a background to the issues by which community nurses and family health care continue to evolve. Influenced by policy and legislative frameworks, the ‘family’ has been recognised as an indispensable partner for promoting health at international and national level. Community nurses are seen as being well placed to promote such re-positioning.

Role developments of community nurses and mutual partnerships with families are encouraged, making both indispensable in order to take the new health agenda forward. Family health assessment is foundational to care giving in this area of practice. The widely espoused model of ‘holistic nursing care’ and ‘family-centred care’ as global descriptors may obscure the many dimensions and competing perspectives inherent within the terms ‘family’ and ‘family health care’.
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There is a lack of research informed by a family-derived theoretical framework, which limits the advancement of a theoretically informed and structured health assessment necessary for the understanding of the interdependent nature of ‘individual’, ‘family’ and their collective health care needs, in order to promote community nursing practice development. A wealth of theoretical family orientations based on systems theory can be located in the literature that ascertains these orientations. Nurse and researcher are required to select a professionally coherent conceptual framework in order to address the needs for assessment practice or research. The wide disparity within conceptualisations makes it necessary to ascertain and provide evidence of the utility of a particular direction offered in family nursing. It is also necessary to be open to alternative perspectives other than those derived from systems theory.

Community nurses’ contributions in their various roles when approaching and assessing relational groups such as families is not well understood. Such understanding requires an in-depth examination of the perceptions, experiences and interactions of those involved in family health care. Therefore, the central question guiding this study is:

*How is family health assessment in different fields of practice conducted, perceived and experienced by the community nurse and the family?*

**SUMMARY**

The examined literature provided a health care policy context from the family and the nurse perspective. The complexity in attempting to conceptualise approaches to family health care was discussed. Current theoretical and empirical knowledge was critically reviewed. Key concepts integral to the study were defined. The review contributed to a thorough understanding of the research problem summarised in key points. The central research question now gives further direction to the selection of theoretical and methodological approaches, which is the focus of the next chapter.
3 THEORETICAL AND METHODOLOGICAL ISSUES

INTRODUCTION
In this chapter theoretical and methodological issues are explored. Some reflexive commentaries weave throughout the discussion. Ontological and epistemological assumptions are briefly outlined. The discussion begins with a critical examination of an alleged constructionist tradition in nursing research. The argument continues by focusing on the relevance and implications of constructionism to this study. The relevance of interpretivism and symbolic interactionism as the selected theoretical perspectives guiding the study are then examined. This is followed by consideration of the limitations of symbolic interactionism and its implications for this enquiry. Theoretical perspectives which commonly inform family research are briefly addressed. The relevance of general systems theory and the importance of differentiating between social systems are examined, with their implications for conceptualising ‘family’. The discussion finishes with remarks on the limitations of family systems theory and its methodological implications for this case study.

3.1 ONTOLOGICAL AND EPISTEMOLOGICAL ASSUMPTIONS
This study aimed to gain an in-depth understanding of family health assessment, and the perceptions, experiences and interactions of community nurses and families, as well as the usefulness of a family-derived theoretical assessment framework. To meet these aims, options in design and methods needed to be considered and the choices justified. Making such decisions is based on judgments which are grounded in assumptions and beliefs. The perception of reality and the building of knowledge can be approached from different value positions, with implications for the conduct of an enquiry. Therefore, the ontological question of “what is” the nature of reality and the epistemological concern of “how do we know what we know” needs to be considered before addressing the question of how to proceed (Crotty, 1998: 8) (italics in original).

Assumptions made in this enquiry were concerned with meaning and action, social concern and social good, and the promotion of knowledge and human interest. These concerns are grounded
in pragmatism, where belief and thought derive their significance from their actualisation based on rationality, assumptions and common sense (Hammersley, 1989; Reynolds, 1990; Maines, 1997; Kasper, 1999). A further belief is that knowledge is grounded in experience and is actively created by people to give meaning to their lives, that are lived out in practical contexts (Hammersley, 1989; Reynolds, 1990; Habermas; 1999; Rose, 2002[1962]; Stryker, 2002). An epistemology grounded in pragmatism is concerned with the solution of practical problems; the consequences of action; and the good that satisfies an interest - a stance suggested that seemed relevant to this study.

### 3.1.1 Constructionism
Ontological and epistemological assumptions grounded in a pragmatist orientation show a striking affinity with ‘constructionism’, where ‘reality’ is viewed as subjective and claims about knowledge relative. Viewing reality as emerging and created in interaction acknowledges the intersubjectivity between individuals, their embedded values and their collectively generated meanings (Berger & Luckmann, 1991 [1966]; Burr, 1995; Crotty, 1998; Habermas, 1999; Denzin & Lincoln, 2000; Flick, 2004). Weinberg (2008) traces pragmatism as one of constructionism’s evolutionary milestones and cautions the avoidance of a narrow or misplaced interpretation. Best (2008) traces the notion of ‘social construction’ to the work of Berger and Luckmann (1991 [1966]). Von Glaserfeld (1984; 2005) argues that the term developed from learning theories, Jean Piaget’s theory of cognition in particular. Here, knowledge is built from assimilation and accommodation of perceptual experience into conceptual schemes (Demetriou, 1998). Learning, knowledge development and interaction, however, depend on language (Bernicot, 1998; Habermas, 1999). The construction of meaning through language as a mediator for social interaction, emphasising its collective nature, is defined as ‘constructionism’ by Crotty (1998). This definition was adopted as fitting for this thesis since meaning was assumed to be constructed by and shared among the nurse, the family and the researcher.

### 3.1.2 Constructionist Research in Nursing
In nursing, constructionist research was influenced by Lincoln and Guba (1985). They discussed the ‘naturalistic paradigm’ as a particular strand of qualitative research, as opposed to the
‘positivist paradigm’. Lincoln and Guba rationalised ontological, epistemological, and methodological, as well as value, assumptions based on the dualist position of each paradigm. Lincoln and Guba (1985) and others (e.g. Erlandson et al., 1993; Appleton and King, 1997) regarded a ‘naturalistic inquiry’ as a qualitative approach unlike any other. In their later work, however, Guba & Lincoln (1989) concede that a broader paradigmatic orientation underpins this approach, they refer to it as “co-operative inquiry” (1989: 39) because an interpretive hermeneutic perspective is combined with an empowerment and change perspective. This emancipatory notion which Guba and Lincoln associate with a constructionist inquiry, however, is commonly associated with critical theory. Critical theory originated in the Frankfurt School (Weinberg, 2008). Drawing on such an approach confirms the influence of Habermas on Guba and Lincoln’s methodological thinking (Denzin, 1989: 69). Habermas’ (1973[1968]) classification was not dichotomous, however. He distinguished between the positivist empirical, the interpretive hermeneutic and the critical theory paradigm, each generating different types of knowledge: instrumental, practical and emancipatory.

According to Melia (1997), expertise in qualitative research in nursing was relatively limited until the 1970s. In qualitative research, the subjective experience of individuals, the context of their activities and the holistic nature of phenomena are respected (Schwandt, 2000). Understanding can thus be inferred from observation and interaction with members in the field (Atkinson & Housely, 2003). Qualitative research has since flourished and qualitative research methodologies abound, with an array of possibilities and a methodological literature full of often controversial debate (Hammersley, 2007). Distinguishing between ‘constructionist research’, ‘social construction’, and ‘critical traditions’, therefore, is of epistemological and methodological relevance in nursing research.

A constructionist paradigm can be regarded as appropriate where multiple perspectives could and would be recognised, due to the emphasis on dialogue. Constructionism was used in family therapy (e.g. Anderson & Goolishian, 1992; Becvar & Becvar, 1996) and social work (e.g. Rodwell, 1998; Gitterman & Germain, 2008). Duhamel and Talbot (2004) adopted a constructionist approach towards the development and evaluation of family systems nursing interventions. Here,
Chapter 3 Theoretical and Methodological Issues

nurses and families were regarded as co-researchers, justifying their research as participatory while drawing on Guba and Lincoln’s (1989) notion of ‘co-operative inquiry’. Ramjan (2003) followed Erlandson et al.’s (1993) constructionist research paradigm, which was also informed by Guba and Lincoln. Davies (2001) combined a constructionist methodology with grounded theory to explore the experiences of family caregivers when helping a relative to move into a nursing home. Varcoe et al. (2004) took a constructionist approach to the exploration of the meaning and enactment of ethical practice in nursing. A social constructionist framework, combined with a critical discourse analytical approach, was adopted by Schofield (2009). While nursing research largely takes a phenomenological, grounded theory or ethnographic approach (Latimer, 2008), over the last decade nursing scholars have begun to adopt critical theory or discourse analytic approaches (e.g. Kendal, 1991; Foulton, 1997; Gilmour, 2002; Darbyshire & Fleming, 2008).

Latimer (2008) traced historical developments in nursing research during the 1980s that supported its socially constructed nature. She cited literature to demonstrate that interpretive and phenomenological approaches dominated nursing research in the 1990s, followed by an evolving trend that was grounded in critical traditions. Latimer’s cited literature, however, would support the point made above of the need to distinguish between epistemological premises that inform methodologies. From a consistent constructionist perspective all understandings are constructions; it follows therefore that any conceptualisation can be regarded as construction (Crotty, 1998). Not every constructionist study, however, is necessarily radical or critical in a political sense, although Hacking (1999) argued that in constructionism the status quo is questioned. Latimer refers to developments in constructionist research in nursing as this “emergent tradition” and as “critical constructionism because it makes issues of power explicit and at the same time its protagonists are not simply applying methodologies derived from elsewhere” (Latimer, 2008: 156 (italics in original)). This view can be challenged. The critical traditions, including constructionism, have sociological and philosophical roots. From Latimer’s (2008) discussion, it is also not clear whether the cited empirical literature is, indeed, epistemologically grounded in constructionism or to what extent this ‘novel’ term is used retrospectively as a strategy to erect “disciplinary borders” and “distancing definitions” (Buus, 2005: 28). In addition, a distinction is not made between a ‘structuralist’ and ‘poststructuralist’ paradigm which would impact on interpretive methodologies. For example, Rodwell (1998: 23) differentiates between a
radical change dimension in constructivist research and a paradigmatic and methodological perspective. Therefore, it is perhaps more fitting to speak of a ‘transition’ in nursing research, when nursing scholars began to recognise the importance of giving voice to their central concern – their patient population. This may then include questioning practice. Such recognition would call for action with all its ethical and political implications. It would require the valuing of multiple perspectives and of not giving undue weight to one paradigm over another, while being explicit about epistemological and methodological implications that derive from a particular approach.

3.1.3 Implications of a Constructionist Approach for This Study

A constructionist approach allowed for multiple perspectives and realities within contexts to be taken account of, while acknowledging the interaction between participants and researcher. As researcher, I was interactively positioned in the participants’ world. Their voice had to be heard as well as mine (Charmaz & Mitchell, 1996). This called for negotiation and co-construction (Charmaz, 2006) - concerns neither reducible to separate entities, nor absolute. Instead, I saw them as interconnected phenomena that were value laden, representing relational human purposes in need of interpretation. The research phenomena needed to be understood as a whole, with participants’ perspectives explored and interactions examined in their social settings (Berger & Luckmann, 1966; Newman, 1995; Searle, 1995).

Charmaz (2000: 523) regarded social phenomena as “human realities” which carried symbolic meanings of peoples’ real worlds. In this sense, ‘reality’ becomes a matter of perspective and meaning; an objective and subjective experience, both of which are “insolubly bound up with each other” (Crotty, 1998: 48). The ‘subjective’ experience of participants must be respected as their ‘objective’ meaningful reality. By implication this called for an ethical and relational stance that regarded both the nurse and the family as experts within their own experience. This mind-set of abandoning the professional expert stance is promoted in the relational practice framework of family nursing by Hartrick Doanne and Varcoe (2005) including others e.g. Tapp (2000), in family therapy by Walsh (2003), and in social work research by Rodwell (1998); a mind-set congruent with my own values. My efforts were reflexively grounded in a caring concern for those who might be affected by my intentions, and the nurse-family encounter mediated by language and
interaction between and among participants and myself. Therefore I regarded a constructionist epistemology and a theoretical perspective grounded in interpretivism and informed by symbolic interactionism, as the most fitting. While my position was influenced by the current body of knowledge in family research that owes much to systems theory, drawing on these theoretical perspectives was helpful for the conceptualisation of this study.

3.2 THEORETICAL PERSPECTIVES GUIDING THE STUDY

The use of theory in research may differ depending on its purpose within the context of a particular study. Theory helps to frame the research process; it may be used for explanation, orientation or theory may be built (Creswell, 2009). It justifies the context and process of a particular methodology (Patton, 2002). Others refer to it as a conceptual structure of “a set of loosely connected assumptions and abstract concepts that helps us to understand a particular phenomenon” (Dilworth-Anderson et al., 2005: 36). Each definitions draws a useful boundary around the concept of ‘theoretical perspective’ relevant to this study.

3.2.1 Interpretivism

Interpretivism is a theoretical perspective grounded in a subjectivist-constructionist epistemology to understand and explain human and social reality, by filtering what (and how) phenomena are viewed to make sense of them (Crotty, 1998; Charon, 2007). Weber (1968) emphasised the need for Verstehen or ‘understanding’ and valuing the “individual (idea)” within an interactive context (Crotty, 1998: 67). This ideographic orientation is frequently taken in the social sciences when an interpretivist approach is adopted, a trend that can also be seen in nursing research discussed earlier. A different purpose is commonly pursued in the natural sciences, where the emphasis is on finding and explaining consistencies or “law-like (nomos)” regularities (Crotty, 1998: 67). Thus nomothetic rather than ideographic concerns are referred to, an important distinction that must be borne in mind when design choices and procedures are selected.

Weber (1968) argued for the need to verify interpretations by bringing ideographic and nomothetic principles together to promote rigour in scientific research. Throughout this study, it
was essential to differentiate between the principles of Verstehen, ‘understanding’, and Erklären, ‘explaining’, to allow me to take theoretical, methodological and analytical decisions. ‘Understanding’ was required for each case, while analysis across cases held the prospect of ‘explaining’ phenomena. Perspectives such as phenomenology, hermeneutics and symbolic interactionism are all grounded in an interpretivist tradition, but each has distinct methodological implications (Patton, 2002). Symbolic interactionism offered the best fit with both the study’s aims and its research question.

### 3.2.2 Symbolic Interactionism

Symbolic Interactionism (SI) assumes that people interact with each other reflexively, by symbolic means. The perspective’s central assumptions are attributed to social psychologist George Herbert Mead (Rose, 2002[1962]). Both Mead and Blumer, his student who coined the term SI, took a subjectivist orientation towards knowledge development associated with the North American Chicago School (Blumer, 1969; Rose, 2002[1962]). A more objectivist and empirical stance was adopted by the Iowa School, which explains its lack of a unified theoretical perspective (Denzin, 2004).

One of the SI perspective’s main premises is that interaction takes place largely via language, which helps align individual intentions for the purpose of co-operative action (Denzin, 2004: 81-82) - a concern that corresponds with pragmatism (Hammersley, 1989; Reynolds 1990; Maines, 1997; Charon, 2007). Action, interaction, perspectives, societies, definitions, symbolic communication, mind and self are defined socially and become meaningful in an unfolding, dynamic process (Charon, 2007). Proponents emphasise its instrumental and rational approach; they regard all human behaviour as culturally defined social interaction between elements of human nature and the environment (Blumer, 1969; 1972; Reynolds, 1990; Crotty, 1998; Stryker, 1981; 2002; Rose, 2002[1962]; Charon, 2007). More recently, the narrative ‘turn’ has been adopted in interactionist research, where people are invited to relate experiences of their social world (Denzin, 2004). The emphasis is either on the reflexive account of individuals joined in action and in situated contexts, or on the discursive narrative constructed from sometimes competing perspectives. Phenomena are approached by questioning how is an “experience
structured, lived and given meaning”? (Denzin, 2004: 83). Biographic and historical traces of people in interaction therefore cannot be ignored. Since symbolic interactionism makes certain assumptions about the constant interaction between ‘society’, the ‘self’ and the ‘mind’, it is important to identify these concepts more clearly (Charon, 2007). The summary below is based on Meltzer’s (1972: 4-22) account that explains Mead’s central ideas. In an attempt to make the complex nature of interaction symbolically visible, Meltzer’s version of SI is represented in Figure 3.1 as a flow chart of processes in ‘society’.
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Conceptualisation of Society in Symbolic Interactionism

Society

Symbolic Interaction

co-operation
individual's intention

ascertaining
imagining
responding to acts of the other

association
individual's intention

GESTURES AND LANGUAGE

SIGNS
intrinsic meaning
induces direct reaction
tied to immediate situation

SYMBOLS
arbitrary meaning
requires interpretation
transcends the immediate situation

CONSTRUCTION OF THE SOCIAL ACT
The self
The other
The generalised other

SIGNIFICANT
completing
role taking
meaning making
incorporating
communicating

Based on Meltzer (1972: 4-22)

Figure 3.1: Flow chart of a symbolic interactionist representation of ‘society’

Society

Symbolic interaction occurs in society through co-operation and association. In Figure 3.1 each arrow represents an individual’s social interaction, which requires each individual’s intention. This may happen through ascertaining, imagining and responding to the acts of the other by gestures.
Chapter 3 Theoretical and Methodological Issues

and language. Gestures are signs with intrinsic meaning which induce direct reaction and are tied to the immediate situation. Symbols, such as language, have arbitrary meaning. They require interpretation and transcend the immediate situation. Symbols are also significant in their meaning. Ascertaining the significance of symbols depends on the mental activities of completing, role taking, meaning-making, incorporating and communicating verbally and non-verbally. The social act is constructed from signs, gestures, language and the interpretation of significant symbols. In this ongoing process the ‘self’, the ‘other’ and the ‘generalised other’ develop and their shared meanings unfold.

My interpretation of society’s symbolic interaction is that this process is maintained through history, emerging anew in the present, and continuing into the future. The arrows with a broken line symbolise this recursive return to society. The diagrammatic illustration of these processes conveys their inherent circularity.

The Self
Symbolic interaction also takes place within the ‘self’ and the ‘mind’. An illustration of Meltzer’s (1972: 4-22) interpretation of Mead’s concepts and its interrelated process is depicted in Figure 3.2. Conceptualisation of the internal process within the ‘self’ is shown on the left of the flow chart.
Conceptualisations of Self and Mind in Symbolic Interactionism

Symbolic Interaction

THE SELF  interact  THE MIND
may respond to own gestures & actions – meaning making
formed through definitions made by others - interpreting
through role taking – associating - empathising

THE MIND
develops alongside with the self
self in action
emerges out of communication
manifests through symbolic interaction with self

‘ME’ symbolic interaction as meaningful behaviour with self
calls for continuous adaptation of behaviour to an environing field
all behaviour involves selective attention and perception
perception involves selective behaviour to certain aspects of a situation

‘I’

MINDED BEHAVIOUR

internal conversation as meaningful behaviour with self
abstract thinking – reflective thinking
mind maintains and adjusts the individual

Based on Meltzer (1972: 4-22)

Figure 3.2: Flow chart of a symbolic interactionist representation of ‘the self’ and ‘the mind’
The ‘self’ develops by responding to one’s own gestures and actions and is formed through definitions made by others and role taking. Meaning making, interpreting, associating and empathising unfolds in interaction between the developing ‘self’ and the development of ‘role taking’. This internal interaction is represented by a broken line. The process is mediated through language, significant symbols, learning and the internalising of definitions. By visualising intentions and expectations the ‘self’ begins to abstract a ‘composite’ role for building up the ‘generalised other’. In a process of organised and socialised behaviour, and the mutual relationship between the individual and society, an internal conversation emerges between the ‘I’ and the ‘Me’. The ‘I’ is seen as impulsive, creative and gives propulsion. The ‘Me’, associated with socialised normative behaviour and conformism, gives direction. The internal conversation between the ‘I’ and the ‘Me’ draws forth abstract or reflective thinking. It may, thus, lead to consciousness and reflexive intelligence. Since the ‘Me’ gives direction, construction of the ‘act’ leads to minded behaviour.

The Mind

The ‘mind’ develops alongside the ‘self’ and is therefore placed next to the interaction process, taking place in the ‘self’ (see flow chart right above). It is the ‘self’ in action that emerges from communication and manifests itself through symbolic interaction with the ‘mind’. This symbolic interaction is meaningful behaviour with the ‘self’, in internal conversation with the ‘I’, a process shown as two parallel arrows similar to the interaction taking place within the ‘self’. Meaningful behaviour with the ‘self’ calls for continuous adaptation of behaviour within an environment. All behaviour involves selective attention and perception. In turn, perception involves selective behaviour in certain aspects of a situation. Since the resulting minded behaviour involves the aforementioned processes for meaningful behaviour with the ‘self’, the arrows are now bi-directional to show their recursive nature. Minded behaviour - the construction of the ‘act’ - is directed by the ‘Me’ while the ‘mind’ maintains and adjusts individual action. In my interpretation, these processes cannot be regarded as uni-directional; they convey a recursive flow.

Blumer (1969) conceives this interaction as jointly and reciprocally proposed and established within social relations through the symbolic meaning given to social action, processes that require
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reflexivity. They appear interrelated and seem to have a circular rather than a linear flow. This is echoed in Meltzer’s (1972) premise that ‘mind’ enables ‘society’ to exist; ‘society’ depends on consensus to exist; and consensus entails minded behaviour. This interaction depends on “a complex interpretive process” that “shapes the meanings things have for human beings” and is thus “anchored in the cultural world” (Denzin, 2004: 82). Given these assumptions, people who do things together need to be studied in their natural settings to better understand individuals as they go about their everyday activities. From a symbolic interactionist perspective, therefore, I viewed the construct of ‘family health assessment’ as a complex, interrelated and interpretive process. Participants’ experiences and interactions required an in-depth understanding.

3.2.3 Limitations of Symbolic Interactionism

Meltzer (1972) argued that many of Mead’s concepts are ambiguous, inconsistent and vague. Dilworth-Anderson et al.’s (2005: 36-38) argument supports Meltzer’s assertion as they define SI as a descriptive, holistic perspective grounded in contextualism that is comprehensive, but lacks precision. The lack of explanatory value in Mead’s theoretical notions is also regarded as limiting, as their focus is on process rather than content (Meltzer, 1972). Some of these limitations, however, can be regarded as strengths as their indeterminacy acknowledges the emergence, and transience, of communication and action in a given situation.

While consideration of the affective and the subconscious domain in human conduct is seen by some as missing (e.g. Prendergast & Knotternus, 1990), the difficulty in operationally defining and empirically testing some of its key concepts is noted by LaRossa & Reitzes (1993). They also cite its potential lack of methodological rigour. Indeed, Denzin (2004) acknowledged the degree of theoretical diversity which resulted in methodological confusion. Moreover, LaRossa & Reitzes question the extent to which people are actually in control of defining a situation and are free to respond autonomously without regard to structural and political dimensions. For example, Prendergast & Knotternus (1990) refer to the perspective’s astructural bias. They argue that structural elements such as environmental factors that impinge on interaction at a micro level tend to be excluded in symbolic interactionist research and explain this as being due to a traditional adherence to indeterminacy and fluidity in an interaction-centred perspective.
A structural bias is seen by Prendergast and Knotternus (1990) as limiting the scope of SI, especially when power and control impinge on interaction at an ecological level. However, phenomena of power and social control seen as “forms of human activity” (Maines, 1997: 2) featured in much of the empirical work of interactionist sociologists (Reynolds, 1990; Dennis & Martin, 2005) and emerged as empirically grounded in interactionist research (Dennis & Martin, 2005).

Given the above, an awareness of the limitations of an interactionist perspective is important for family research in nursing. Moreover, as Latimer (2008) suggested, taking account of these interactive power dynamics in health care research is worthy of consideration. Given the strengths and limitations of SI, its implications for this study need to be examined.

### 3.2.4 Implications of Symbolic Interactionism for This Study

A symbolic interactionist perspective has informed much family research in the field of family sociology and family therapy (LaRossa & Reitzes, 1993). In nursing, studies which take an explicitly symbolic interactionist approach seem relatively rare (Benzies & Allen, 2001). Some studies make a fleeting reference to SI due to its affiliation with grounded theory (Cowley, 1991; Kean, 2007), or refer to it as a general interpretive approach (MacVicar, 1998). Others clearly explain symbolic interactionist concepts as their guiding influence within a grounded theory study (Byrne & Heyman, 1997; Hall, 1998; Hall & Callery, 2003; Woodgate & Degner, 2004). SI has been used in an ethnographic study to describe and interpret data (Tinning, 2008). In light of the consulted theoretical, methodological and empirical literature, I thought it important to be explicit about my perspective.

In SI, speech and action are regarded as the essential vehicle for the interpretation of communicative behaviour that builds and shapes the relational dimension between individuals. The study aimed to gain an in-depth understanding of nurse-family interaction for the purpose of family health assessment, and SI offered a way to focus on relational capacity that was grounded in experience and symbolically mediated in this interaction. The need to consider the relational dimension in communication with family members is recognised by scholars (Whyte, 1994; Leahey
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& Harper-Jaques, 1996; Robinson, 1996; Harrick, 1997; 2000; Nolan et al., 2003; Hartick Doanne & Varcoe, 2005). For care to be caring, nurses need to be able to take the role of the other when giving care (Niven & Scott, 2003; Bergum, 2004). ‘Role-taking’ thus becomes an ethical imperative of professional conduct. Nursing work is action and interaction within a continually evolving social context, a process which Figure 3.1 aims to represent symbolically with an interactionist mind-set. Apart from meaning making based on the definition of a situation, the process of nursing care also calls for reflexivity, awareness and consciousness (Cortis & Kendrick, 2003). These internal processes are illustrated by Figure 3.2, given SI assumptions for guiding this study. As has long been recognised by some (e.g. Yeo, 1989; Reed 1993) theory, practice, and research relate and inform each other at multiple levels. As more recent literature confirms, theory, practice and research are imbued with ethical agency (e.g. Doanne, 2004; Rodney & Street, 2004; Rodney et al., 2004). This relational matrix of dimensions that helps shape a practice profession is examined by Rodwell (1998) in the context of social work practice and constructionist research. The interweaving of strands from theory, practice, research and ethics is also empirically exemplified by Varcoe et al. (2004) in the development of ethical theory relevant to nursing practice. From the outset my experience of working with families, my theoretical knowledge of family nursing and my ethical concerns influenced this thesis. The interrelated nature of theory, practice, research and ethics were the subject of my earlier work relating to intentions and conceptualisations (O'Sullivan Burchard, 2005). These intentions and conceptualisations needed to be accommodated without compromising rigour, however. A methodology would have to allow me reflexively to contain my concerns, interests and strategies, to limit any bias induced by my preliminary assumptions.

During the initial conceptual phase of this study two notions struck me as being of particular relevance. One was Cooley’s view of ‘family’ as primary group in which “the self of the person arises out of experience” in that sociality (Denzin, 2004: 84). The other was Mead’s premise that “the whole (society) is prior to the part (the individual)” and “[t]he social act … must be taken as a dynamic whole” (Mead, 1967[1934]: 7). These assumptions influenced my thinking about ‘family’, ‘family health assessment’ and a possible study design. From a symbolic interactionist perspective ‘family’ exists before the individual and draws forth family members’ experiences. Therefore, family as a social group would have contextual and interactional significance for the individual family member with particular health needs. Similarly, for the community nurse, the ‘family
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group’ would be of contextual and interactional significance. Moreover, the encounter between the nurse and family in ‘family health assessment’ had to be understood as a whole. The implication for a study design was that a case study also had to be considered as a whole without losing sight of its contextual and interactional elements.

For these reasons, SI provided a particularly useful orientation. It accommodated the relational dimensions between the nurse and family in their cultural environment. The nurse and family members were regarded as active participants within an emerging situation. Learning about their perspectives held the promise of a deeper, holistic understanding of the construct of ‘community nurse-family interaction in family health assessment’. Consideration had to be given to the definition of the relational dimension as it would unfold during home visits. The aim was to seek insight into the nature of their co-operation and how they might bring about purposeful, goal-directed behaviour in assessing family health needs and concerns. Therefore, the analytic focus had to be on the nature of their goal-directed actions and interactions and how they were perceived, experienced and revealed. When it came to conduct and procedure, methodological requirements had to be borne in mind that related to taking the role of the other, to make meaningful communication possible (Meltzer, 1972). The assumption is that social behaviour calls for an ‘empathic’ response; by imagining the other’s response, it becomes a shared and thus a meaningful act (Meltzer, 1972; Rose, 2002[1962]). Such an ‘empathic’ response is regarded as inherently therapeutic, not least because it ‘reveals’ a genuine interest in the other (Arendt, 1969 [1958]; Rogers; 1993[1961]; Egan, 2002). Moreover, in this process of assigning and interpreting meaning which may lead to intersubjective understanding, the involved actors construct their own definitions of the unfolding situation (Denzin, 1978). Therefore, I had to consider the participants’ views insofar as that was possible (Denzin, 1989, Crotty, 1998). I also had to be mindful of the symbolic meanings of language and any other significant objects or gestures, to understand their relevance in different contexts and from different perspectives. Thus, SI helped me to conceptualise the ‘nurse-family relationship’, ‘nurse-family interaction’, the plurality of ‘family’, the construction of the social act of a nurse-family encounter, the situation in which ‘family health assessment’ occurs, and the ethical implications of revealing my own role, actions and interactions. But, I also had to consider the predominant conceptualisations of ‘family’ and ‘family health care’.
3.3 THEORETICAL PERSPECTIVES RELEVANT TO FAMILY RESEARCH AND STUDY

The literature on theoretical perspectives for describing, explaining or predicting ‘family’ and ‘family health care’ presents many different theories when attempting to conceptualise family phenomena. Of all theoretical influences, developmental and systems theories had the greatest impact on nursing work with families (Wellard, 1997; Friedemann, 1989; 1995; Kaakin & Hanson, 2005). For encompassing the interrelated dimensions of family, family members and their environment at various levels, systems theory informed much theoretical, empirical and clinical work in social psychology, psychiatry, and family therapy (Becvar & Becvar, 1996; Hammond, 2003; Dilworth-Anderson et al., 2005). Its influence is evident in the resilient model of family adjustment and adaptation (McCubbin and McCubbin, 1993), and family therapy theories (e.g. Bowen, 1978; Rolland, 1994). During the 1970s and 1980s, nursing scholars also drew on systems theory when conceptualising nursing models. Family nursing scholars saw the potential of systems theory and borrowed its concepts in an attempt to advance family nursing in theory, practice and research. See also Chapter 2, Section 2.3.3.

3.3.1 General systems theory

The scientific community across a range of disciplines was influenced by Austrian biologist Ludwig von Bertalanffy’s General Systems Theory1 (GST) (Hammond, 2003). Von Bertalanffy (1901-1972) was concerned by the mechanistic and reductionist values that had taken hold of society since the Industrial Revolution (Hammond, 2003). In his attempt to promote a more holistic theoretical framework - a “general theory of organisation” - he introduced his idea of living systems being “open systems” characterised by “organised complexity” (von Bertalanffy, 1968: 33). He developed GST in which he applied organic thinking to social and psychological structures and processes.

The main concepts of GST are wholeness, environment, boundaries, openness, homeostasis and equifinality (Whitchurch & Constantine, 1993). Wholeness refers to the interrelationship of parts (or subsystems) to the whole system. The parts are internally hierarchical and relate to each other

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1 Von Bertalanffy referred to General System Theory in his own writing in the singular. The plural is common practice in the literature and has been adopted throughout this study.
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and the environment. The nature of boundaries between elements and the environment defines a system as either open or closed (von Bertalanffy, 1968). A system and its subsystems can thus be distinguished by the permeability of its boundaries. Living systems, such as societies, are open and make information exchange possible. Such ‘open systems’ can adapt in response to internal and external stimuli from their environment - a process described as continually aiming for a steady state or homeostasis, and equifinality: “the same final state may be reached from different initial conditions and in different ways” (von Bertalanffy, 1968: 398). This assumption implies that goal orientation would need to be understood as potentially multi-directional.

Von Bertalanffy conceived systems as “sets of elements standing in interaction” (1968: 37) and maintained that “constitutive characteristics are not explainable from the characteristics of isolated parts” (1968: 55). Hammond (2003: 105) emphasises that von Bertalanffy regarded ‘open systems’ as “maintaining itself in a nonequilibrium steady state through continual interaction with its environment.” He saw such living systems as active and self-organising in nature, interconnected and interdependent, value orientated, spontaneous and creative in behaviour (Hammond, 2003). This organic approach was not always shared by von Bertalanffy’s contemporaries. Indeed, other scholars interpreted systems thinking according to their own world view and fitted the perspective to their disciplinary requirements or misinterpreted the theory (Hammond, 2003). Vetere (1987) interprets GST as a classification system that allows parts to be organised into a hierarchy of interrelated classes of systems which can be described by their typical patterns of behaviour.

Kean (2007) uncovered some misrepresentations of GST, in particular its relationship to the concept of systems feedback and von Bertalanffy’s alleged attribution of ‘the whole is more than the sum of its parts’ as a means to conceptualise ‘family’. But drawing on Ransom (1984), Kean asserted the statement’s incorrect attribution to von Bertalanffy, because his original sources were ignored in the Anglo-Saxon literature. Kean (2007: 44), citing White and Klein (2002), also emphasised “[v]iewing the family ‘as system’ implies that systems, in this context, are not viewed as reality, but rather as a metaphor, an epistemological statement that defines a way of knowing”.
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Such an epistemological definition makes conceptual abstraction of phenomena possible in terms of sameness or difference (Luhmann, 1995[1984]).

Von Bertalanffy’s initial logico-mathematical approach saw his thinking also applied to ‘closed systems’ in engineering, computer technology, information theory and feedback systems or cybernetics (Scott, 2001). Cybernetics is associated with feedback theory; the exchange and control of information within systems (Scott, 2004). Hammond (2003) identifies two schools of thought in cybernetics which developed due to the transplantation of the concept from one discipline to another. One is mechanistic and deterministic, drawing on the equilibrium model of the natural and the behavioural sciences (Scott, 2001; Hammond, 2003).

The other cybernetics development can be defined as change and adaptation by way of circularity and feedback loops in human systems’ symbolic communication (Becvar & Becvar, 1996). This was regarded by von Bertalanffy as integral to his organic conception of GST (Kean, 2007: 45). The application of cybernetics evolved and was adopted in the cognitive sciences, computer technology, and artificial intelligence, thus, informing “the study of social processes” (Hammond, 2003: 67). In this context, cybernetics is also referred to as second-order application and becomes a trans-disciplinary perspective (Scott, 2004). The notion of second-order cybernetics is an important one in the context of human systems as it assumes a knowing observer within an observing system (Luhmann, 1995[1984]; Scott, 2004). Control is achieved by communication and self-regulation in a circular fashion. In systems theory therefore causality cannot be understood to be merely linear, i.e. of cause and effect, but rather as circular or at least as a reciprocal or recursive pattern.

Others associated second-order cybernetics with its principle of circularity and feedback with constructivism because knowledge remains contingent on context, the construction of belief systems and the meanings which are brought to bear on a problem (Knodt, 1995; Luhmann, 1995[1984]; Becvar & Becvar, 1996; Kjellman, 2002; Hammond, 2003; Scott, 2004). The principle of circularity and feedback loop behaviour informed a systemic approach to communication.
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theory such as pragmatics i.e. the use of everyday language within and for a given context and purpose (Watzlawick et al., 1967). According to Scott (2004) circularity influenced also the cognitive-biological sciences e.g. the work of Piaget (1972) and Maturana and Varelas’s (1992) and von Glaserfeld’s (1984) notions of radical constructivism. The pragmatics cybernetics model of circularity and feedback has also been adopted in family therapy (Becvar & Becvar, 1996) and Wright and Leahey (1994; 2000) drew on it for their Calgary Family Model (see also Chapter 2, Section 2.3.3).

3.3.2 Differentiation in Social Systems

Luhmann (1995[1984]) examined the concept of social systems and distinguished between the internal and external features from a sociological perspective. Mauksch (1974), a North American physician, viewed the idea of the individual as a constitutive element of different systems as promising for conceptualising ‘family health’. He saw the usefulness of differentiating between individuals with their bio-psycho-social dimensions. Individuals participate in various social systems and “as a component of the family unit itself infusing into the family system” (Mauksch, 1974: 522). Such pluralistic configuration creates “interactive forces” (Mauksch, 1974: 523). Mauksch’s assumptions can be easily recognised in the family nursing literature (see Chapter 2, Section 2.3.3). ‘Family’ can be regarded as the smallest ‘unit’ of a societal system characterised by interaction and organisation (Hall, 1998; Denham, 2003; Hall & Callery, 2003). Here, systems are interpreted in relation to each other and at different levels, e.g. subsystems within a family are the parent-parent dyads or parent-child dyads. Supra-systems make up the wider environment in which families and societies operate, such as eco-systems out of which ecological perspectives developed e.g. Bronfenbrenner (1979; 1995) or Gitterman and Germain (2008). However, comparisons of sameness or difference need to take place at the same hierarchical level and each level must have its specific use of meaning (von Glaserfeld, 1984; Luhmann, 1995[1984]).

Luhmann’s distinction between society and interaction as two kinds of system formation is an interesting one especially, since he draws a comparison with SI. He sees the socio-psychological conceptualisation of society as residing in individuals. In SI personal and social identity relate to the ‘self’ and ‘society’. Both are also socio-psychological conceptualisations. Luhmann regards an
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SI conceptualisation as inappropriate for dealing with the societal system’s complex problems. Yet he also claims that “every interaction has a relationship to society that is problematic for it because as interaction it cannot attain self-sufficiency in the sense of complete closure in the circuit of communication” (Luhmann, 1995[1984]: 406 (italics in original)). His assertion suggests that interaction may not hold a prospect of resolution. Luhmann’s proposition questions the extent to which people enter into conversation and arrive at a mutual consensus based on their experience despite different perspectives. Therefore, it is important to find out how individuals arrive at a mutual understanding of a particular situation in their dialogue. Luhmann also asserts that:

“Interactions are episodes of societal process. They are only possible on the basis of the certainty that societal communication has been going on before the episode begins, so that one can presuppose sediments of earlier communications; and they are possible only because one knows that societal communication will still be possible after the episode concludes” (Luhmann, 1995[1984]: 407).

This statement struck me as particularly important towards understanding the interactions during home visits. Since the community nurse enters a unique ‘societal system’ - the family - it would seem important to consider their temporality in terms of their relationship, and its reciprocal effect on the nurse and the family and their recursively emerging ‘system’. Yet this new ‘nurse-family’ structure also interrelates with their respective environments, both of which occur not only at a temporal, but also at a biographic and symbolic, level. From a constructionist epistemology, the ‘family as a system’ and the ‘nurse-family as a system’ would interact within an environment of contextual significance. From a symbolic interactionist perspective, the temporal nature of their interaction as “a stream of action” (Charon, 2007: 118 (italics in original)) must also be taken into account. So a differentiation between levels of time and individual narratives is just as important as it is to conceptually differentiate between structural levels. The need to recognise different levels in family and family research is widely discussed by family nursing and family social science scholars and was discussed in Chapter 2, Section 2.3.3. Therefore, it is imperative to clearly conceptualise ‘family’ in support of methodological decisions.

3.3.3 Family Levels and Its Methodological Implications

From a systems theoretical perspective, positioning the family conceptually has methodological implications. To be explicit about the conceptualisation of ‘family’ as the unit of analysis has long
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been recognised as important, and very challenging in family research (e.g. Gilliss, 1983; Feetham, 1984, Uphold & Strickland, 1989; Gilgun, 1992; Daly, 1992; Robinson, 1995; Becvar & Becvar, 1996; Gilliss & Knalf, 1999; Bell et al., 2000; Knafli & Gilliss, 2002; Houck et al., 2005; Dilworth-Anderson et al., 2005). According to Feetham (1991), research that focuses on the family as a whole or ‘as a system’ is referred to as family research. At this level, information is sought from the whole family: it includes multiple family members as informants (Houck et al., 2005). Alternatively, information from individual member’s perspectives as a unit of analysis is concerned about the family. Since an individual family member’s perspective of the family cannot represent a family view as a whole, it is regarded as family related research (Uphold & Strickland, 1989; Feetham, 1991; Houck et al., 2005). Here ‘family’ means the system is conceptualised from the context of an individual family member.

The evidence from ‘family unit-focused research’ is likely to be substantively different compared with ‘family as context-focused research’, as noted by Bomar (2004) and Houck et al. (2005), in terms of its impact on nursing practice, health care policy and contribution to methodological understandings. It is thus vital to understand both and to distinguish between ‘family as a whole’ and ‘family members’ perspectives’. One also has to recognise that both phenomena mutually influence each other’s health behaviours or needs (Handel, 1992; Bomar, 2004). Furthermore, as Dilworth-Anderson et al. (2005) point out, family can be conceptualised from a generational representation, e.g. comprising a parent-child dimension, which suggests a hierarchical definition of family. For others, the definition of family is based only on their familial relations of intimacy, implying a non-hierarchical, relational definition. Thus, ‘family’ is a multi-level concept that includes hierarchical and relational structures due to nested relationships of dyads (Sayer & Klute, 2005: 290). According to Luhmann’s systems hierarchy ‘family’ can be interpreted as operating as a social system and psychic system at one level, and as interaction system and societal system at another. Each provides an environment for the other. These are complex family conceptualisations which are potentially confusing. They also raise the question of whether and to what extent it is justified to refer to similarities between systems at different levels. Indeed, the ongoing debate in the family nursing and family therapy literature reflects these concerns when levels in family systems are defined (e.g. Gilliss, 1983; Friedemann, 1989; 1995; Gilliss, 1991; Whall
In this study, ‘family’ was methodologically approached from a family systems theory perspective as the aim was to capture family members’ perceptions and experiences. The definition chosen (see Chapter 2, Section 2.5), however, also implies time and context as important contingencies that are associated with a symbolic interactionist perspective as discussed above. Moreover, I assumed that while within a family group, membership was likely to embrace individuals related by blood ties; household membership would not necessarily match family membership, as defined by kinship, in all cases. Households could just as easily comprise post-divorce and/or other blended families - a family composition recently dubbed as “families-within-families” in a grounded theory study by Kean (2007: 130). The reviewed literature in the previous chapter also made it apparent that health care policy, service provision and role development are becoming increasingly problematic for community nurses when working with families. Some organising framework for family health care may therefore assist nurses in their assessment practice. According to Checkland (2008[1999]) systems thinking offers an approach towards dealing with ‘organised complexity’. Thus, the integration of a systems perspective offered some scope for this case study.

3.3.4 Limitations of Family Systems Theory

While Dilworth-Anderson et al. (2005) regard family systems theories as integrative and having predictive value, its scope is seen as limited due to its generality, ambiguity and difficulty in organising its concepts for empirical research by Mercer (1989). Others consider systems theory, although holistic, as too comprehensive and therefore open to numerous interpretations due to its largely content-free, abstract and non-specific concepts (Whitchurch & Constantine, 1993; Checkland, 2008[1999]). Although a systemic approach offers an alternative to linear causality in conceptualising the interaction between family and environment, it also confines family dimensions according to structures which may be devoid of meaning and experience (see also Chapter 2, Section 2.3.3). Some family social scientists are critical of family systems theory, and question the creation of hierarchical structures with its static connotation (McKie et al., 2005).
From a nursing perspective, Wellard (1997) raises concerns about family systems theory due to its normative influence and potential to constrain a de-contextualised view of social worlds. A systemic approach may attribute differences in dynamics and perceptions to ‘the system’ rather than to the diversity of individuals who may be interacting via different sentiments, perspectives and symbolic meanings. Indeed, Hall (1998) found families’ expectations, values and goals, and their attempts to balance these as representative of a trajectory of family life and development that did not fit into a systems perspective. Wellard (1997) argues that, thanks to a rather widespread acceptance of ‘family as a system’, the metaphor has turned into a normalising professional discourse. As Wellard contends, systems theory has promoted the development of functional conceptualisations of care and “a prominence given to individuals rather than the collective interest of the individuals who make up the family”, despite claims of holistic practice (Wellard, 1997: 83). Similar objections were raised by others, e.g. Hartrick (1997); Hall (1998) and Hartrick Doanne and Varcoe (2005; see also Chapter 2, Section 2.3.3). These nursing scholars caution against the use of mechanistic and prescriptive formulas grounded in systems theory when working with families. It would appear that family systems theory has been given a privileged position in family theory and family research. At the same time, it is argued that the economic-political and socio-ethical dimensions which might impinge on nurses and families working together have been neglected. A further concern is raised by Denham:

“[a]though systems thinking allows one to view the whole as well as the parts, it is difficult to hold both in mind concurrently and weigh the endless possibilities of independent, intradependent, and interdependent actions. Concentrating too much on the whole can result in overlooking the implications of the parts, although attention to the parts risks the possibility of overlooking the effects of the whole” (Denham, 2003: 203).

Such a cautionary note points to a conceptual and perceptual dilemma which may have implications for attempts to gain a holistic understanding of a particular phenomenon, in either practice or research. Checkland (2008[1999]), however, argues that by taking a systemic approach, multiple perspectives, contexts and values can be accommodated to better understand ‘organised complexity’ within an interaction system. While mindful of its limitations, I regarded a family systems perspective as useful for addressing the research problem.
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3.3.5 Implications of Family Systems Theory for This Study

One of the aims of this family research was to deepen understanding of community nurse-family interaction and the construct of ‘family health assessment’. This called for ‘family as a group’ to be differentiated theoretically without ignoring the perspectives of individual family members. Moreover, since any differentiation implies a definition of boundary, consideration of relevant factors in each part of the system was seen as crucial when attempting to understand the nurse-family interaction. Dilworth-Anderson et al. (2005: 39) caution, however, that “[a] family can have an attitude or enact behaviour only when members collectively act in a coordinated way.” Furthermore, the nurse and the family’s history and biography need to be acknowledged to gain an understanding of their respective accounts and co-constructed meanings during their interaction episodes. These are concerns of flow and boundaries of time. Both elements needed consideration in this study, because a family health assessment was not assumed to be a singular event. Instead, as Luhmann points out, action was likely to unfold in episodes of interaction at different levels and to be imbued with symbolic meaning in Mead’s sense. Therefore, I considered the use of both the symbolic interactionist and the systems perspective as promising within this constructionist case study. The systems theory concept of ‘wholeness’ informed this study. The ideas of ‘circularity’ and ‘feedback’ offered scope for examination of the nurse-family interaction at different levels, and from a pragmatics communication perspective.

Finally, I considered the selected theoretical perspectives of SI and GST appropriate as they supported an exploration, description, and interpretation of the community nurse and family’s interactions, perceptions and experiences. The concept of ‘wholeness’, and the differentiation between family levels and that of system and environment, were theoretically and methodologically relevant. The design choice of multi-case study, as will be discussed in the next chapter, is considered a holistic approach to a research problem (Stake, 1995). Informed by systems theory, I recognised the importance of considering the constitutive characteristics of the chosen case study design in terms of possible interrelationships between the cases. This would allow for (1) an in-depth understanding of the interaction process in family health assessment; (2) an extrapolation of patterns; (3) a comparison of similarities and differences across the cases which might yield some explanatory power. With each case, situational factors brought richness and variation to the empirical evidence constructed from multiple voices and contexts.
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SUMMARY
The above discussion placed my approach and the thesis within a philosophical context of belief and intention grounded in pragmatism. Ontological, epistemological and methodological assumptions and concerns were made explicit. This constructionist epistemology accommodates multiple perspectives that arise within different contexts. It was argued that this was relevant to the study, because of its dialogical and relational ambitions.

The interpretative tradition from Weber’s integrative perspective of Verstehen and Erklären was seen as most helpful for grasping methodological and analytical decisions. The central research question suggested a theoretical fit with symbolic interactionism. While due regard was given to the perspective’s limitations, its relevance was shown to be convincing as it was compatible with the study’s philosophical, ontological and epistemological assumptions.

Since family research and family nursing literature draw chiefly on systems theory, its potential, assumptions, concepts and limitations were critically examined. It was argued that a structural differentiation in systems needs to be complemented by a temporal, symbolic differentiation in processes. It was concluded that both a symbolic interactionist perspective and family systems theory may be useful in offering conceptual scope for an in-depth understanding of the research problem.

As a constructionist investigation, this study aims to advance a type of cooperative inquiry that gives voice to community nurses and families working together. At the same time, it acknowledges the contribution to co-constructed knowledge in family health care. The study also attempts to describe and explain the social reality of ‘family health assessment’ as it might unfold in nurse-family interaction. I will therefore draw on symbolic interactionism and family systems theory as guiding theoretical frameworks. Both offer a holistic approach that fits the research problem. By drawing on two complementary theoretical perspectives, the aim is to deepen the analysis by way of comparison and their approximation, and to go beyond a descriptive level of analysis.
Methodological decisions flow from this discussion, with design choices considered and examined in the next chapter.
4 THE CASE STUDY DESIGN

INTRODUCTION
This chapter appraises the potential and purpose case study. The major schools of thought regarding case study are briefly addressed. An examination of some nursing case studies that were influential for shaping this study follows and design choices are detailed. Rationales for selecting a comparative, qualitative design that is theoretically orientated and the building of each case are outlined. The discussion continues by examining ways of promoting rigour that fit with constructionist assumptions. Pitfalls of case study research are identified and the planned case study design set out.

4.1 THE POTENTIAL OF CASE STUDY
Case study research has a distinct position in the paradigmatic and methodological traditions and is linked historically with pragmatism (Hammersley, 1989; Creswell, 2007). It has a long tradition dating from the early symbolic interactionists in North America. Thanks to the flexibility and scope which case study offers, it has been adopted in many disciplines e.g. anthropology, psychology, sociology, medicine, education, family therapy, social work and nursing. As a method, case study is not always associated with research, a contributing factor to the lack of a clear consensus in its definition and consistency in application (Hammersley & Gomm, 2000). It is therefore necessary to define its use clearly within a given context. Hammersley and Gomm identify some common parameters for case study research drawn from the literature. Primarily, it is a “specific form of inquiry” typified by “a range of dimensions” (Hammersley & Gomm, 2000: 2 (italics in original)) relating to the:

- relatively small “number of cases” selected in a particular enquiry
- “amount of detailed information” relating to the specific case
- building of cases “out of naturally occurring social situations” with the researcher integral to procedures used
- “kind of data” collected which is qualitative and varied
- type of analysis which generally focuses on in-depth understanding
choices for conceptualising findings such as ‘thick’ description, theoretical inference or empirical generalisation

methodological interpretation of rigour (Hammersley & Gomm, 2000: 2-3 (italics in original)).

Case study is thus a design comprising certain features, that is adaptable to different epistemological positions and offers scope for enquiry. The literature highlights the influential work of Stake (1995) and Yin (2003a&b) for case study research. Yin takes a relatively empiricist stance, which can be inferred from the emphasis placed on the hypothetical-deductive method in his procedural guidance. By contrast, Stake is orientated towards a qualitative naturalistic perspective that emphasises descriptive intents. Stake (1995), for example, defines case study as a method of specimens and differentiates the approach by purpose whereas Yin (1982) defines it as a problem orientated strategy and offers a design typology (Yin, 2003a). On the other hand, Stake elaborates on developing the foreshadowed problem and issue statements. Both exponents amongst others informed this study’s approach (e.g. Merriam, 1998; Mitchell, 2000; Creswell, 2007). Stake’s perspective became increasingly influential as my study developed in areas of design, methods and reporting (1995; 2005; 2006). According to Stake (2000a: 24) case study adds “to existing experience and humanistic understanding”. These two aims were highly congruent with the intentions of this enquiry, and its epistemological and methodological underpinnings.

However, Stake, offers little guidance on a theoretically orientated case design. He emphasises the idiosyncratic, the subjective, and the richness of phenomena that is accessible from a small number of cases for generating insights (Stake, 1995). He uses the term “naturalistic generalisation” which alludes to learning from the case or its application to other cases (Stake, 2000b: 22); a notion similar to that expounded by Guba and Lincoln (1989) when they differentiate between the fit of case findings between the sending and the receiving context. More recently, Lincoln and Guba give preference to Cronbach’s proposition (1975) referring to generalisations in natural settings as “the working hypothesis” (Lincoln & Guba, 2000a: 38 (italics in original)).

Donmoyer (2000) confirms the use of a small number of cases or even just one case to be the strength of case study as it allows for in-depth examination of multi-dimensional problems.
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Creswell (2007: 76) is even more specific, viewing “no more than four or five cases” as typical, whereas Yin (2003a) and Silverman (2005) argue that robustness in case study is promoted by the use of theory rather than by the number of cases. This approach opens the possibility of comparison with theory, referred to as ‘analytic generalisation’ by Yin, (2003a&b) or ‘theoretical generalisation’ by others e.g. Sharp (1998) and Patton (2002). For this reason a case study approach accommodates “one’s theoretical priorities”, unlike phenomenology or grounded theory (Silverman, 2005: 136). It also offers procedural flexibility - particularly useful for studying phenomena in nursing practice orientated towards family health care. Here knowledge is often gained via interaction, depth and detail of settings, situations and events using various data sources and processes (Lincoln & Guba, 1985; Daly, 1992; Stake 1995; Rolfe, 1998; Pontin, 2000). Some also identify its potential in advancing a holistic nursing science (Schultz & Kerr, 1986; Hutchinson, 1990). Others regard case study as a suitable mode for reporting context-rich and multi-dimensional projects (Lincoln & Guba, 1985; Merriam, 1998). Duhamel’s call for nurses to advance “practice-based research and research-based practice” is particularly relevant, as she states: “[a] shift from individual to interactional data in family research is needed and the adoption of a perspective which enhances the dimension of “belief systems”, “interactions”, and “relationships” between family members themselves and between the nurse and the family” (Duhamel, 1995: 10). This enquiry aims to respond to this call by drawing on the potential of case study while giving due regard to the methodological considerations necessary for research that aims to inform family health care practice.

4.2 THE PURPOSE OF CASE STUDY

The spectrum of methodological approaches in case study research, their scope and their limitations are evident from the literature. Despite variations in definition and design, the common purpose of case study research is the extensive, holistic, detailed and in-depth study of phenomena in context (Stake, 1995; 2000a&b; 2005; Miles & Huberman, 1994; de Vaus, 2001; Patton, 2002; Yin 2003a&b; Creswell, 2007). The use of several “bounded system[s]” (Stake, 1995: 2) or cases may also “add depth and dimensions to theoretical understanding” (Donmoyer, 2000: 64). Therefore, the purpose it serves depends on the research intent.
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Nursing scholars used case study research for various purposes. For example, case study research informed service development and evaluation studies in health care (Twinn & Lee, 1997; Whyte, 2004; Payne et al., 2007). Some were multi-site studies with multiple cases (Brockelhurst & Butterworth, 1996; Cowley et al., 2000; Latter et al., 2000; Goodman, 2001; Macduff & West, 2003). This design choice offered promise for this study; others have adopted it for theory development (Pearson, 1991; Whyte, 1994; Schwartz-Barcott et al., 2002). These studies confirmed the scope for integrating a theoretical perspective. Tungulboriboon (2002) used a mixed-method approach to explain young peoples’ self care practices, closely following Yin’s approach. Bryans (1998; 2003) used two simulated cases for data collection and analysis in a study that focused on assessment practice of district nurses (1998) and four cases for her later study (2003). Its merit and limitations were considered in Chapter 2, Section 2.4. A number of case studies highlight some of the pitfalls of this design choice. Kennedy (2005) reports a case study on district nurses’ home visiting practice. A rather weak conceptualisation and definition of the case and rationale for case selection raises questions about the study’s trustworthiness. A lack of boundary setting and focus is also evident in the case study by Cowley & Houston (2003) in which they examine a structured assessment tool for health visiting. A comparative case study by Dale (1995) uses a limited range of data sources that show weaknesses in procedures and reporting. These highly selective case studies encouraged reflection on design choices for this research.

4.3 THE CASE STUDY DESIGN

For this enquiry, the key problem, central question and issue sub-questions influenced the type and structure of the case study design (Stake, 1995: 21; Hammersley et al., 2000: 250). To achieve the best fit to answer the research question a qualitative approach was necessary, to accommodate epistemological orientation and theoretical influences. The conceptualisation of the design was critical in the uncovering of different perspectives, repeated experiences over time and contexts from meaningful community nurse-family interactions. A small number of cases from different sites suggested a way forward (Firestone, 1993; Stake 1995; Hammersley et al., 2000; Yin 2003a; Atkinson & Housley, 2003). The design called for multiple cases to compare assessment of families’ health care needs in different fields of practice. Comparison aimed to find similarities and differences in family health assessment practice and was sought against the
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theoretical perspectives brought to the enquiry. Therefore, a comparative case study design showed the best fit in order to achieve these objectives and accommodate methodological requirements. The selected comparative approach fitted the research problem in its different situational contexts. It was designed for an in-depth understanding of the research phenomenon and to inform community nursing assessment practice in different disciplines. Moreover, selecting multiple, information-rich cases added to the study’s scope by bringing greater sophistication and analytical leverage to bear on the particular problem (Patton, 2002). Therefore, it promised potentially to generate more compelling and robust evidence towards developing the concept of ‘community nurse-family interaction in family health assessment’ (Silverman, 2005).

The case study design also allowed for the range of methods to meet methodological objectives. This would not have been possible using other qualitative approaches, some of which can be distinguished from case study by showing less conceptual ambiguity (Yin, 2003a). Some of the reviewed case studies appeared to contain conceptual ambiguity, which may create uncertainty. This notion of having to accept uncertainty is also associated with a constructionist enquiry because of its unpredictable, unfolding nature (Guba & Lincoln, 1989). The literature review revealed a gap in knowledge from which the research problem was identified. For this reason, this case study is problem-orientated. At the same time, Stake’s (1995) definition of a collective case study which is instrumental in its purpose also applies due to its focus on process.

4.4 BUILDING THE CASE

In comparative case study, the researcher can explore each case in depth and use it to illustrate a particular issue over time and in different contexts. Stake (1995; 2005) and Yin (2003a) regard the building and specifying of the case as an important conceptual requirement. In this study, each case comprised a community nurse and a family jointly regarded as a ‘bounded system’. As detailed in Chapter 3, Section 3.3.3, family was defined ‘as a group of individuals’ and ‘as a system’ from a symbolic interactionist perspective and a family systems perspective. The nurse and the family were the object or unit of analysis. Together they constituted the case as a bounded system. Each case was bounded by activities before, during and after several home visits that sought multiple sources of information comprising of accounts from the nurse and the family,
natural occurring talk and observations from their encounters, and nursing assessment documents pertinent to the field of practice and health care. In each case their interaction, as the process, was the focus. The home visit was the context; embedded in each single case were sub-units of analysis as the phenomena of interest, including the nurse and family perceptions, their experiences before and/or after a number of home visits, and how these were borne out in their communicative behaviours. An in-depth examination of each case facilitated an insight into its unique characteristics, while a comparison of similarities and differences enabled a deeper understanding.

4.5 PROMOTING RIGOUR IN CASE STUDY

The methodological interpretation of rigour in case study derives from attending to the human instrument, reflexivity, triangulation, seeking disconfirming evidence, selecting alternative interpretations and participant validation (Stake, 1995; 2005; Seale, 1999a). Each element contributes to the adequacy and utility of case study using criteria of differing terminology. The debate about evaluative criteria used to judge the quality of research is extensive. Some scholars even see quality criteria as social control (Gaskell & Bauer, 2000). Others apply epistemological differentiation as a defining characteristic or take methodological differentiation as justifying evaluative criteria (Rolfe, 2006). As Rolfe elaborates, these perspectives continue to polarise the quantitative-qualitative debate along with the rigour - trustworthiness terminology. Although agreeing in part with Sandelowski and Barroso (2002) that a judgment on the quality of research depends on the reader’s aesthetic and rhetorical appraisal, and is thus co-constructed with the researcher as suggested by Rolfe (2006) and others, Rolfe’s conclusion is open to question. As Rolfe contends, the evaluative judgment belongs to the reader. However, the reader must make a judgment when assessing the merits of each study. In this way the researcher is held to account. It is the researcher, not the reader, who asks the research question in the first place. Therefore, the researcher has a degree of accountability among those with whom the research findings will be shared. In addition, the researcher is in a position of power in that they are tasked with uncovering these findings. Thus, research accounts and their evidence call for scrutiny. Transparency regarding methods used within the context of an investigation demonstrates accountability to the reader. Without providing some means for such scrutiny, the reader’s judgment about a study’s merits would be compromised - raising doubts about its quality in the
first place. Alternatively, if findings were not meaningful to the reader, doubts may be raised about the study’s contribution to knowledge, with methodological adequacy and empirical utility called into question.

4.5.1 The Human Instrument

Within a constructionist methodology, the researcher seeks understanding while interactively involved in building new knowledge. The type and extent of the interaction with which the researcher makes sense of all the elements of the research process has therefore a direct impact on its outcome. The researcher must adopt a number of roles to achieve the twin goals of sense-making and development of a fuller understanding (Stake, 1995). Stake is explicit and comprehensive in defining the roles a case study researcher may be required to fulfil. In addition to expected field work roles such as interviewer or participant observer, Stake also highlights less obvious roles for example, teacher, advocate, evaluator, biographer and artist.

Within a constructionist enquiry that uses a case study design each of these roles are required. In case study and as constructionist, the researcher is not a standardised instrument as one might expect, for example, in a randomised controlled design. Rather, the researcher as human instrument seeks out naturally occurring phenomena and evaluates situations likely to offer access to these, to achieve a fit in methodology and design. During involvement in the intersubjective nature of human conduct, the researcher becomes a “social explorer” and an integral part of the field methods employed (Porter, 1989; Atkinson & Housley, 2003: 130). This requires interaction and also the adoption of the role of the ‘acting other’ (Denzin, 1989). The consequence of such interaction is not just to become instrumental for knowledge generation. Rather, insights are co-created in dialogue with self and the other. The ‘human instrument’ is not a passive tool, but an active, reflective, mindful collaborator who can accommodate participants in dialogue and skilfully construct a meaningful account from various sources and instances. Drawing on participants, data, literature and derived understandings, this co-construction can contribute to an interpretive interactive understanding – termed ‘the hermeneutic circle’ (Guba & Lincoln, 1989; Rodwell, 1998; Krippendorf, 2004).
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The researcher must take into consideration exposure to scrutiny – an integral part of a constructionist methodology, as well as any other procedure. Such scrutiny relates not just to the use of self, but also to the fair representation of perspectives of those who contribute to the research. Avoidance of bias in representation calls for an awareness of self (Rodwell, 1998). The use of self depends on the level of consciousness brought into human dialogue (Newman, 1995). This type of dialogue, which takes account of the self and the other, is referred to as reflexivity (Hammersley & Atkinson, 1995). Reflexivity enhances insight into the unfolding process of inquiry and responsiveness to the participants’ social world – especially when developing interview schedules and conducting interviews in order to promote trustworthiness and ethical conduct. While aiming to develop rapport with participants I considered the stance of collaborator when out in the field. To gain understanding, I thought it necessary to adopt the role of reflexive learner and professional colleague, bearing in mind my developing role identification as ‘researcher’. I anticipated children to be part of families, therefore being a parent myself helped me to see the family situation from a parental perspective.

It is necessary to guard against bias in the evolving process of understanding, as both action and interaction are value bound. Bias can easily turn the human instrument’s strength into a limitation. Reflexivity is one way of keeping bias at bay, especially during data collection and analysis (Hammersley & Atkinson, 1995). Being attentive to - indeed, seeking - disconfirming evidence in response to theoretical perspectives and interpretative accounts is a strategy to contain bias (Denzin, 1989; Stake; 1995; Yin, 2003a). The often small number of cases in case study involves an in-depth engagement with the field which requires attentiveness to rigour and the seeking of opportunities to enhance this further. Reflexivity in conduct is thus a means to promote rigour; another is triangulation (Stake, 1995).

4.5.2 Triangulation in Case Study

Triangulation is a confirmatory strategy used to look for convergence between data sources (Sandelowski, 1995a). The aim is to collect multiple dimensions of a particular phenomenon and to bring multiple points of view into focus, enabling grounded revision of interpretations (Mitchell, 1986; Stake, 1995; Flick 2004b). Triangulation is a design feature recommended for case study
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research as it offers the researcher the opportunity to enhance the robustness of a multi-case study and particularly, where there is a small number of cases (Stake, 1995; 2005; Patton, 2002; Creswell, 2007). As Seale (1999b) emphasises, however, while triangulation is not an assurance of validity, it can deepen understanding of the phenomenon despite the small case number. It commonly refers to the use of different methods to minimise the limitations of a particular method (Silverman, 2005).

In a study by Hartrick (1998b), the health promoting practice of a multi-disciplinary team was explored. The team included five nurses, a physiotherapist, a respiratory technologist and a nutritionist. The purpose was to encourage participants’ reflexive, critical practice. Hartrick triangulated the data sources from individual interviews, audio-recorded group education sessions and structured journal reflections. Findings showed incongruity between participants’ espoused values and values used across the data sources. Triangulation of methods had been used intentionally for analytic purposes; it also enhanced the study’s trustworthiness.

The usefulness of triangulation is also cited as a means of gaining a broader understanding of a family response to a child’s chronic illness, and family members’ perspectives, by Breitmayer et al. (1993). They inspected interview data “that would converge with and confirm information from related interview questions” (Breitmayer et al., 1993: 239). Triangulation can be regarded as an asset in family research as it promotes access to different dimensions. Breitmayer et al.’s approach showed promise for this case study.

Within this multi-case study, the aim of the pre-home visit interview was to give access to the nurse’s experiences and intentions. The audio-recorded home visits generated data about actions and interactions, and observations allowed inferences to be drawn from non-verbal communication. A sequence of home visits was followed up by an interview with the nurse and a separate interview with the family. Each source gave a different dimension and perspective to the phenomena of interest. Documented family information provided a further source on pertinent aspects of “family health assessment” some of which could then be explored in the interviews. The
selected within case data source for triangulation was time, such as perspectives, categories or dimensions gained through data reduction before, during and after those home visits.

This methodological strategy of a “between-method” approach to triangulation was regarded as indispensable for this case study (Denzin, 1989: 244). Indeed, for Stake “[t]riangulating key observations and bases for interpretation” (2005: 460) is a conceptual responsibility. Multiple social realities and dimensions can then be identified. For example, the socially constructed perspectives of the participants generated different types of data. Each represented distinct, but related, phenomena and in different contexts. Therefore, attention had to be given to the construction of data sources to accommodate the likely different dimensions of the phenomenon of ‘community nurse-family interaction in family health assessment’, and to explore it “from many different angles” (Seale, 1999a: 55). Triangulation can help to seek disconfirming evidence “by increasing sensitivity to the variable relationship between an account and the reality to which it refers” (Seale, 1999a: 59). This seemed a promising strategy to enhance trustworthiness. After all, different methods yield different types of data in different contexts, representing different socially constructed realities. The decision to use interview data from participants and nursing documents, in order to illuminate the naturally occurring interaction between them and to avoid aggregation of phenomena, was necessary given the study’s constructionist orientation.

4.5.3 Creating a Hermeneutic Circle in a Case Study Design

The concept of ‘hermeneutic circle’ was developed from philosophical traditions of thought and methodological approaches which interpret written materials derived from an understanding gained from their cultural and historical context (Habermas, 1984[1981]). Underlying all traditions, however, is the principle that understanding calls for interpreting texts for their meaning as a whole and with reference to its individual parts (Ramberg & Gjesdal, 2005). This is an interactive and dialectic engagement with texts, as one’s iterative movements are made back and forth between the part and the whole.
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Such a dynamic principle of understanding can be used as a methodological device to support a constructionist enquiry, and is recommended for case study (Guba & Lincoln, 1989; Stake, 1995). The researcher’s interpretations, as tentative understandings, are returned to participants and thus exposed to potential critique, creating dialogue and possible consensus about the co-constructed meanings. Knowledge development here brings to light the co-constructed nature of meanings from data to which the participants contributed (Patton, 2002). Guba and Lincoln (1989) claim that this soliciting of consensus or otherwise, referred to as member checking or participant validation, may empower and change participants due to the creation of ‘shared’ meanings. The resulting joint constructions may also be more informed and may thus enhance trustworthiness. As Guba and Lincoln explain, the hermeneutic circle does not only consist of participants’ contributions. Rather, the researcher requires to expose either pre-conceived notions or derived understandings from the data to continuous challenge. Different data sources may also contribute to the need to revise interpretations in progress. The introduction of literature sources and divergent theoretical perspectives are additional necessary elements to the hermeneutic circle in order to create meaning and advance understanding. Ultimately, offering the research product to the wider professional and scholarly community for critique will determine its authenticity. Achieving authenticity therefore also depends on the building of co-constructions with those who enter into dialogue with the account offered by the researcher.

In this multi-case study, each case was conducted sequentially. Some form of feedback was required from participants either following the intra case or the across case analyses. In each case the nurse, the family and the researcher could lay claim to constructions of respective accounts. Data sources were of a diverse nature, however. Interpretations derived from interviews could be used as justification for seeking feedback from participants. Interpretations from naturally occurring talk cannot be regarded as constructed representations. These represent instead the participants’ reality of their encounter at the time. Interpretive accounts of these data sources were subjected to rigorous challenge by the researcher, for example by searching for disconfirming evidence in the data and triangulating it with alternative data sources such as interview texts or documents. The hermeneutic circle, therefore, became a necessary device for this comparative case study design to promote trustworthiness and authenticity.
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Meaning brought about by consensus, however - e.g. by way of member checking of researcher’s constructions by participants - may not necessarily be genuine. Therefore, consensus and meaning derived from co-constructions cannot be taken for granted. To achieve an authentic consensus, a true and cooperative understanding between free agents is called for (Bernstein, 1991). As Habermas (1973[1968]) contends, knowledge production exemplifies different types of human interests, methods and purposes; it therefore needs to be exposed to critique. Thus the question arises: to what extent the creation of a hermeneutic circle in Guba and Lincoln’s sense can be free from unconscious, distorting or compulsive influences? Co-constructed meanings cannot be assumed to be shared. Indeed, Stake (1995) notes that the most frequent response of participants was their lack of acknowledgement of his case reports. Moreover, Sandelowski (1993: 3) cautions that member checking “may serve paradoxically to undermine the trustworthiness of a project”. Participants demonstrate their commitment during data collection. By the time a case report is received, the present has overtaken the past. Connecting the past with the present may not appear as desirable to participants as contexts may have changed and new perceptions developed.

4.5.4 Aiming for Adequacy and Authenticity
Judging the quality of this comparative case study depends in large measure on the pragmatic claims of its usefulness. Moreover, given its epistemological assumptions, it is by its nature constructed. The construction of the research account rests on the appropriate fit of theoretical perspectives, selected design and methods used. As Patton (2002) suggests, both subjective and objective strategies can be seen as valuable throughout the research process. Such a perspective implies that an evaluative judgment of the study depends on criteria that go beyond an aesthetic and rhetorical appraisal by the reader, as suggested by Sandelowski and Barroso (2002).

Lincoln & Guba (1985: 76-77) put forward the criterion of trustworthiness for evaluating methodological adequacy that fits a constructionist epistemology and includes four elements: credibility, transferability, fittingness and dependability. These are commonly applied to qualitative research. Triangulation and accounting for disconfirming evidence are recommended strategies which can help support credibility, as is seeking participants’ validation (Lincoln & Guba,
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1985; Seale, 1999a). In their later work Guba & Lincoln (1989) introduced authenticity criteria which refer to fairness, plus ontological, educative, catalytic and tactical authenticity.

4.6 PITFALLS OF CASE STUDY

Despite its scope, case study is also viewed with scepticism by some, especially when objectivity and representativeness are seen as overriding factors in an evaluation of its merit. In a sense, a case study’s strengths are also its limitations. The detail in data and the scope of data sources create challenges for data collection and analysis. Creswell (2007) highlights the constraints the researcher may experience in an effort to set boundaries to the case. Some of the previously mentioned case studies confirm this lack of clearly defined cases and boundaries, which then compromise rigour. Representation of findings can also be problematic; decisions need to be made on whether all data can be analysed and which findings should be presented. Gathering the necessary breadth and depth of data, and its analysis, is resource intensive in terms of time and expertise, creating practical difficulties (Vallis & Tierney, 1999). Both Stake (1995) and Yin (2003a) allude to the qualities, roles and attitudes, and even intuitions, which a case study researcher must harness. As the literature suggests, and as this researcher can confirm, case study is not for the faint-hearted. As much as case study is able to accommodate multidimensional phenomena, complexity increases when multiple cases are used in terms of revealing richness of findings and their interrelationships (Creswell, 2007). Although multiple cases may support rigour, rich context-specific detail may become compromised if the analytical goal is comparison across cases. The rich descriptive account that generates a vicarious experience is favoured by Stake (1995). Yet a theoretically orientated, comparative case study focus may not lend itself to such a detailed narrative. In order for interpretations to remain meaningful to participants and readers of the study, the researcher must balance the dual factors of taking representations out of context and the requirement for sufficient detail.

The representativeness of sample size and generalisation of findings to populations is arguably the most profound criticism that has been levelled against the use of case study. Both impact on the type of analysis and the purpose of theory. Hammersley and Gomm (2000) give an account of the range of factors that need to be considered for such a design. Their reference to negotiating
authenticity and authority for case study evaluation struck a chord with my experience. If the analytical goal is comparison, a case study calls for a degree of planning in terms of design and procedures to achieve robustness. According to some scholars, however, (Lincoln & Guba, 1985; Guba & Lincoln, 1989; Erlandson et al., 1993; Rodwell, 1998), the research must remain open to emergent issues when a constructionist stance is adopted. Yin (2003a) makes a similar call for flexibility to be maintained. He also argues, however, that the case study researcher must avoid an inadvertent shift in focus which may create unintentional bias (Yin, 2003a). Such a shift can easily occur when attempting to refine a research question - a common feature of qualitative research and typical of a naturalist constructionist inquiry (Lincoln & Guba, 1985). Yin’s case study approach was an initial influence during the conceptual phase of the project, but with an increasing understanding of a constructionist methodology these recurrent shifts appeared less disconcerting. Such shifts could also be viewed as resembling a pendulum in motion – as they appeared, the focus eventually returned to the natural centre of gravity which then emerged as the essence of the research problem. This experience accords with Stake’s account of pursuing the evolving issue and the formulation of further topical questions that arise as the study unfolds. Guided by Stake’s (1995; 2000a&b; 2005) conceptual approach to case study, I was now able to formulate the planned design.

4.7 THE PLANNED CASE STUDY DESIGN

Informed by Stake (1995) and Hammersley and Gomm (2000) decisions could now be made for designing this case study, taking account of a range of pertinent features and their respective elements which are displayed in Figure 4.1.
Chapter 4 The Case Study Design

<table>
<thead>
<tr>
<th>Features</th>
<th>Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreshadowed problem</td>
<td>Although family health care has emerged as a new focus of care, there is a poorly conceptualised common language to inform and develop such practice. Understanding of community nurses and families’ perspectives and interactions when assessing family health is limited. The contribution community nurses make in their respective roles when assessing family needs holistically and collaboratively is not clear calling for an examination of theoretical perspectives that may guide the assessment practice of community nurses.</td>
</tr>
<tr>
<td>Central question</td>
<td>How is family health assessment in different fields of practice conducted, perceived and experienced by the community nurse and the family?</td>
</tr>
<tr>
<td>Issue sub-questions</td>
<td>Who is involved in the interaction process? What family health assessment constructs might help to understand the interaction process? How might the situation of family health assessment be described? How might the interaction process between the community nurse in different fields of practice and the family be explained? What themes may emerge from gathering information about the nurses and families’ experiences and perceptions?</td>
</tr>
<tr>
<td>Number of cases</td>
<td>4 -5</td>
</tr>
<tr>
<td>The case</td>
<td>A community nurse and a family group or household</td>
</tr>
<tr>
<td>The situation</td>
<td>Family health assessment bounded by activities before, during and after several home visits</td>
</tr>
<tr>
<td>Amount of information</td>
<td>Accounts of experiences and perceptions from the nurse prior to home visits Activities and interactions during 2 – 4 home visits Accounts of experiences and perceptions from different family members after a sequence of home visits Accounts of experiences and perceptions from the nurse after a sequence of home visits Documentary evidence about the family assessment visits</td>
</tr>
<tr>
<td>Type of data</td>
<td>Interviews, naturally occurring talk, observations, documents, field notes, research diary</td>
</tr>
<tr>
<td>Type of analyses</td>
<td>Thematic, conversation speech exchange, interpretive</td>
</tr>
<tr>
<td>Approach to rigour</td>
<td>Triangulation, trustworthiness, authenticity, member checking, audit trail</td>
</tr>
<tr>
<td>Type of reporting</td>
<td>Narrative</td>
</tr>
</tbody>
</table>

Figure 4.1: The case study’s features and elements
The research phenomenon of this comparative case study is ‘community nurse-family interaction in family health assessment’. As the case study’s ‘binding concept’ (Stake, 2005), it guided the identification of the problem informed by the literature review and my prior knowledge. From these sources were derived ontological and epistemological assumptions, theoretical perspectives and methodological implications. To guide the study, the problem was formulated into one central question. From this central question, issue sub-questions were developed - although some of these became more refined as the study progressed. Case selection, and the building and bounding of each case could then be specified. These specifications, including the approach taken to rigour, have been discussed above. The selected methods, in terms of amount of information, type of data and analyses, were then identified. Finally, the style of reporting needed early consideration as it was influenced by the constructionist orientation, methodological choices, data and the findings. While taking account of the interactive nature of all these elements and features, my understanding of the integrative and holistic nature of case study developed alongside that of the research phenomenon.

**SUMMARY**

An examination of the methodological issues of case study confirmed that Stake’s approach offered the best fit to the research problem and the framing of the central question. His approach accommodated the constructionist orientation and the epistemological assumptions that underpinned this enquiry. A review of case studies in nursing further informed the chosen *comparative multi-case study design*, which can be defined as problem orientated and instrumental.

The selected methods for this multi-case study with a comparative intent will be the focus of discussion in the next chapter.
5 THE METHODS

INTRODUCTION
The methods for conducting this multi-case study are considered in this chapter. The discussion begins with setting out details concerning ethical conduct in research. Explanations follow as to how participants’ rights and autonomy are protected in this study, given ethical and legislative frameworks. Procedures for seeking ethical approval and gaining access to research sites for recruitment are described. The choice of sampling strategy is argued and justified. The range of data collection methods for gaining an in-depth understanding into the research phenomenon is then discussed. The merit of each method is examined and its potential for this study defended. Planned procedures are detailed and limitations of each method considered. Data preparation issues are then considered and the planned methods for the within-case analysis outlined. Their potential regarding their suitability for the purpose of this study is critically examined, while any limitations are taken into account. Possible options for the cross-case analysis are examined with the proviso that the scope will be influenced by the findings of the within-case analysis. Early considerations are given regarding the likely presentation of case findings.

5.1 CONSIDERING ETHICAL CONDUCT
5.1.1 Protecting Participants’ Rights and Autonomy
Personal moral values, professional standards and research ethics are portrayed by Cerinus (2001) as being the sides of a triangle, each contributing to the integrity of a study. Professional standards are formalised in codes that capture the shared values of professional groups such as the Code (NMC, 2008) and the RESPECT Code of Practice for Socio-Economic Research (2004). Both codes define standards and conduct. Although regulatory and prescriptive, codes cannot cover every eventuality, as their nature is aspirational (Homan, 1991). The RESPECT Code emphasises the interrelated nature of upholding scientific standards, compliance with the law and avoidance of social and personal harm. Ethical conduct is particularly challenging in research that takes place in the participants’ real world. Theoretical principles of research governance and methodology may need to be reconciled with practical possibilities. Birch et al. (2002) emphasise the need for the researcher to respond to ethical and methodological questions pragmatically.
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However, key ethical principles need to be adhered to, for the protection of participants at all times (Downie & Calman, 1994). These are: ‘do no harm’, i.e. non-maleficence; ‘do positive good’, i.e. beneficence; ‘have respect for people’; and ‘treat people fairly’. In practice, this means individuals have the right to information, to either give or refuse consent, to change their minds throughout the research process, to be protected from harm, to be positively affected by it, and to have their privacy protected. Such protection dates from to The Nuremberg Code of 1947, was reviewed in the Declaration of Helsinki in 1964 and was updated in 2008 (Centre for Research Ethics & Bioethics (CODEX), 2009).

The protection of participants when using a constructionist methodology in case study research with a small number of cases poses particular challenges (Guba & Lincoln, 1989; Yin, 2003a). The researcher is visible and seeks prolonged contact with participants. The preservation of anonymity is desirable, but in practice it is difficult to attain. Fieldwork, by its nature, means entering a research site and interacting with people in their natural setting. For example, community nurses often work in teams, share offices and may help each other with their caseloads. Participants’ anonymity is safeguarded through the avoidance of attribution in data excerpts and accounts (Cerinus, 2001). Therefore, one must guard against inadvertent breaches of privacy and confidentiality from the time of recruiting to reporting. Confidentiality agreements must also be sought from those transcribing interviews (Kvale, 1996). And a fair, accurate and relevant representation of participants’ accounts and their interaction demonstrates ethical research practice in reporting and dissemination (Gillies & Alldred, 2002). The aspirational nature of conduct, however, becomes legislative when storing and processing data, as data protection legislation must be adhered to. These aspirational principles and legislative requirements were adopted throughout this study.

A further requirement to protect participants and their autonomy is to seek their informed voluntary consent which requires information processing and decision making. This depends on rational thought and cognitive capacity. Protection applies to individuals irrespective of age, and consent can be sought verbally or in writing. The latter is the preferred option in nursing research (Behi, 1995). Family research implies the likelihood of children and young people being involved,
meaning their protection must be maintained within current and local legislation, and ethical practice (Neill, 2005). A parent and/or guardian would normally give consent for their child to take part in research depending on the child’s competence (Broome & Stieglitz, 1992; Medical Research Council (MRC), 2007). Parental consent and that of the young person, if competent, must be sought to ensure good practice. Seeking assent, a term used if young people are not in a position to give consent, also represents good ethical practice as it demonstrates respect towards young people (Broome & Stieglitz, 1992; Thomas & O’Kane, 1998).

Since no legislation deals specifically with children’s and young people’s participation in research, legislative principles are suggested to reasonably apply to consent procedures (Neill, 2005; MRC, 2007). The Children (Scotland) Act 1995 (The Scottish Office) and the Protection of Children (Scotland) Act 2003 (The Scottish Government) provide the legislative framework for children’s and young people’s consent to medical procedures or treatment in Scotland. Here young people can consent to treatment at the age of sixteen. Below this age the young person can give legally binding consent depending on his or her decision-making competence, which depends on developmental maturity (Broome & Stieglitz, 1992; Neill, 2005; MRC, 2007). Consent, regulated by legislation and enshrined in ethical research practice, implies an individual’s agreement or willingness to a particular action. Although voluntary, it calls for continual assurance by the researcher from an ethical and methodological perspective. As the case for this study comprised a community nurse and family, and family was methodologically defined as a group of two or more individuals (see Chapter 2, Section 2.3.3 and Chapter 3, Section 3.3.3), the possible inclusion of children and young people influenced decisions for recruitment and consent. Information and consent/assent forms were prepared which gave due regard to potentially different developmental stages of children and young people in the family. In light of studies reviewed (see Chapter 2, Section 2.4), gaining access to a community nurse working with families required careful consideration.

5.2 GAINING ACCESS AND SEEKING ETHICAL APPROVAL

Gaining access to the research site is a multi-layered process of seeking ethical and management approval. Site selection is influenced by the research design and sampling strategy. A small
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number of cases from different sites were planned. Community nurses, from different fields of practice, who were willing to open their assessment practice to scrutiny, were to be approached. The ethical implications of case study with a small number of cases further influenced decisions for site selection. Given my current professional role and previous contact with nursing staff in the local health board in various capacities, I thought it preferable to gain access to a research site outwith the local environment. The selection of research sites was further influenced by the need to gain access to community nurses who worked in different fields of practice. This required health boards to be identified where health visitors, community children’s nurses, family health nurses and district nurses worked in primary care settings. A range of sites were selected which promised to ensure the desired variation in community nurses.

5.2.1 Seeking Ethical Approval

As a moral code, ethical principles provide for professional self-regulation, inform ethical guidelines and drive ethical approval of planned research. Research governance fulfils national requirements designed to ensure theoretical principles are formalised, applied and scrutinised (Birch et al., 2002). Since this research was planned as a multi-site study, national requirements had to be met. The Standard Operating Procedures for UK Research Ethics Committees implemented by the NHS Central Office for Research Ethics Committees (COREC, 2004) were followed when approval was sought. This organisation has since been incorporated into the National Research Ethics Service (NRES, 2007). As chief investigator, I ensured adherence to the monitoring and audit requirements of the Local Research Ethics Committee (LREC). Before seeking approval from the LREC, School Ethics Committee requirements had to be met. The application included indemnity cover offered by institutions to research students. This fulfilled Clinical Negligence And Other Risks Indemnity Scheme (CNORIS) (NHS SEHD, 2003) requirements with regard to non-negligent harm, supported by safeguards that covered negligent harm. Integral to seeking ethical approval was the submission of consent forms and participant information sheets. The consent forms were prepared for community nurses and family members (see Appendix A) and included assent forms for children and young people between six and 15 years of age. Information sheets were developed in response to anticipated information needs of those involved in the study and recognition of the specific developmental needs of children and young people (see Appendix B). Only when ethical approval is granted, and notification received in
writing, may the principal investigator begin the study. The ethics committee, as the approving body, requires annual interim reports and a final report following completion of data collection. These requirements were all met.

Research and management approval processes, and research training of those undertaking a higher research degree demonstrate the safeguarding of ethical requirements of NHS institutions (SEHD, 2006a). Research and management approval processes were to be completed for each site before access was granted. This second level of approval required follow-up phone calls to be made, as well as preliminary site visits. Each health board has its own procedures, which resulted in duplication and delay. Gaining access to the sites was to be set in motion by writing to the Director of Nursing (see Appendix C), explaining the study, seeking approval and contact details of key informants, such as lead nurses, to facilitate the recruitment of community nurses. Once a community nurse had given her informed written consent, discussion would take place about selecting a family from the nurse’s caseload. Approval would then be sought from the general practitioner to approach the family for recruitment (see Appendix D).

Gaining access to the research site required a range of demands at different stages and levels to be balanced by adhering to a top-down process. Once ethical approval was granted, site selection depended on the outcome of these procedures. A description of the outcome in each case is given in Chapters 6, 7, 8 and 9.

5.3 PURPOSIVE SAMPLING
As Lincoln & Guba (1985; Guba & Lincoln; 1989) contend, a naturalist-constructionist enquiry relies on purposive sampling which is not representative of a population. Therefore, purposive sampling fits well with a case study. As sampling in case study research tends to be purposeful, some refer to it as ‘case selection’ (Creswell, 1998; Curtis et al., 2000), others call it ‘theoretical sampling’, and other types exist (e.g. Glaser and Strauss, 1967; Patton, 2002). Sandelowski (1995b) states that purposeful sampling with maximum variation is commonly used in qualitative nursing research. Its rationale is based on maximum variation being sought either about particular
experiences or the essential features of a phenomenon. A decision must be taken regarding the types of variation, the extent to which the variability is achieved, and when instances of it are likely to occur. Purposeful sampling for maximum variation is a further option. This can be done for either phenomenal variation or selective and criterion sampling which can justify the sampling of a small number of cases. Subsequent cases are selected based on target phenomenon, which requires selection criteria. This sampling strategy is based on a pragmatic rather than an analytic consideration. The latter requires data collection and analysis aimed at ‘theoretical saturation’. The former is dependent on an priori decision-making before data collection commences, while aiming for information redundancy without compromising the robustness of this sampling strategy (Sandelowski, 1995b).

The key concepts integral to the study defined the phenomenon of interest – community nurse-family interaction in family health assessment - before data collection in order to guide the research. It was essential to find community nurses who perceived their assessment practice to focus on the family as a whole, rather than on the referred individual family member. It was also likely that recruiting nurses and families who would be willing to open up their interaction to observation would pose difficulties. I assumed nursing work with families to be common practice, but whether this applied to family health assessment was not clear. For this reason, the pool of potential participants was assumed to be limited. Sampling, or rather selecting cases purposeful and for maximum phenomenal variation, seemed to offer flexibility and scope given the case study design and its purpose. Maximum variation was sought by recruiting community nurses with a particular assessment practice linked with their field of practice. I assumed a health visitor would take a specific preventative and health orientated focus towards families with a young child. A community children’s nurse offered a focus on the family with a chronically ill child. The assessment practice of the family health nurse encompassed health or illness issues relating to the whole family. A district nurse might focus on the ill adult within the family. Health and long term care needs were considered relevant to families. This selected phenomenal variation, i.e. varied experiences and instances of ‘family health assessment’, was theoretically relevant. A small number of carefully selected and theoretically orientated cases for collecting data was regarded as sufficient (Sandelowski, 1995b; Patton, 2002; Yin, 2003a; Donmoyer, 2000; Silverman, 2005). As Sandelowski (1995b: 182) emphasises, however, the sampling strategy calls for methods that
allow access to the range of diverse instances necessary to arrive at a holistic and in-depth understanding.

In order to meet the study’s aims, I considered methodological adequacy and recruitment issues in case selection. A case study can comprise one, two or more cases (Stake, 1995; Donmoyer, 2000; Yin, 2003a). Selecting multiple cases using selection criteria makes comparison and explanation possible, a principle described as “replication logic” (Yin, 2003a: 47). This replication of cases is based on the experimental method, instead of the sampling logic typical in survey research. Replication was inconsistent with the chosen methodology, however. An alternative approach had to be found that accommodated the sequential process and the comparative design. Firestone (1993) supports “intentionally sampling for theoretically relevant diversity and replicating cases through multisite designs” (Firestone, 1993: 22). This alternative approach increased the likelihood of successful recruitment, fitted the study’s aims, supported purposive sampling for maximum phenomenal variation and allowed the research process to unfold.

5.4 DATA COLLECTION
A range of detailed evidence was sought that would give access to multiple realities, actions, interactions and different perspectives. The use of a single method would have limited an in-depth understanding of the research phenomenon, as each method yields different types of data for different purposes. Studies which take an ethnographic, interactionist or constructionist approach use fieldwork methods for data collection (Kendall, 1993; Hall & Callery, 2003; Varcoe et al., 2003). An interactive engagement within an unfolding process required the use of methods in a cyclical and sequential fashion for each case (Guba & Lincoln, 1989). As a community nursing assessment is not a one-off event, I considered it important to look at assessment visits that would go beyond the first stage, as recommended by Bryans (1998), and not place the focus solely on the first assessment visit as had been done by Kennedy McAuley (2000). Each method is now considered in sequence.
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5.4.1 Interviews

In-depth interviews provide a purposeful, conversational and in-depth method with which to gain insight into subjects’ experiences and perceptions in order to construct accounts of their perspectives (Silverman, 2006). Ethnographic interviewing is social interaction - rapport must be built to uncover interviewees’ perspectives. They also have to be encouraged to reveal their experiences, beliefs and attitudes (Hammersley & Atkinson, 1995). Participants and researcher have to collaborate if making sense of the phenomena of interest, the situation and the process is to be achieved through co-construction of meaning (Silverman, 2006; Charon, 2007). Due to the reliance of the interview method in building a working relationship, several interview sessions may help to build the rapport between interviewee and interviewer (Rubin & Rubin, 1995). Thus it is vital to be able to connect with participants for both situations: a single encounter to develop into a sufficiently meaningful conversation, and a sequence of interviews to gain an understanding about participants’ practice. Since a family health assessment was likely to involve different generations, e.g. children of varying ages, age-appropriate responsiveness had to be taken into account (Eder & Fingerson, 2002). Although I had gained much experience in building rapport with children, families and students in my professional roles, as researcher I had to consider a role that would best suit interviewing. A collegiate stance seemed the most appropriate. A researcher’s knowledge of a participant’s culture, however, may lead to familiarity of the field and thus preclude openness and sensitivity (Hammersley & Atkinson, 1995). As I no longer worked in clinical practice, the stance of ‘curious learner’ seemed the most appropriate as it also aligned with the researcher’s enquiry role; a case researcher role not mentioned by Stake (1995).

According to Habermas (1999) interpersonal interaction is influenced by power dynamics, as is interviewing for research purposes, calling as it does for a certain level of control by the researcher (Silverman, 2006). Power dynamics are contingent upon situation and context, therefore reflection on these issues was required. While the nurse interviews might be conducted in a health centre, the home would be the venue for the family interview. Different communicative behaviours, power relationships and perceived levels of control exist in home care settings (McIntosh, 1981; Sinclair & Whyte, 1987; Scannell et al., 1993; Whyte et al., 1995). As discussed in Chapter 3, Section 3.3, research involving families poses conceptual and interactional challenges, with methodological implications. Accounts of the individual voices of family
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members, as representations of the family group, had to be elicited. In a family interview of at least two family members, the aim would be for both to contribute as informants of the family experience (Racher et al., 2000; Houck et al., 2005). Each family member would be involved in the co-creation of an account. Simultaneously, their account would represent the family perspective as a whole. Interviewing skills had to be applied that would enable all individuals to contribute equally in a natural turn-taking dialogue. By comparison, the one-to-one situation with the nurse would ensure that accounts would be elicited relating to different occasions. It was therefore essential to respond to participants’ situations and perspectives with respect, and to gain their trust throughout the data collection (Silverman, 2006).

The flow of interactions, the effect of questions and communicative behaviours required to achieve a conversation built on mutual respect and trust, required some thought. Leading questions could distort the data and interruptions compromise the flow of conversation (Rubin & Rubin, 1995). As Hammersley & Atkinson (1995) suggest, through reflection on field visits, bias and reactivity can be more consciously addressed. Occasional note-taking during the interview process is recommended to avoid losing sight of focus and timing (Gaskell, 2000). Active listening, as a means of signalling interest, also required consideration, as it helps to clarify or stimulate deeper responses and enhances effectiveness in method (Hammersley & Atkinson, 1995; Flick, 2002). As a visual ‘aide memoir’ before embarking on field visits, I developed a flow chart that integrated these aspects, based on Hammersley & Atkinson (1995). It highlights the many issues that may influence an interview (see Appendix E).

A standardised interview schedule was selected as it made comparison across cases possible, although, not all interview types offer the same methodological scope (Patton, 2002). Open-endedness had to be maintained for methodological reasons. Participants should respond in detail and at length, and be able to ask follow-up questions (Silverman, 2006). The episodic interview was chosen for the pre-home visit nurse interview as it offered scope for the interview guide to be structured along the lines of a tighter study design aimed for comparison within a constructionist methodology (Flick, 2000; Flick, 2002: 104). As a concrete purposeful approach, the episodic interview elicits narrative episodic accounts; it is not, however, the whole narrative of
experiences that is being sought. Participants’ accounts were sought based on the description of specific experiences as they pertained to concrete situations. Access to conceptual schemes, in terms of semantic knowledge, may be elicited by alternating the more open narrative with concrete pointed questions (Flick, 2002). The episodic interview offered a good fit when it came to accessing the nurse’s experience and their underlying conceptualisations. The former would assist in uncovering her conceptualisations of family and family health assessment and the latter would help elicit experiences about these particular aspects of assessment practice.

For the post home visit interviews a less conceptually orientated format was considered appropriate. The focused semi-structured interview was chosen for both the nurse and family post home visit interview. It was assumed that each case would have its unique care context and specific issues, meaning I had to be able to take account of the unfolding events that would occur during the preceding home visits. Following a preliminary analysis of the pre home visit interview and the audio-recorded home visits, case-specific issues could be pursued further in the post home visit interviews with the nurse and the family. All interview guides had to be prepared in order to accommodate comparison while allowing me to be responsive to variations in each case (Patton, 2000; Flick, 2002). As suggested by Duffy et al. (2004) I practised my interviewing technique in a simulated environment before starting the data collection. It was a helpful exercise, as a sympathetic colleague provided useful feedback.

In light of the study’s theoretical orientation, the content of the interview schedules was informed by critical reading of the reviewed literature (Miles & Huberman, 1994; Gaskell, 2000). While the sensitising concepts gave some direction to the interview schedule from an etic perspective, an emic perspective required consideration to ensure “naturalistic indicators” were identified as empirically grounded evidence (Lincoln & Guba, 1985; Denzin, 1989; Stake, 1995; Flick, 2002; Patton, 2002; Krippendorf, 2004).

Although interview data gives access to participants’ accounts, they must be regarded as reconstructions and not as reality. Interview data therefore remains susceptible to bias and raises
questions about trustworthiness and authenticity (Guba & Lincoln, 1989). Naturally occurring talk would give access to co-constructions between and among the community nurse and family members. It would allow me to gain an in-depth understanding of the interaction process in family health assessment in time and context. Audio recording of such co-constructions suggested that a relevant complementary method be employed.

5.4.2 Audio Recorded Interactions

*Audio recordings* of conversations between participants give access into their talk-in-interaction (Holstein & Gubrium, 2007[2004]). This method was deemed suitable for understanding this process as it targeted the study’s ‘how’ question (Silverman, 2006). Silverman argues that audio-recordings of interaction are more reliable as data is generated in “*naturally occurring* situations” compared with “*researcher-provoked* data” such as interviews (Silverman, 2006: 237 (*italics in original*)). Therefore, the method enhances the dependability of evidence collected and its availability for analysis.

In comparison with interviews, it was anticipated that this type of data collection would be affected more significantly by contextual factors. The presence of family members, home environments and health concerns would all define the nurse’s professional perspective and the resultant actions and interactions. In this way, participants would produce their own contexts for their interaction which were critical for the purpose of this enquiry (Silverman, 2006). From a constructionist perspective, audio recordings of conversations represent the reality of those present rather than an account of their experience. Their talk-in-interaction would unfold to create interplay of content and process with methodological implications (Holstein & Gubrium, 2007[2004]). But the nature of their communicative behaviour and its impact would lack representation in the audio-recordings and the subsequent transcripts. Thus, access to observed audio-recorded interaction was considered essential to complement the naturally occurring events.
5.4.3 Observations

Observation is the method of choice to gather “first-hand information” about interaction processes (Denzin, 1989; Silverman, 2006: 21). Observation of phenomena yields evidence to initiate the “circle of interpretation” (Kaplan, 1964: 362) of enacted communicative behaviours, such as signs and gestures that are imbued with “act meaning” by actors (Kaplan, 1964: 32). From a symbolic interactionist perspective such indicators have purpose and are goal directed (Charon, 2007). The method was methodologically consistent as it would lead to further understanding of participants’ interactions based on their non-verbal behaviours and symbolic meaning. It would add another perspective to the research phenomenon. These signs and gestures would not be accessible through any other method apart from video recording (Silverman, 2006). Observation complemented the interview data and naturally occurring discussion, and promised to give access to the constitutive elements of the research phenomenon.

A participant as observer role was considered the most appropriate, due to ethical constraints during the nurse’s home visit (Gold, 1958; McIntosh et al., 1999). Observation of home visits in community nursing is reported by others, e.g. Bryans (1998), McIntosh et al. (1999), and Kennedy (2002). They noted the method’s advantages and limitations. Bryans adopted a ‘participant as observer’ role in her studies. Kennedy (2002) took an ‘observer as participant’ role, where she helped the district nurse with some activities. Not everything can be observed within a communication situation, therefore, the chosen focus was on spatiotemporal arrangements of participants, characteristics displayed by the nurse and participants’ activities.

Two procedures were planned. An ethnographic approach, informed by Spradley (1980), would help to capture the necessary contextual information. An initial exploratory phase, with descriptive observations of the environment and positioning of participants during the first few minutes of the visit, would give time to settle into the activity. More focused observations of specific physical signs would follow. Although a time sampling frame is regarded by Fassnacht (1982) as less accurate, due to difficulties in defining the start and conclusion of behaviours, I still thought it useful to adopt a five minute sampling frame, regarded as worthwhile by McIntosh et
Observations could then be made selectively and purposefully, and specific signs recorded by hand (Kellehear, 1993).

The observation procedure incorporated a degree of standardisation, without neglecting contextual factors, to compare observation data from different cases. An observation guide was prepared, which was informed by an interactionist perspective. The framework was consistent with a constructionist perspective, as it drew on the representational function of communication and was evoked via differentiated and selective symbols and signs (Fassnacht, 1982). These symbols and signs were assumed to represent the nurse’s relational stance, expressed via non-verbal interaction and action. Since speech is accompanied by gestures to further specify or reinforce the linguistic message, observational units were selectively chosen, based on their schematic representations and informed by theory (Fassnacht, 1982: 25). My intended focus was on the communicative behaviours which I assumed would contribute to an interpersonal climate of acceptance, appreciation and respect, suggesting a sense of security and belief in the other for the promotion of ‘building trust’ as suggested by Tapp (2000) and Niven & Scott (2003). I regarded this as important for gaining a deeper understanding of the nature of interaction between the community nurse and family members. Since observation requires focus and concentration, observation of non-verbal behaviours would be unlikely to include all participants with the same detail. Facial expressions and types of listening behaviours may communicate a caring, non-judgmental stance suggesting an empathic understanding, positive regard and unconditional commitment plus an acceptance of clients’ goals for the promotion of ‘showing empathy’ (Egan, 2002; Niven & Scott, 2003). For this reason, I thought more detailed observations could most usefully be directed towards the community nurse. Yet group interaction and family life are dynamic. Hall (1998) observed family life in a grounded theory study and found its observation challenging. With this in mind, and on my supervisor’s advice, I informally practiced my observational skills at opportune moments, as the importance of training and the need for rehearsal is also recommended in the literature (Kellehear, 1993).

Although it is possible to identify actions by means of signs or gestures, Habermas (1999) cautions that the intentions of actors cannot be inferred from observation alone. Signs and gestures must
be interpreted as representations displayed during a particular situation; they are time and context bound. Based on the nurse’s actions and non-verbal behaviours, intentions could only be guessed at derived from inferential interpretation of signs and gestures displayed. Thus interpretation of observations is assumptive. Moreover, the method is limited due to reactivity in response to an observer’s presence (Adler & Adler, 1998). Intrusion into participants’ everyday events should be minimised by remaining neutral and impartial (McIntosh et al., 1999). Others have commented on its reactivity and its limitations in terms of consistency, accuracy and dependability (Lincoln & Guba, 1985; Kellehear, 1993; Valisner, 2000).

That said, observation would complement the ‘how’ question relating to the research phenomenon. I anticipated that the method would give scope for an inspection of possible convergence and consistency of interaction in support of trustworthiness (Guba & Lincoln, 1989) and corroborations (Sandelowski, 1995a). The idea was to compare transcribed audio-recorded data sources with observation records. However, the data collected would be treated as complementary to more dependable sources. I regarded a more unobtrusive method for the collection of further data as useful.

5.4.4 Documents

Nursing assessment documents, despite their confidential nature, provide a record open to inspection and a resource representing community nurses’ presentational customs in documentation (Silverman, 2006). Documents give access into culturally taken-for-granted structures of organisational systems (Hammersley & Atkinson, 1995). As a method of data collection, it is non-reactive compared with observation and interviewing, and less prone to bias (Kellehear, 1993). It would give access into structural aspects of ‘family health assessment’ such as assessment frameworks that might be used in different fields of practice and would promote comparison of assessment practice. As a legislative means to evidence practice, documenting assessment practice reflects professional actions and interactions. Such professional practice evidence contributes to a specific version of reality in which the individual nurse presents ‘social facts’ which are then shared within the organisation. The evidence of social constructions and such representations cannot be considered as transparent, however (Atkinson & Coffey, 2004).
From a methodological perspective documents were not viewed as a resource or objective standard (Wolff, 2004; Silverman, 2006). Their purpose was instead considered in relation to ‘family health assessment’, the functions of these documents and their use (Silverman, 2006). Thus inclusion of the method promised to enrich the depth of understanding sought concerning the phenomenon.

The need for a structured collection of documents is emphasised by Hammersley and Atkinson (1995). Miles and Hubermann’s (1994) approach to collecting documents appeared useful. The format offered the opportunity to facilitate an initial systematic examination, to define the documents’ general context, to ease the development of case records, and to provide a structure for comparison across cases (Stake, 1995). It was planned to access documents after all other sources of data had been collected, to maintain openness towards participants and processes. It was anticipated to require interrogation of documents from a family health perspective for its social representativeness (Wolff, 2004; Silverman, 2006). Comparison of coded data and insights gained from interview texts to confirm or refute the use of a case-specific assessment framework in the documentation, was seen as necessary. The interpretation of the symbolic and interactional relevance and the meaning of documents was a requirement from a theoretical perspective.

5.4.5 Field Notes

Field notes support observation and understanding of participants’ practices and are considered a private record (Silverman, 2006). The recording of field notes assists with the development of processed entries during field work and the monitoring of reflexive entries after each contact with participants (Hammersley & Atkinson, 1995). However, the construction of field notes is commonly associated with spending prolonged periods of time in the subjects’ world. In this study, participation with nurses and families was limited to the home visits. As Kennedy McAuley (2000) reports, going out on visits with community nurses can be difficult in terms of achieving prolonged times of observation in the field, due to busy schedules and ethical constraints. I decided to regard field visits as a potential opportunity to record information, questions and reflections as the situation presented itself. I considered it useful to keep a notebook with some guiding structure as suggested by Hammersley & Atkinson (1995).
5.4.6 Research Diary

A research diary promotes a reflexive stance and was in keeping with the study’s methodology. Reflexive accounts may become a legitimate source of data as they offer insight into the study’s evolution and the researcher’s empirical learning process (Edwards & Talbot, 1999; Daly, 2007). The research project’s progress can be traced and illuminated based on reflexive account, and becomes part of the study’s audit trail (Lincoln & Guba, 1985). Since such recordings are considered to be the researcher’s private entries, their confidentiality should be maintained (Edwards & Talbot, 1999). As a means to reflect on and avoid bias, I considered it important to document evolving insights and to engage with theoretical assumptions early in the project. A further reflexive record was set up as I became familiar with the computer-assisted qualitative data analysis software NVivo which offered the scope of a project log. It is recommended for tracing chronological progress and is a legitimate data source as it may contain methodological, theoretical and analytical notes (Richards, 2005; Silverman, 2006). The planned methods selected to be adopted for each case study, their type and purpose, are summarised in Figure 5.1 below. Its construction was informed by Silverman (2006).

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<tr>
<th>Method</th>
<th>Type</th>
<th>Purpose</th>
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<tr>
<td>Interviews</td>
<td>Pre home visit / Nurse interview</td>
<td>Construction of meaning as representation of experience through interaction</td>
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<td></td>
<td>• In-depth</td>
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<td></td>
<td>• Episodic-narrative</td>
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<td>Post home visit / Nurse interview</td>
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<td>Post home visit / Family interview</td>
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<td>• Standardised open-ended</td>
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<tr>
<td>Interaction</td>
<td>Home visit interactions of nurse and family</td>
<td>Construction of meaning as representation of relations and transactions through interaction</td>
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<td>Audio</td>
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<td>Recordings</td>
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<tr>
<td>Observations</td>
<td>Home visit interactions</td>
<td>Comprehension of social processes in real life contexts</td>
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<td></td>
<td>• Non-participant</td>
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<td>Documents</td>
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<td>Reconstruction of historical and cultural representations</td>
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<td>Reflection and reconstruction of chronology relating to research conduct and process</td>
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</table>

Figure 5.1: Planned data collection methods, types and purposes

It was anticipated that data collection methods of *interviews, audio-recorded interactions, observations, documents, field notes* and *research diary* would generate rich and large amounts of information. Some thought had to be given to their processing.

5.5 DATA PREPARATION

Effective data management is linked with data preparation and is vital in a case study design (Yin, 2003a). The transition from speech to text is mediated by the selected modes of recording data, either electronically using an audio-recording device, or by hand. Depending on mode, different methodological and theoretical judgements and decisions are called for (Poland, 1995). The verbatim transcription of interviews and naturally occurring conversation transposes the audio-recorded communications into written texts which then become open to further manipulation (Kvale, 1996). This transition is open to a variety of influences with immediate consequences for a study’s analytic quality (Silverman, 2006). Transcriptions can be prone to errors, inadvertent alterations or omissions due to recording quality, all of which may lead to distortion in meaning (Poland, 1995). Therefore, the checking of transcriptions is important to ensure trustworthiness of the material, as data preparation signifies commencement of the analytic process.

Given the relational dimension associated with the nurse-family encounter, the interactional nature of enquiry, and the interpretive analytic approach, it was relevant to consider how to accommodate contextual elements. For example, pauses, laughter, emphasis in speech and overlapping talk create contextual nuances in interaction (Poland, 1995). To capture as much contextual information as relevant for each analytic purpose, transcription symbols were
considered to ensure authenticity. Silverman’s simplified format (2006: 398; see Appendix F) offered consistent symbols for the transcription of talk-in-interaction. These would help to convey the contextual interaction elements while a consistent approach would contribute to the quality of the project. Computer-Assisted Qualitative Data Analysis Software (CAQDAS) is a further means to support consistency in handling diverse data sets (Gibbs, 2002). I therefore considered the use of such software as valuable. My intention was to record and transcribe verbatim all interviews and home visit recordings. This would allow me to return to the texts for each case at any time, instead of relying on memory, notes or repeatedly listening to tapes which could result in omissions or distortions. Data collection was likely to cover a length of time and, given the small number of cases, I wanted to avoid the risk of data loss. In addition, full access to all data sources would be necessary to develop an in-depth understanding of phenomena. My aim was initially to transcribe a first interview. For any further transcription undertaken by secretarial staff, a confidentiality statement was prepared for signing to avoid compromising participants’ confidentiality.

5.6 DATA ANALYSIS IN A MULTI-CASE STUDY

From a constructionist viewpoint, it was important to take account of multiple perspectives in analytic procedures which could also be defended from a symbolic interactionist and family systems orientation. While understanding of each case was sought, comparison of similarities and differences was also of concern and details of the case had to be preserved. The analytic goals required description and interpretation. The comparative analysis across diverse cases opened up the possibility of looking for patterns which might justify building an explanatory framework. The work of Stake (1995), among others, influenced the planning of analytic methods.

5.6.1 Within-Case Analysis

Drawing on a range of data sources which generates largely textual data during field work is supported in a constructionist methodology (Hammersley, 1989; Atkinson & Hounsley, 2003). The linguistically constituted material then becomes available for uncovering modes of analyses (Hammersley & Atkinson, 1995; Krippendorf, 2004). Stake (1995) proposes two main approaches: direct interpretation and categorical aggregation. Both analytic methods aim for meaning in the
Chapter 5 The Methods

data, but each varies in their focus. Both however, may be usefully applied with different
emphasis in an instrumental case study (Stake, 1995). According to Stake, *direct interpretation*
involves inspection and interrogation of the data for single instances, pondering the meaning by its
being taken apart and then re-assembled. In this procedure, data becomes a meaningful
representation of the phenomenon of interest based on the drawing of inferences. Significant
meaning, even of single instances or patterns in the data, may emerge that may involve looking for
sequences. This presented an important analytic rationale for approaching interaction processes.
Single and patterned regularities of instances may contribute to a deeper understanding of a
particular issue (Stake, 1995; Krippendorf, 2004). Compared with Stake (1995), a broader
explanation of generating meaning from the data is offered by Huberman & Miles (1998). They
refer to ‘tactics’ such as comparing and contrasting instances, noting of patterns and themes,
seeking plausibility and clustering. Their purpose is to enable conclusions to be drawn from the
data, which should be captured in interpretive accounts. Some may take the form of descriptive
narratives. The aim here would be to provide for a “vicarious experience” of the case for the
reader (Stake, 1995: 86). According to Stake, assertions take the form of propositional claims.
They may link the researcher’s propositional knowledge derived from the analysis with current
theoretical assumptions. This analytic mode I regarded as equally relevant for this case study
because of its theoretical orientation. Thus the utility of theoretical assumptions may be
supported or refuted. Both interpretations and assertions must be grounded in the data to be
trustworthy and credible. Methodologically, inferences, interpretations and assertions are
constructions as they portray meanings and are therefore justified within the context of this study.

In *categorical aggregation*, multiple instances of a particular phenomenon from the data are
gathered together. This means coding instances of similar meanings in text units which define a
particular phenomenon according to conceptual groupings (Huberman & Miles, 1998). This
procedure also enables *patterns* to be searched for. The aim is to look for consistency within
certain conditions. For example, two or more categories may be associated by way of
*correspondence* (Stake, 1995). Seeking such correspondence or isolating relations may also be
more easily achieved by looking for repetition in the data and tallying categories in matrices.
These help to identify and unify meanings, themes and patterns (Miles & Huberman, 1994; Stake
1995). Some refer to this analytic approach as thematic analysis (Patton, 2002; Priest et al., 2002).
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Others contend that it is merely one analytical mode of semantical content analysis based on assertions and inferences e.g. Krippendorf (2004). It allows for an “extrapolative use of patterns” (Krippendorf, 2004: 50) from “texts as re-presentations” (Krippendorf, 2004: 63 (italics in original)). This approach of categorical aggregation, of direct interpretation and of seeking correspondences to discover patterns seemed to offer a methodological fit for the within-case analysis. These analytic procedures were also chosen as they could accommodate the different data sources, which included texts from the interview accounts, the talk-in-interaction, the observation records and the texts likely to be embedded in nursing assessment documents.

Instrumental case studies are designed to deepen understanding of the research phenomenon. Stake suggests that “the need for categorical data and measurements is greater” in such studies (1995: 77). This analytic rationale would support forms of enumerative induction within case studies, where simple counting of instances of phenomena can demonstrate their magnitude (Silverman, 1993; Seale, 1999a). Indeed, Seale presents an argument for the combination of qualitative instances with counts of frequency of phenomena. This needs to be “supported by a genuinely self-critical, fallibilistic mindset, involving a commitment to examine negative instances” (Seale, 1999a: 131). Corroborating instances and looking for disconfirming evidence can support analytic rigour. Stake suggests this can be done by tallying the most pertinent categorical data. The purpose is to reach a deeper understanding of the case. The usefulness of judicious counting of instances of phenomena in the data is also noted by Sandelowski (2001), who argues that it may inform decisions on selecting the most meaningful avenue to take for interpretation, as relationships may become more visible when categories are aggregated.

Such corroboration of instances is of a different nature compared with aggregation in quantitative content analysis where necessary and sufficient occurrences of phenomena support the discovery of patterns and the testing of hypothesis (Hammersley, 1989). Analytic induction is a method for hypothesis testing in qualitative case study. Lincoln & Guba (1985: 309) refer to it as negative case analysis as a way to support trustworthiness. A small number of cases are explained on the basis of an explicit modification of the phenomenon’s definition to arrive at a causal relationship or interpretation (Hammersley, 1989). In the early conceptual phase of this study I considered this
Chapter 5 The Methods

analytic approach, but rejected it on ontological, epistemological and methodological grounds. According to Hammersley (1989) both the testing of hypothesis and analytic induction are rule-governed and call for explicit, coherent attempts to apply the hypothetico-deductive method. Although Lincoln and Guba discuss analytic induction as a procedure within the context of naturalistic inquiry, I considered it inconsistent with a constructionist epistemology and symbolic interactionist perspective. As Hammersley argues, seeking “discovery of universal (‘deterministic’) relationships” is incongruent with symbolic interactionism (Hammersley, 1989: 198). Here, design and procedures must allow for the unfolding interaction and situation in the field which cannot be controlled and is not open to replication by others. Similarly, I reasoned that different cases and contexts are not replicable. This had also been my rationale for rejecting Yin’s case study approach. Therefore, Stake’s (1995) analytic methods offered a better fit to achieve coherence in this multi-case study.

While categorical aggregation is grounded in inductively coded categories, Stake acknowledges the usefulness of pre-established codes that have “potential correspondences” which “will usually be made before data are collected” (Stake, 1995: 84). Without further explanation, Stake’s claim suggests a hypothesis-driven approach which is inconsistent with his constructionist viewpoint. By contrast, Miles & Hubermann (1994) state explicitly that some pre-established concepts could be brought into the analysis in a theoretically orientated case study – a possibility not mentioned by Stake. Instead, he continues that “[o]ften, the patterns will be known in advance, drawn from the research questions, serving as a template for the analysis” (Stake, 1995: 78). From a constructionist mindset this is an equally perplexing statement. Nevertheless I considered it reasonable and, indeed, necessary for this case study to openly acknowledge my theoretical conceptualisations as researcher, and to expose them to scrutiny. To refer explicitly to combining an inductive and deductive analytic focus, as suggested by Miles and Hubermann (1994) and Patton (2002), would support trustworthiness in the analytic methods. A deductive analytic focus could then be brought in, with a theoretical orientation and key concepts flowing from that. For example, an initial coding framework could be useful to aid comparability across data sources and give direction to the analysis. Such a framework would need to be used tentatively in order to maintain openness for emerging instances that were grounded in the data and in multiple perspectives (Lincoln & Guba, 1985; Miles & Huberman, 1994; Flick, 2002). On reflection I
considered it reasonable to go ahead with a conceptual-analytic framework within a constructionist methodology and to maintain my focus on the analytic goals. Further thought was required on how best to accommodate the multiple perspectives.

Dealing with the problem of accommodating different perspectives in analysis is reported in the literature. Ribbens McCarthy et al. (2003) interpreted the multiple perspectives of families by shifting the analytic focus to family members’ different views. This allowed an examination of their multiple perspectives and was similar to what I intended to achieve, namely, to understand the nurse and the family’s perspectives in a variety of cases. Procedurally, this would be achieved by maintaining separate text data sets, or ‘corpora’, for each case as recommended by Bauer & Aarts (2000). These data sets would relate to the nurse pre and post home visit interview, the family post home visit interview, audio-recorded interactions, documents, observations and field notes. Analytically, I also had to take account of the structural differences of these data sources and their non-formalised meanings to ensure further procedural adequacy and maintain cross-case comparability (Yin, 1982; 2003a; Krippendorf, 2004). Stake says little about this analytical issue, but it appeared to be important for this study, given the range of different data sources which are not uncommon in case study. For example, interview accounts and conversation texts call for inferential intents to be distinguished. In the conversation texts, the interplay of content and process may require analytic shifts between the content and its sequences. Here the analysis is concerned with features of talk or “the sequencing of conversations” (Silverman, 2006: 212), a differentiation highly relevant to this study. Since assessment of health needs is likely to require information gathering in dialogue through the asking of questions from a range of family members, different conversational sequences may occur with unique features depending on nurse, family and health care situations. Such variations in interaction would need to be captured analytically.

Perärkylä & Silverman (1991) report on the nature of question-answer sequences within a counselling context using a process analytical scheme for speech exchanges. They define such sequences as an “Information Delivery format” that surfaced in “quasi-conversational’ turn-taking procedures” typical of “Interview format[s]” (Perärkylä & Silverman, 1991: 629 (italics in original)).
Chapter 5 The Methods

Similar processes have also been described as “systemic or “housekeeping” functions” from a pragmatist-interactionist perspective by Beavin Bavelas (1992: 26). She also argues that content and interactive processes are inherent in dialogue and suggests that both elements be taken into account. The analytic procedure is consistent with an ethnographic-conversation analysis orientation (Perärkylä & Silverman, 1991). The scope of this process-orientated analytical scheme was exploited by Bryans (1998; 2000a&b; see also Chapter 2, Section 2.4) when district nurses’ interactions were examined. Characteristic communicative behaviours of nurses were discovered by Bryans which showed distinct interaction patterns. Due to these conversational patterns occurring across two simulated cases, comparison allowed Bryans to show the explanatory power of their patterned regularities. This analytical approach maintained the contextual detail of each case, while offering scope to take account of features of conversation in their sequence. This process-analytical method demonstrated potential for the purpose of this study. If patterned regularities across several home visit interactions, and several cases in different fields of practice, were discovered, explanatory power might be achieved similar to Bryans’ study. However, in Perärkylä & Silverman (1991) and Bryans (1998) study, interaction involved only two individuals. In this study, the aim was to represent the voices of several group members in dialogue.

From a semantical content analytical perspective Krippendorf also notes that “inferences concern the continuation of the process” (Krippendorf, 2004: 67 [italics in original]). This further convinced me that it was important to treat each data source as distinct text corpora from the outset, as suggested by Bauer & Aarts (2000), and to maintain awareness of these analytic-methodological issues. Consistent with a constructionist viewpoint, I reasoned that only in engagement with the data would I be able to fully appreciate these important analytic choices, and that I might have to respond in ways unknown to me at this stage. Despite what seemed a formidable analytical task, my aim was to arrive at suitable, yet efficient, analytic procedures for three reasons. It would help me to cope with the variety of textual material as soon as it became available; it would assist in demonstrating analytic rigour; and it would allow me to answer the research question.

One of Stake’s tactics for analytic rigour is to look for relationships in the data and to corroborate instances supported by triangulation (Stake, 1995). By comparison, Krippendorf argues that in
qualitative content analysis, analytic rigour depends on logic, specific components, and systematic and explicit procedures (Krippendorf, 2004). Since the extrapolative use of themes and patterns is grounded in interpretation, it is essential to show how assertions are built to ensure standards of rigour. Interestingly, this issue is addressed in Stake’s later work (2006) which focuses on cross-case analysis in multi-case studies. Thus, it is important to maintain an audit trail of procedural and analytic moves. Sandelowski (2001) suggests that conclusions are documented, verified and tested numerically within a qualitative data analytic approach. This also seemed a useful strategy to consider, especially when categorical aggregation and counting categories were to be carried out. But concerns about credibility of qualitative content analytic procedures, categorical aggregation, direct interpretation and identification of features of talk require an understanding of their limitations.

Krippendorf thinks the most important factor to contribute to the limitations of content analytic approaches is a lack of explicitness and systematic application of procedures. This would require procedures that would allow the reader to trace the findings to their inferential context, e.g. the conceptual-analytical framework. Thus, a researcher’s conceptualisations and interests become an acknowledged part of the analytic process as argued earlier, something I considered to be consistent with a constructionist methodology. However, the resulting research design is then procedurally less open and the researcher may become “blinded by methodological commitment” (Krippendorf, 2004: 187). Moreover, an initial coding framework imposes a structure on the data and the analytic procedures, to the detriment of attentiveness to participants’ perspectives. A lack of groundedness in the data may undermine a qualitative inquiry. Concerns of this nature have been raised by several scholars, e.g. Atkinson (1992), Mayring (2004) and Silverman (2006). For this reason searching for disconfirming evidence, especially in a study with a small number of cases, is crucial, as it can safeguard against bias and over-confidence in the findings (Seale 1999a).

5.7 CROSS-CASE ANALYSIS AND SYNTHESIS
While it was possible to find guidance for within-case analytic procedures in the literature, similar advice to formulate strategies for the analysis across cases was rather limited. The planned analytical procedures took account of multiple perspectives within each case. The analytic
concern within each case mirrored those that needed consideration across cases. Similarities and differences between and among cases required consideration. Aggregation of case-specific instances that were meaningful in order “to arrive at some indicator of comprehensibility” seemed equally relevant (Stake, 1995: 74). Furthermore, direct interpretation may be necessary for specific cases.

To assess the degree of commonality and difference at this stage, and where the emphasis might lie, posed a challenge. I reasoned that with each new case my understanding of analytical procedures could deepen and that my insight into the research phenomenon would grow. Miles & Huberman (1994) recommend the development of matrices which can aid the aggregation of findings from different cases. Such aggregation can be approached from different angles and would depend on the case-specific findings and issues. For example, role order matrices appeared useful given the different perspectives of the nurse and family. Extrapolation of themes and patterns from a number of cases also becomes possible using such an approach.

While Patton (2002) emphasises their descriptive nature, Krippendorf suggests that extrapolation of themes and patterns can be used to build explanations within a qualitative research approach. Both propositions demonstrated merit for the goals of this investigation. Being able to describe and infer meanings from a single case is an ideographic concern (Stake, 1995). Seeking correspondences and regularities of themes or patterns across cases, however, is a nomothetic concern (Patton, 2002). Moreover, each case would represent a distinct professional group and practice. The perspectives of nurse and family in each case would show similarities or differences, so comparing and contrasting the different cases would be essential.

While giving useful analytic guidance for rich descriptive instances, advice on how to pursue a cross-case analysis with a view to explaining patterns from multiple cases is missing in Stake’s earlier work. Hammersley (1989), however, offers a useful discussion on this matter. He argues that both modes – description and explanation – can be brought together in the pattern model where “the aim is to describe and simultaneously to explain the features of a particular
phenomenon” (Hammersley, 1989: 204). As these features or patterns arise they can then be “shown to be related to the wider context in which [they] occur[s]” (Hammersley, 1989: 204). My understanding of this wider context was taken to mean the cases and the theoretical perspectives brought to the analysis. The pattern model of explanation is viewed by Hammersley and others (e.g. Atkinson & Housley, 2003) as offering a good fit with the principle of ‘sensitising concepts’, constructionism and symbolic interactionism. The pattern model is regarded as a “‘holistic’ approach” (Hammersley, 1989: 179). Hammersley cites the work of Diesing (1972), who presents a helpful methodological discussion about the integrative nature of case study and the pattern model as an explanatory framework. Aiming for this explanatory framework could be justified from a systems theory orientation. Moreover, it seemed to fit well with a ‘holistic’ case study design.

Hammersley’ reasoning was persuasive in my decision to pursue the pattern model as an explanatory framework. I regarded Stake’s deliberations on ‘naturalistic generalisations’ as less convincing. My aim was to present both plausible and meaningful descriptions and assertions based on participants’ accounts. These could relate to and complement explanatory patterns in the interaction process between the nurse and family across different cases. My goal was to present a study whose conclusions would be credible, and would be of use to practising community nurses who wished to adopt a family-derived framework for their assessment practice and to advance family health care.

These deliberations raised my awareness of how I might present descriptions, interpretations and assertions. A case profile is suggested by Flick (2002: 186). It provides a unifying structure based on first analytic procedures which can then be extended. Since each case represents a system, according to Stake (1995) and Diesing (1972), I thought it appropriate to draw on Wright and Leahey’s (2000) Calgary Family Assessment Model (C-FAM) to develop a case description. The main descriptors could be modified, and the Genogram used to represent the family composition in diagram form. A systematic, unified, yet case-specific, format would give the reader a vicarious experience of each case. The usefulness of a Genogram for methodological purposes is discussed
by Rempel et al. (2007) and has recently been adopted for data collection purposes by Kean (2007).

5.8 PROMOTING RIGOUR

My intention was to give the reader a deeper understanding of each case. This would allow the reader to evaluate the trustworthiness of interpretations and the authenticity of assertions (Guba & Lincoln, 1989; Stake, 1996; 2005). Such an approach would require systematic and explicit procedures to be applied in support of an audit trail, and the corroboration of different perspectives and data sources, to demonstrate the study’s credibility. Feedback sought via the return of descriptions, interpretations and assertions to case participants, offered a degree of dependability. It was important that case reports were made accessible to participants. Seeking their testimony by asking for verification, clarification and potential additions to the data would help to find out whether participants recognised their experiences from descriptions and interpretations (Seale, 1999a). Disconfirming evidence needed to be sought to account for contradictions in the data (Lincoln & Guba, 1985). Finally, the building of an explanatory framework grounded in patterns of talk-in-interaction could be pursued. I envisaged that such a pattern model might help to synthesise interpretations and assertions. Within-case analysis had already begun when Stake’s later work (2006) became available. The approach taken at the time is therefore presented in Chapter 10.

Five NHS health boards were invited to participate and recruit community nurses for the study. Three health boards agreed to participate and negotiate access. Four Directors of Nursing referred me to seven Nurse Managers who gave permission to recruit community nurses. Recruitment was done by distributing invitations to potential nurse participants.
As Table 5.1 shows the response rate of community nurses was 11 percent (n=79) of which seven nurses agreed to participate.

<table>
<thead>
<tr>
<th>Community Nurses Sampled</th>
<th>Community Nurse Invitations Distributed (n = 79)</th>
<th>Community Nurse Responses Received (n = 9)</th>
<th>Community Nurses Recruited (n = 7)</th>
<th>Family Invitations Distributed (n = 12)</th>
<th>Family Responses Received (n = 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visitor</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Community Children’s Nurse</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Family Health Nurse</td>
<td>11</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>District Nurse</td>
<td>55</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 5.1: Recruitment outcome

These nurses were then given family recruitment packs which achieved a response rate of 33 percent (n=12). However, further variations unfolded in each case as reported in Chapter 6, Section 6.1 and the following respective case study chapters.

**SUMMARY**

In defence of the planned methods for this comparative multi-case study, ethical principles and procedures were critically examined. Relevant choices were justified for the selected methods. These were considered to complement each other, to fit the study’s theoretical assumptions, be consistent with the constructionist methodology and uphold the need for a robust study. In particular, intentions regarding the gaining of access at multiple levels according to research governance criteria within the context of family research were set out, as were the purposive sampling strategy for maximum variation, the sequential selection of a small number of cases, the data collection methods and the possible within-case analytic procedures. Since decisions regarding the cross-case analysis and synthesis were premature at this stage, its discussion was rather tentative.
Chapter 5 The Methods

Following the critical and careful examination of methods and procedures, the selected and justified choices gave sufficient direction to proceed with the first case. Reporting on its conduct is the focus of the next chapter.
6 DESCRIPTIONS, ANALYSES AND FINDINGS CASE ONE

INTRODUCTION
The issues and purpose of this first, the case study within the context of this multi-case study, are outlined. By its nature preliminary, it allowed for a rehearsal of the planned methods, which are as close as possible to the planned intentions. A description of conduct and procedures follows. Initial findings that were derived after several iterative cycles of analysis are laid out and discussed. The lessons learned as the research proceeded, and the modifications made, are reported to achieve coherence in the overall flow of this thesis.

6.1 ISSUE IDENTIFICATION
This case study gave me the opportunity to discover whether methodological inconsistencies or other substantive issues needed attention and allowed for the testing of procedures (Patton, 2002). The central research question and the relevance of issue sub-questions were reviewed to assess their fitness for achieving the study's objectives. It also provided a first opportunity to evaluate the usefulness of the CAQDS programme NVivo7. Any traces of attribution to participants were eliminated from procedures and data files during each stage of the research. To protect participants' identity fictitious names were chosen for this and subsequent case studies.

Information on the chronology of the study is provided in Figure 6.1. It illustrates the time line of recruitment phases and data collection periods. The dashed lines in the diagram show how a case was lost if a community nurse withdrew from the study. Two community children’s nurses responded to the invitation for the second case study, but one withdrew shortly after it began. Four family health nurses responded to case study three. Two nurses did not wish to proceed once the study was explained. Both the remaining two consenting nurses found it difficult to identify a family from their case load. One nurse moved locality and subsequently regarded families on her case load as being ‘unsuitable’. Case study four involved several recruitment attempts. One district nurse eventually responded but withdrew seven months later due to difficulties in indentifying a family from her case load. Since several health boards had been
identified as potential sites in the COREC application, three other health boards were approached, of which one granted access. One district nurse responded to the 20 recruitment invitations that were distributed. The study comprised four completed cases.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Recruitment</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>HV CCN FHN DN</td>
<td>HV CCN FHN DN</td>
</tr>
<tr>
<td>Sep – Oct</td>
<td>Case 1</td>
<td>Case 1</td>
</tr>
<tr>
<td>Nov – Dec</td>
<td>Case 2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2005</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – Feb</td>
<td>Item 1</td>
<td>Item 1</td>
</tr>
<tr>
<td>Mar – Apr</td>
<td>Item 2</td>
<td>Item 2</td>
</tr>
<tr>
<td>May – June</td>
<td>Item 3</td>
<td>Item 3</td>
</tr>
<tr>
<td>July – Aug</td>
<td>Item 4</td>
<td>Item 4</td>
</tr>
<tr>
<td>Sep – Oct</td>
<td>Item 5</td>
<td>Item 5</td>
</tr>
<tr>
<td>Nov – Dec</td>
<td>Item 6</td>
<td>Item 6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2006</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – Feb</td>
<td>Item 1</td>
<td>Item 1</td>
</tr>
<tr>
<td>Mar – Apr</td>
<td>Item 2</td>
<td>Item 2</td>
</tr>
<tr>
<td>May – June</td>
<td>Item 3</td>
<td>Item 3</td>
</tr>
<tr>
<td>July – Aug</td>
<td>Item 4</td>
<td>Item 4</td>
</tr>
<tr>
<td>Sep – Oct</td>
<td>Item 5</td>
<td>Item 5</td>
</tr>
<tr>
<td>Nov – Dec</td>
<td>Item 6</td>
<td>Item 6</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>2007</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – Feb</td>
<td>Item 1</td>
<td>Item 1</td>
</tr>
</tbody>
</table>

Dashed line: nurse withdrew from study

Figure 6.1: Time line of recruitment and data collection periods

6.2 GAINING ACCESS AND SAMPLING

Once ethical approval was granted via the Central Allocation System of NHS COREC, a health board in Central Scotland was approached to facilitate recruitment of community nurses from three fields of practice. Gaining research and management approval involved lengthy correspondence and personal visits. It was necessary to explain the study to the divisional clinical service development managers of primary care services who were responsible for district nurses, health visitors and community children’s nurses. Recognising these managers as gatekeepers to potential recruits, I realised during one of these meetings that one was also a key informant and translator for cultural norms (Fontana & Frey, 1994). She advised on a more practice-grounded terminology

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for one of the selection criteria, was willing to gauge interest among staff and was prepared to
distribute recruitment information.

For recruitment to go ahead at least three out of four selection criteria had to be met. In the
recruitment letter, the community nurse was invited to respond to the criteria shown in Figure
6.2.

<table>
<thead>
<tr>
<th>Selection Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Experience in a community setting for at least 3 years</td>
</tr>
<tr>
<td>2. Qualified as a Specialist Practitioner Qualification in*</td>
</tr>
<tr>
<td>3. Knowledgeable in family health nursing</td>
</tr>
<tr>
<td>4. Agreeable to conducting a holistic family assessment</td>
</tr>
<tr>
<td>*specified by the community nurse</td>
</tr>
</tbody>
</table>

Figure 6.2: Community nurse selection criteria

One community nurse volunteered. Janine, (her pseudonym), was a health visitor (HV) and
fulfilled all selection criteria. At the first meeting the study and audio recording equipment were
explained in detail. It was an important opportunity to build up rapport (Hammersley & Atkinson,
1995) and promote a mutual understanding about each other’s perceived roles. Informed
voluntary consent in writing was gained. Janine identified five potential families from her case
load but wanted time to reflect and ‘sound out’ potential families. The information letter was
eventually distributed to the family thought most willing to be approached. The decision to select
a family remained Janine’s, and critically influenced the case, its context and how her assessment
practice might be understood.

Permission was sought and secured from the general practitioner to approach the family. A week
later Janine informed me about the family’s agreement to negotiate the recruitment visit. It was a
dual-parent family with two pre-school children – Jill (4 years) and Max (2 years). Janine had
hoped that both parents might be interested as they wanted to start an intervention programme
for Max. On arrival Mary the mother, and Max were present. Following detailed explanations,
Mary gave informed voluntary consent in writing. Her permission was also given to approach the
family’s general practitioner for access to information from her child’s health record relevant to
the research. Mary regarded verbal consent for the participation of her children as sufficient. She also informed me that her partner did not wish to take part. Recruitment took 14 weeks – four weeks for the nurse and 10 weeks for the family.

### 6.3 COLLECTING THE DATA

Data collection took place in three phases over 14 weeks. Each episode required negotiation with participants. Time was limited due to Janine’s busy work schedule. Field visits were maximised by asking questions, watching, listening and examining at chance and planned moments, with notes taken where possible. Most of the data was derived from the home visits and interviews, followed by information from documents. Figure 6.3 shows methods and occasions relating to each phase, the participants and reasons for referral to the community nursing service.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Method</th>
<th>Occasion</th>
<th>Participants</th>
<th>Referral Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pre-home-visit nurse interview</td>
<td>1</td>
<td>Health Visitor</td>
<td>Assessment of development and behaviour problem of youngest child</td>
</tr>
<tr>
<td>2</td>
<td>Audio-recorded nurse-family interactions during home visits</td>
<td>2</td>
<td>Mother with 2 pre-school children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-participant observation of nurse-family interaction during audio-recorded home visit</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Post-home-visit family interview</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-home-visit nurse interview</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Examination of nursing assessment document (s) relating to referred patient/family</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional field visit</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 6.3: Data collection summary Case 1**

#### 6.3.1 Nurse Interview: Pre-Home Visit

The first attempt at data collection threw up a few surprises. Instead of the planned pre-home visit interview with Janine, an informal conversation about her practice and the recruited family was all that was achieved. On one level I had not anticipated this, but with a constructionist mind set, and keen to build a non-hierarchal participant-researcher relationship, ‘going with the flow’
Chapter 6 Descriptions, Analyses and Findings Case One

seemed a reasonable stance to take. The meeting helped build rapport, but I sensed it was me who was being ‘assessed’. Janine had exercised her duty of care and scrutinised my intentions. After all, I was an outsider who sought access to the privacy of a family on her case load to whom she had a professional duty (NMC, 2004). She also had to protect the continuing relationship of care once I had left the field. Her caution was justified.

The re-scheduled interview took place in the same venue and offered the required privacy. The essential equipment was in place. Participant’s rights and verbal consent were confirmed (Behi, 1995). Seeking and documenting pertinent biographical details built up rich contextual data (Flick, 2000). As a preliminary conversation, it also promoted rapport. The purpose and format of the interview were then explained (Flick, 2000). I sought to create an enabling and encouraging atmosphere (Hammersley & Atkinson, 1995). Once recording started the interview unfolded in a natural, conversational style (Wolcott, 1995; Rubin & Rubin, 1995). Occasional notes were jotted down alongside the interview guide. The central research question, issues sub-questions and pertinent literature informed the interview guide (Miles & Huberman, 1994; Gaskell, 2000). Five broad areas were delineated:

1. Personal experiences and conceptualisations about assessing families
2. Specific knowledge about family assessment
3. Perceived instrumental behaviour when exploring health needs with family members
4. Family orientation
5. Professional orientation

For more detailed information on interview topics see Appendix G.

Alternating questions were prepared to fit the episodic-narrative interview technique and developed to elicit in-depth responses, each serving a specific purpose (see Chapter 5, Section 5.4.1). My aim was to elicit the meaning of family health assessment from Janine’s experiential point of view, and how she conceptualised the process. Questions alternated between (1) narrative generative; (2) periodic invitations to present an account of a specific situation; (3) concrete pointed for seeking a subjective definition; and (4) question for seeking abstractive relations (Flick, 2002: 104-106, see Appendix H for the interview schedule).
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Occasionally, Janine responded to concrete pointed questions with elaborate accounts. The interview guide was, thus, congruent with a constructionist orientation. Sometimes I asked for greater specificity and range on certain episodes (Flick, 2002: 76-77). Responses were rich in depth and personal context. All items of the interview guide were covered, but not always in the identified sequence. Janine’s flow of thought called for reflective responses and active listening on my part. My aim was to gain a ‘shared’ understanding of meanings. Silences in conversation gave time to reflect, although on occasions the conversational flow was interrupted by my leading response. Such responses may undermine trustworthiness in the data (Seale, 1999a). Evaluative interruptions are equally counter-productive; I discovered a few when scrutinising the verbatim transcript.

At times emerging leads or hunches had to be followed up; to allow the participant to talk about issues that mattered to her. A co-constructed dialogue evolved where meanings were explored and unexpected events accommodated. There were moments when Janine talked about experiences which fitted questions I had not even asked. The interview lasted about 90 minutes. Afterwards, the inter-personal climate changed, as if we both ‘clicked’ back into our respective roles as described by Goffman (1961a). Back in the car, I jotted down feelings and observations, and listened to the full recording hearing statements I had not registered at the time, probably because of my intense emotional involvement which I had not expected. Such sentiments may compromise an interview and bias one’s perception (Rubin & Rubin, 1995). The development of a more structured tool further assisted reflection (Flick, 2000: 83-84). This tool contained prompts in the form of questions relating to the interview guide; whether principles of the alternating interview format were followed; the degree of openness and sensitivity towards the interviewee; the detail and depth achieved by the interviewee; whether evaluation and small talk occurred after the interview and the documenting of additional information. A final question encouraged reflection on the planned method for coding and interpretation. Comments in response to these prompts, shortly after the interview, created immediate and permanent feedback that was available for further reflection when I wrote up the case. All handwritten notes were transferred into electronic word document files.
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6.3.2 Home Visit 1: Audio Recorded
Before the first home visit, a meeting was arranged with Janine to confirm approval from the family’s general practitioner and Mary’s consent. This time I was invited ‘backstage’ to her office (Goffman, 1959), suggesting the beginnings of a productive relationship. Much of the information Janine shared made more sense to me as I had since listened intently to the previously recorded interview. I received template copies of the paper documentation and other leaflets about the service. We opted to leave a review of the live electronic documentation system until after the home visits. We negotiated that I would not observe the next planned home visit, but the following. We agreed that this arrangement gave the family another opportunity to get to know me. This meant drawing on Janine’s co-operation to audio-record the home visit. Despite her agreement, I sensed a degree of hesitance, but was reassured. The plan was that I would go along, set up the equipment and withdraw. On the day, when setting up the equipment, and despite much laughter, I could sense an atmosphere of tension among us. Max, however, seemed unperturbed and showed a keen interest in the voice recorder. Afterwards we met up in my car, and she handed me the voice recorder. “You know” she commented “I was so aware of always saying ‘that’s brilliant’- I don’t usually do that. Also we had yoghurt on the carpet, a burst to the toilet and the telly playing for some time. There will be some long pauses on the tape because of that” (HV_FN_5). The recording confirmed her account. Lively family life showed up in the verbatim transcription as plenty of ‘inaudible’ spaces in text and the audio recorded interaction gave insight into the participants’ construction of events and the nature of their interaction.

6.3.3 Home Visit 2: Audio Recorded and Observed
The conversational mode of data collection was complemented with non-participant observation at the next home visit. It gave me the opportunity to test the observation guide. Though able to observe the interaction between participants, I had to respect the family environment and be as unobtrusive as possible. I was directed to a dining table opposite the settees. I had full view of Janine when I turned sideways and we made occasional eye contact. Mary I could only observe side on and she made no eye contact during my observation. Max and Jill, however, joined me at the table; and watched me intently, realising that I would smile and look, but not speak. Their interest in this ‘curious visitor’ eventually faded. A similar response to non-participant observation during home visits by district nurses was reported by MacIntosh et al. (1999). The children’s initial
curiosity and their eventual disregard was, however, a valued contribution to my understanding of the interactions during the home visit.

Five headings such as space, actors, activity, object and self, provided a framework for description (Spradley, 1980). Figure 6.4 below shows the components of the observation guide based on Spradley (1980) and Fassnacht (1982). Physical signs of non-verbal gestures were selected and aligned with the chosen ‘segments of reality’ which were taken as symbolic in their co-construction of ‘building trust’ and ‘showing empathy’ and their corresponding psychological representations (Porritt, 1990; Egan, 2002; Niven & Scott, 2003). Abbreviations of sign and gestures as the representations of the physical system were placed in the fourth column providing a coding system for observation and analysis. The representational relationship was sought using a five minute time sampling frame that lasted about an hour (Kellehear, 1993).

<table>
<thead>
<tr>
<th>Description (Exploratory)</th>
<th>Segments of Reality (Selective)</th>
<th>Primary System of Representation - Physical System</th>
<th>Secondary System of Representation Psychological System</th>
<th>Tertiary System of Representation Conventional System*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space</td>
<td>Building trust</td>
<td>Keeps eye contact</td>
<td>Interpersonal climate of respect</td>
<td>EC</td>
</tr>
<tr>
<td>Actors</td>
<td></td>
<td>Shows openness</td>
<td>Interpersonal climate of acceptance and appreciation</td>
<td>SO</td>
</tr>
<tr>
<td>Activity</td>
<td></td>
<td>Respects interpersonal space</td>
<td>Sense of security</td>
<td>RIS</td>
</tr>
<tr>
<td>Object</td>
<td></td>
<td>Smiles</td>
<td>Belief in the other</td>
<td>S</td>
</tr>
<tr>
<td>Self</td>
<td></td>
<td>Laughs</td>
<td></td>
<td>L</td>
</tr>
<tr>
<td>Showing empathy</td>
<td>Listen attentively</td>
<td>Listens attentively</td>
<td>Empathic understanding</td>
<td>LA</td>
</tr>
<tr>
<td></td>
<td>Shows symmetry in facial</td>
<td></td>
<td>Caring context</td>
<td>SE+TV</td>
</tr>
<tr>
<td></td>
<td>expression and tone of voice</td>
<td></td>
<td>Unconditional commitment</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>Nods</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Coding Key: EC = eye contact    SO = shows openness    RIS = respects interpersonal space    S = smiles    L = laughs
LA = listens attentively      SE+TV = shows symmetry in facial expression and tone of voice    N = nods

**Figure 6.4: Representational observation guide of signs and gestures**

Other indicators that were significant symbols of meaning and relation during the interaction were also recorded. The signs and gestures I regarded as significant because of their symbolic meaning,
yet complementary because of their limited dependability. It was possible to identify Janine’s actions by means of signs or gestures, but her intentions could only be guessed. The five minute time sampling frame, where two young children competed for the attention of adults, was demanding. My decision to focus predominantly on Janine made the task more manageable, but I still had to make sense of the situation. The handwritten observation record and a representational map (Denzin, 1989) were transferred into an electronic document file. A section of the observed interaction is given below in Figure 6.5.

**Figure 6.5: Excerpt of observation record Case 1**
6.3.4 Nurse Interview: Post-Home Visit

The focused semi-structured interview opened up perspectives in structures, values and meanings during the two home visits. The repeated listening to the pre-home-visit nurse interview, the audio recorded home visits, and reflections on field notes and contact summary forms informed the conceptual direction of this interview guide (Miles & Huberman, 1994). Agreement was sought in order to proceed with the interview which started with a request for contextual information. I was interested in Janine’s expectations of the study and also wanted to learn more about her professional interests and how long she had known the family. By now, I felt that I had gained an understanding of this particular case. Compared with the first field visit, this post home interview was more relaxed with both of us more at ease. The same interview principles were followed (see Appendix I for the focused semi-structured interview schedule). The interview lasted 35 minutes.

The previously received and examined paper documents, using a document summary form based on Miles and Huberman (1994), informed the electronic document system to which access was provided during this field visit. Access was password-protected, therefore Janine navigated through the software programme, and responded to my questions while I took handwritten notes.

With data collection at an end, I was keen to hear Janine’s thoughts on the procedures. She commented on the observed home visit: “The visit you being there was much less intrusive than just having the recorder sitting there. You just faded into the background.” (HV_FN_7). I tried to convey how I would capture what I had learned so far and shared my first impression of interactions: “they struck me as a choreography of steps and movements, not interweaving but more of a dance, routine steps were followed by creative turns with backward and forward moves” (HV_FN_7). This metaphor made sense to her: “gosh, yes, that describes it, whilst you are saying that, that describes it” (HV_FN_7). These were, however, just tentative impressions. I reminded her I would appreciate her comments on the preliminary case report and promised a copy of the final report.
6.3.5 Family Interview: Post-Home Visit

This was a one-to-one interview with Mary and both children were present. By now, I was no longer a stranger. Jill and Max contributed to my understanding of the family situation, but each child’s communicative behaviour reflected their developmental milestones, which limited their contribution to the study (Hood et al., 1996; Thomas & O’Kane, 1998; Helseth & Slettebó, 2004). The interview guide had been developed from topics identified from initial analysis of the data collected, and was guided by the research aims and objectives. The interview was intended to elicit Mary’s account of experiences and perceptions of the previous home visits (see Appendix J for the interview schedule).

I was uncertain about the usefulness of the interview guide and keen to find out whether it would suit the purpose. Mary was reminded of her rights and with her agreement recording got under way. In an attempt to overcome potential apprehension about the voice recorder, and to protect it from inquisitive little fingers, it was placed out of direct sight without compromising its function. The interview format was explained, and I began by asking about family information to build up contextual data. This was documented in the prepared form.

By now Jill and Max were engrossed in their play - a timely moment to start recording. The interview started well, but eliciting in depth responses became increasingly difficult. Both children demanded their mother’s attention. At first, this did not interfere with the flow of conversation, but the children wanted to watch a DVD, the television was switched on which drowned out the adult talk, and sibling rivalry flared up. Colouring pens, which I had brought as a small token of appreciation for Jill and Max, came in handy. The children’s attention was diverted, the squabbling was defused and the television was turned off. The interview continued, but promoting the flow of conversation required prompts and probing – on one occasion I feared the interview would dry up. Instead of a conversational flow, it turned into a question-and-answer sequence. But attentive listening to her domestic concerns, which suddenly featured in her conversation, brought about a change in interaction. By letting go of my interview agenda and withholding my research concerns, I gave Mary space to be heard in a way that appeared to meet her needs. After 40 minutes the interview came to a natural end. Once the voice recorder was turned off, Mary continued to talk freely about personal concerns – something that can be a
therapeutic experience for participants (Patton, 2002: 406). Mary commented favourably about having taken part. She had felt relaxed about events and hoped the study would help other families and nurses. She was reminded about receiving a report and that I would welcome her feedback.

6.4 PREPARING THE DATA
Data sources were transcribed verbatim and prepared as discussed in Chapter 5, Section 5.5. Frequent listening to the audio recordings allowed me to appreciate nuances in communication. On paper, conversations were de-contextualised (Kvale, 1996). Transcripts were not always laid out in the same way and therefore were consistently formatted, which aided entry into the NVivo7 data base (Gibbs, 2002). Participants’ accounts were thematically analysed and did not require the use of detailed transcription symbols compared with naturally occurring talk as there was less overlap (Kvale, 1996). The transcribed audio-recordings generated 49,854 words. Additional material comprised five pages of observation records, eight contact summary forms with field notes attached and document summary forms relating to the five examined nursing documents.

6.5 ANALYSING THE DATA
6.5.1 Case Profile One
To gain an early understanding of the case, a profile was constructed from biographical data, field notes, information collected before or after interviews and the family interview (Flick, 2002). The case profile was developed into a descriptor, to provide a contextual ‘frame’ for the subsequent report on the analysis. The descriptor gives contextual and developmental information about the HV, information on family context and development, and reasons for referral. My reflections on this preliminary case give a brief description about events during field work. The case profile presented below in Figure 6.6 draws on Wright & Leahey’s (2000) Calgary Family Assessment Model (C-FAM), discussed in Chapter 2, Section 2.3.3 and Chapter 5, Section 5.7.
## Chapter 6 Descriptions, Analyses and Findings Case One

<table>
<thead>
<tr>
<th>Case Profile 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Visitor Context</strong></td>
</tr>
<tr>
<td><strong>Health Visitor Development</strong></td>
</tr>
<tr>
<td><strong>Family Context</strong></td>
</tr>
<tr>
<td><strong>Family Development</strong></td>
</tr>
<tr>
<td><strong>Referral Reason</strong></td>
</tr>
<tr>
<td><strong>Researcher Reflections</strong></td>
</tr>
</tbody>
</table>

**Figure 6.6: Case profile 1**
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The family composition is shown as a family Genogram in Figure 6.7. An explanation of Genogram symbols is given in Appendix K.

The Genogram gives an overview of the family, with the family members who participated in this case represented as shaded symbols. The Genogram was drawn neither for assessment nor for data collection purposes, but for illustrative reasons based on the information gathered.

6.5.2 Nurse – Family Accounts

The descriptive analysis proceeded in a number of iterative cycles of inspection, interrogation, categorical aggregation and direct interpretation. This included various stages of data transformation and analytic progression, while spanning all data sources (Miles & Huberman, 19...
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1994; Stake, 1995). The first stage comprised an initial, repeated listening of audio recorded home visits to promote immersion in the data, followed by a repeated reading of transcripts and other documents to get a feel for them as a whole. Condensing and interrogation of texts to reduce them into meaningful units was undertaken as described in Chapter 5, Section 5.6.1. This included the development of tentative criteria regarding coding rules or definitions to describe and distinguish between similar or related phenomena. Each activity called for analytic choices, informed by theoretical perspectives, planned methods, and criteria for rigour, while keeping later cross-case comparison in mind. These analytic moves were influenced by data type, its quality and volume, and how best to present results. The usefulness of a project log became apparent as it helped to trace insights and decisions (Richards, 2005).

Once I had developed a basic understanding of NVivo7, it made navigation and coding through data sets relatively easy. Visual representation of domains and categories in the form of decision trees typical for NVivo7 clarified relationships, and helped me to distinguish between them more systematically. The software programme helped with category descriptions and ensured some dependability for coding of later incoming data. For example, under nurse perspective, I defined *role specific meanings* as ‘refers to role specific meanings’. However, this was a place holder node or domain. ‘Node’ is the term used in the NVivo7 software programme and stands for ‘code’ a rather confusing change in terminology. Data segments were not coded under this domain, but only under the subsequent categories and sub-categories of the place holder node (Gibbs, 2002; Richards, 2005). Categories were developed through open coding. Themes were defined at category level and carried latent meanings while maintaining analytical context (Priest et al., 2002; Krippendorf, 2004).

The usefulness became apparent after the research and issue-sub-questions were aligned into topic areas and interview questions, with a start list of codes drawn from theoretical perspectives (Miles & Huberman, 1994; Gaskell, 2000). It made it possible to start with a tentative coding scheme that provided a theoretical-conceptual structure for the analysis as a hierarchy of tree nodes (Gibbs, 2002). Meanings and experiences grounded in the nurse and family perspective were brought into this conceptual structure, thus integrating the deductive with the necessary inductive analytic approach. Expressions which seemed to be particularly meaningful were
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treated as ‘in vivo’ codes. Although ‘in vivo’ codes with their data segments were relevant to the exploration of issues, some did not fit immediately into the tree structure and were gathered as free nodes. The theoretical-conceptual structure was used to build distinct data sets. These reflected the research problem, different perspectives and supported the consideration of data in context (Miles & Huberman, 1994; Stake, 1995).

Given data sets and data sources, a further concern was how to fit the different components together, requiring intense analytic reflection. Here I was influenced by Patton’s discussion of sensitising concepts which draws on Conroy’s work (1987, cited in Patton, 2002: 456-457). Theoretical aspirations needed to be considered and a representation of participants’ perspectives was necessary. I aimed for a comparison of family health assessment across different fields of practice. And the reader had to evaluate the fit of my interpretations of participants’ accounts.

The solution was the development of heuristic framework questions that fitted the purpose of this study. These questions represented an analytic template as described by Stake (1995). They provided an integrative, systematic structure for data records with which to portray the nurse and family perspective in each case, while focused on the phenomenon of interest. The framework questions accommodated different domains:

1. role specific meanings to contextually enrich each case based on perceptions and experiences
2. conceptualisations about family health assessment to contrast conceptual meanings and experiences
3. orientations of the nurse and family towards each other to examine beliefs, values and attitudes based on relations and experiences
4. espoused communicative actions representing intentions and experiences, to compare these with interactions as evidenced from actual home visits
5. nursing documentation used for the assessment process to compare structural elements and their experiential meaning for the nurse and family
6. participants’ reflective accounts to capture the shared journey in this study
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Each domain was colour-coded with hard copies of the analytic NVivo7 reports stored in correspondingly coloured folders. This helped with the tracing of materials within the many files that accumulated. A consistent and comparative approach for the intra-case perspectives could be developed that would suit comparison across cases. The format provided a consistent template for the description and interpretation of meanings (Krippendorf, 2004), and could also be adapted for different data displays and the reporting of findings. Moreover, it supported dependability in the analysis. I was now able to proceed with the second stage.

Stage two:

1. selective coding of previously open coded data segments linking domains, categories, sub-categories and framework questions
2. displaying of coded data sections and categories to build unified case records portraying the nurse and family perspective
3. synthesising of several small themes by collapsing categories or sub-categories to obtain a broad view of the data
4. writing and annotating of themes and patterns to generate depth in meaning
5. drawing of initial inferences with which to construct case reports portraying the nurse and family perspective

Meaning units from previously open coded data were selectively coded and extracted from the NVivo7 coding reports to construct a data record. Selective coding was guided by the framework question, with each section grounded in the domains, categories and sub-categories that had been extrapolated. The selectively coded smaller units belonging to the category were placed under it, a procedure made possible by use of NVivo7’s link function. This guaranteed the tracing of selectively coded smaller units to the coded data segment in the data base and allowed me to return to the context to which this particular meaning belonged. This procedure represented categorical aggregation, as a simple count of coded data segments under each category was entered. This content analytical approach allowed some judgment to be made about the magnitude of the coded category (Sandelowski, 2001; Krippendorf, 2004). The same procedure was applied to the family interview text.
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The process of distillation resulted in a theoretically guided *data record*. The selected data segments were interrogated for their meaning. For each category and sub-category, interpretations were abstracted via annotations or memos for their latent meanings, and succinct constructions extrapolated. These were used to compile the *case report* of the nurse and the family perspectives which later became one of the sources for the cross-case analyses (see Chapter 10, Section 10.3). The *case reports* were laid out according to the analytic framework questions. Contextual flavour was thus maintained and further depth in the level of interpretative analysis achieved. *Data records* and *data reports* showed a consistent, meaningful structure for member checking. The structure helped participants to verify the coded sections in the *data record*, including its analytic categories, and to evaluate the credibility of my derived understanding as reconstructions in the *data report*.

The *nurse data record* was developed from the pre and post home visit data sets which up to now had been kept separate. Both data sources now complemented each other. Janine’s ‘voice’ was accessible and traceable. Transcript symbols were removed except for brackets indicating text cuts which did not add to the meaning. The same procedure was used to construct the *family data record*.

Figure 6.8 below is a merged illustration of one category. The excerpt displays the HV’s *data record* entry in the left-hand column and its derived understanding from the *nurse case report* in the right-hand column. The excerpt captures Janine’s professional values, her role perceptions, experience and her relational approach that seemed to have shaped her nursing work with families.
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THE NURSE PERSPECTIVE

Substantive Conditions of Meaning Making and Social Order
1. How does the nurse see her role in working with families?

<table>
<thead>
<tr>
<th>Domain: Role Specific Meanings</th>
<th>Category: role perceptions</th>
<th>Derived Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>HV: I would never see myself going in just to see the child or the mother [ ]</td>
<td>4</td>
<td>Janine pursues a health agenda and orientates her assessment practice towards the whole family. She regards herself as a resource for families, is conscious of professional boundaries. She aims for a middle ground between friend and non-expert role. If required she would take on an advocacy role.</td>
</tr>
<tr>
<td>[ ] I see myself going in to visit the family. [ ] to look at the family’s health and give them support and information, and that I am a resource that they can call on, and it is not just about the baby and it is not just about the mother’s post-natal health. [ ] I am not going in to be their friends, but I am not going in to be this professional expert. [ ] my starting point is [ ] taking a partnership approach – I can take on an advocacy role. [ ] But then to make it safe for yourself and also for the parent [ ] I have a health agenda [ ] looking at it as the family as a whole.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(C1_HV_Pre_HoV_Int)

Figure 6.8: Co-constructions of role perceptions Case 1

Figure 6.9 gives a comparison of themes grounded in the nurse-family perspectives based on their co-constructed accounts. Participants are identified in column one. The occurrence of data units representing a particular theme is given in brackets. While the nurse perspective reflects her experience and intentions, the family perspective - in this case is based only on the mother - is grounded in her individual experience.

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Nurse Perspective</th>
<th>Family Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janine (HV)</td>
<td>Promoting dialogue (11)</td>
<td>Developing family confidence (6)</td>
</tr>
<tr>
<td>Mary (4)</td>
<td>Seeking understanding (5)</td>
<td>Receiving support and advice (6)</td>
</tr>
<tr>
<td>Jill (4)</td>
<td>Pursuing strategic action (5)</td>
<td>Sharing health concerns (2)</td>
</tr>
<tr>
<td>Max (2)</td>
<td>Picking up cues (4)</td>
<td>Being listened to (1)</td>
</tr>
<tr>
<td></td>
<td>Looking at all the aspects around (3)</td>
<td>Negotiating actions (1)</td>
</tr>
<tr>
<td></td>
<td>Verifying cues (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Negotiating a working relationship (1)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6.9: Case-specific themes capturing the nurse and family perspective Case 1

Figure 6.10 below is a merged illustration of one of the above categories relating to the nurse perspective. The excerpt displays the HV’s data record entry in the left-hand column and its

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derived understanding from the nurse case report in the right-hand column. The excerpt captures Janine’s experience and her intention to promote dialogue in a reflective manner between parents.

<table>
<thead>
<tr>
<th>Domain: Role Specific Meanings</th>
<th>Derived Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category: promoting dialogue</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Janine is keen to get parents to talk to each other. Asking about the baby’s progress is a stimulus for both parents who then might start talking about themselves and their family. Promoting dialogue facilitates parents thus to reflect on their own experience. Although this tactic does not always work, she regards it as useful as it enables her to understand family concerns within a mutually dependent co-creation of meaning about their situation. In promoting dialogue she facilitates family members’ recognition of each others’ contribution because of their reflective, explorative talk.</td>
</tr>
<tr>
<td>HV: [ ] you are asking parents what new things they have noticed their babies doing and survival tips to pass onto other parents. [ ] when the men are actually there, and if you can encourage them to start talking [ ] you can actually get this conversation going, this dialogue going between the two of them about how stressed they are both feeling, or how he is worried about her being so tired and breastfeeding [ ] it is a bit about reflecting back on how they are reacting and what is going on within the family, [ ] not getting into sort of blame, but sort of getting people to reflect a bit on why you think so and so is behaving like that. [ ] try and encourage parents, even though i won’t use the word ‘reflect’ probably, getting them to look at what has been happening. [ ] try to get them sort of to explore what might have triggered some of that behaviour off. [ ] And the whole time that opens up sort of for the parents to talk about how they feel the baby is coming along or any questions that they have got [ ] I prefer visits, if there are things like behavioural issues around that both parents are present if there are two parents within the family. It makes it a round visit, it allows them, if they haven’t been able to share with each other how they are feeling, an opportunity to sort of express how they are feeling so the other person can hear if it is safe, because [ ] it is not just the just two of them getting into a discussion that could turn into an argument – there is a third person that can acknowledge, who can advise, hopefully for both of them, the positive things that are happening. [ ]</td>
<td></td>
</tr>
<tr>
<td>(C1_HV_Pre_HoV_Int)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6.10: Co-constructions of promoting dialogue Case 1
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The following example is a merged illustration relating to the family perspective. The excerpt displays the mother’s data record entry in the left-hand column and its derived understanding from the family case report in the right-hand column. The excerpt captures Mary’s experience of a developing family confidence that is closely associated with her own self-worth and growing competence in parenting. In this case, it was a ‘one informant’ perspective of the family.

<table>
<thead>
<tr>
<th>THE FAMILY PERSPECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantive Conditions of Meaning Making and Social Order</td>
</tr>
<tr>
<td>4. What is the family’s definition of the situation?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain: Conceptualisations and Experiences</th>
<th>Derived Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category: developing family confidence 6</td>
<td></td>
</tr>
</tbody>
</table>

Mary: [ ] it (approach to family) has made me more confident as a Mum in how I deal with the problems that arise in my family. [ ] I probably wouldn’t have coped at being a Mum basically. [ ] she is a life saver, ((laughter)) she is like a guardian angel – she has made life much, much more bearable when, because I was getting to the stage where I felt that I couldn’t cope and to the stage where I didn’t want to cope any more it was getting that bad that I just didn’t want to be here anymore as a Mum [ ] she always made an effort to make it to give me a reason to go on and try new tactics and stuff like that. [ ] She makes me feel good about myself [ ] She is very supportive, and not even just concerning with the kids she is very supportive when me and ((partner)) are having problems as well she is willing to help on that aspect as well which isn’t part of her job but she makes it part of her job [ ] and it makes my self confidence as a Mum a bit better than it was a few months ago. xix (C1_Fam_Int)

Mary experienced affirmation and encouragement with regard to her role as mother and partner resulting in an enhanced sense of self worth thus developing family confidence. Concerns about her relationship with her partner did not fit her role expectation of health visitors. Confidence builds competence in parenting.

Figure 6.11: Co-constructions of developing family confidence Case 1

The diagram in Figure 6.12 illustrates the interrelated and interdependent nature of participants’ perspectives. It represents an early conceptualisation of phenomena. Each curve symbolises a part of the case that needs explored to understand the case as a whole. Each curve is also part of a circle that is dynamic. Depending on the situation, their perspectives evolve.
These data displays show the varied approaches that were taken in order to achieve data transformation, analytic progression and first conceptualisations of phenomena.

### 6.5.3 Nurse-Family Interactions

#### 6.5.3.1 Features of talk

Analysis of naturally occurring conversation was carried out by hand and processed as electronic Word documents, enabling a closer, more prolonged engagement without software requirements. Interaction texts were read and re-read, notes taken and content summarised. Each line of dialogue was numbered to help with the analysis. The pre-home visit nurse interview was inspected for evidence of declared intentions as ‘espoused communicative action’. This tactic helped me approach the interaction texts from Janine’s perspective (Denzin, 1989). Analytic insights gained from the interview data were useful as they allowed me to look for evidence in the naturally occurring talk with which to corroborate her intentions. Janine’s use of assessment documents took on a different meaning. Differences between home visits showed up too. This ‘prior knowledge’ alerted me to inspect the data for the type of information she sought and how it was sought. From observation I had gained some insight into the interactions, and it was useful to compare the observation record with the interaction text. The observational focus on showing empathy during the second home visit prompted a search for possible confirming or disconfirming
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evidence in the text data. These considerations led me to inspect the texts for features of talk such as question-answer sequences and utterances that might represent commendations and empathic responses.

**Question-answer sequences**

For the purpose of gathering information some question-answer sequences had an investigative flavour, such as open or closed questions. These were of a pointed nature and helped to define a particular family problem. These type of questions suggested that Janine had an instrumental effect on Mary and seemed to provide the HV with a degree of control over the situation. Below is an example:

676 HV [ ] while I remember will I put that at the end just (.2) for things to plan
677 for the next month (.2) to try and find something of interest to him?
678 M Yes
679 HV How do you want me to word it? What do you think? (2.0) [ ]
(C1_HV_HoV_2)

The utterances occurred when Janine encouraged Mary to draw on her own ideas in order to set a goal in response to her son’s behaviour problems. Janine’s pause suggests that she wanted to give Mary time to think and prompt her into a response. In doing so, Janine elicited information about Mary’s perception on how she might evoke some kind of change in her son’s behaviour thus promoting his development as well as her confidence in her own parenting skills. This question-answer sequence showed a direct relationship between the mothers’ interpretation of events and how she might set a potential parenting goal for herself. Such a sequence was defined as linear questioning and resembled a form of interventive inquiry suggested in Tomm’s (1988) model of family therapy which draws on the Milan School of systemic family therapy (Brown, 1997). The usefulness of Tomm’s propositions was seen by Wright & Leahey (1994) and introduced in their family assessment and intervention model.

By comparison, and sensitised by Wright and Leahey’s assessment framework, I recognised question-answer sequences as circular in the data. The following sequence is an example:

540 HV Do you think that’s having an effect on him ([son]) the fact that you
541 two are getting on with each other?
The circular nature of Janine’s question in line 540 appears to encourage Mary to develop her own insight. Janine associates the possible effect of the parental relationship on their son’s behaviour and encourages the mother to reflect on these interrelationships. While the question starts of as closed and self-directed, it is also other-orientated. It includes an attempt to inquire about the parental relationship and its effect on their son. While this question type also allows Janine to gather information about the son’s behavioural problems, its format takes account of the connectedness among family members. This form of questioning is thus systemic as it explores both parents’ behaviour and its impact on family subsystems. In this case, the parent-parent dyad and the mother-child dyad which are brought into a reflective focus and carry a potentially therapeutic effect. The question appears to have raised Mary’s awareness of the interrelated nature of the family situation and her coping abilities. The therapeutic outcome may be associated with helping the mother to see a difference in parental relations over time and how this may effect a change in their son’s behaviour. Having been given space to reflect at length, Mary became distracted at this point by her son’s mischievous behaviour.

This type of a more exploratory, reflexive question-answer sequence was similar to Bryans’ findings (2003). In this study open questions had a distinct relational element, as gathering information of different family members’ perceptions and their likely interpretations of events emerged in this question format. These sequences appeared to have a more exploratory intent about family relationships and behaviours. This type of questioning is also an element of Tomm’s (1988) model of interviewing families for therapeutic purposes. Tomm proposed a two-dimensional model referring to therapist intentions and assumptions. The continuum from an orienting to an influencing intent, and the other, ranging from lineal to circular assumptions creates four quadrants of four different questioning types: lineal, circular, reflexive and strategic. The usefulness of this model for creating therapeutic relationships in family therapy practice was tested by others (Dozier et al., 1998; Ryan & Carr, 2001). Family nursing scholars like Loos & Bell (1990), Hartrick et al., (1994) and Bell (2002) advised the use of circular and reflexive questions as
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a means of inquiry into family events and relationships and point out the distinction between various question formats.

These distinct types of question-answer sequences were raised by Janine to gain information about family members and their health. They seemed to allow the mother to develop a different perspective on events and behaviours and to see their influence on relationships in her family over the course of these home visits. Mainly very pointed or linear questioning was used. Since they had an investigative intent, they helped elicit much of the factual information required to evaluate the family situation. Although circular questions did not feature often, they created a distinct interaction and caught my interest. They signalled the participants’ appreciation of all family members. The mother’s partner was taken into the circle of concern despite his absence. Circular questions seemed to promote a more comprehensive and sensitive understanding of the family situation for both, the health visitor and the mother. While linear questioning had an instrumental purpose, circular questioning had an interpretive, exploratory purpose. Once the two question-answer sequences were distinguished, counting their occurrences gave also a deeper understanding of the assessment process. While information was gathered from different questions, these different questions also developed from the information gained, creating a pattern of circularity in interaction.

Comparison between both home visits suggests that the first visit was more exploratory and reflective. A less direct approach in a first assessment visit may support the need to build or at least re-establish rapport from previous care episodes. From observation of the second home visit, though, rapport appeared well established. Observation of the home visit may well have influenced Janine’s communicative behaviours which then showed a more investigative approach. Table 6.1 summarises the question-answer sequences.

<table>
<thead>
<tr>
<th>Question-Answer</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear Questioning</td>
<td>27</td>
<td>55</td>
<td>82</td>
</tr>
<tr>
<td>Circular Questioning</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 6.1: Question-answer sequences during home visits Case 1
Chapter 6 Descriptions, Analyses and Findings Case One

Commendations

Therapeutic features of talk are integral to Wright & Leahey’s Calgary Family Assessment Model (2000). I was keen to find out whether this type of utterance would show in the talk-in-interaction. Janine frequently commended Mary, but also Max and Jill and, although absent, Mary’s partner. Here is an example of a complex commendation and its suggested therapeutic impact:

746 HV ( ) the thing is that up until now you’d taken the time to really work it out
747 HV what is going to work 
748 M [yes, the crayons, he loves the crayons
749 HV what’s really lovely is as well (.2) listening to you is the fact that you
750 HV have given him the space 
751 M [look look can you pick that up please (.2) thank you [talking to son]
752 HV yes you’ve given him the space to actually (.2) to develop their
753 HV imagination (.4)
754 M What’s that? ((talking to son)) Sit on my knee ( )
755 HV Lovely [ ]
{C1_HV_HoV_1}

This is a turn of talk where Janine commended Mary for her previous behaviour in the presence of her son in lines 746, 749 and 752. Her commendations were a response to observed patterns of behaviour that occurred over time. Mary did not respond verbally to Janine; instead, the effect of having been commended seemed to become a response of emotional warmth towards Max in line 754. Both are then affirmed in their relational behaviour. However, Janine’s utterance in line 755 was a response to a one-time event of the family dynamic. It is suggestive of a compliment which may have had a therapeutic effect. While offering a therapeutic response, Janine was able to evaluate the changes in the family’s behaviour, an inference she confirmed in the post-home visit nurse interview as she talked about the changes in family dynamics that had occurred since data collection began. The turn-taking sequence also highlights the entwined nature of intervention and assessment. As the excerpt shows the commendation was an intervention which facilitated an assessment of family dynamics. It also underscores the therapeutic impact a family health assessment may have when family strengths are valued.

Empathic responses

Symbolic interactionist assumptions and the observational approach, alerted me to Janine’s empathic responses. With these utterances she shared family members’ feelings or experiences
by imagining what it would be like to be in their situation i.e. being able to take their role and conveying an understanding of the individual or the family group. I regarded any statement by Janine which acknowledged or interpreted family members’ explicit or implicit feelings or experiences as indicators. By offering an empathic response she conveyed her intention to seek to understand the individual’s perspective and that of the family as a group. Here is an example of one such response:

521  M  [ ] and we’re now working as a family and really trying as a family
523  HV  I put that down as ‘working as a family’ I think that is what came across
524  M  before because you were so frustrated [ 
525  M  ( ) I thought I was living this nightmare on my own (.2) doing it all myself
526  M  I mean (‘) I thought I was having this nightmare on my own and he was
527  M  just here and no really taking much of an interest [ ] (C1_HV_HoV_1)

Janine, in line 523, acknowledged the sense of frustration experienced by Mary that family life is not what she expected it to be. Working as a family was symbolically confirmed for Mary as being heard. Moreover, Janine signalled to record Mary’s evaluation of the changing family dynamics.

Both commendations and empathic responses were interpreted as representations of Janine’s relational stance towards the family (Tapp et al., 1997; Tapp, 2000). As the data suggested, Janine’s relational stance was demonstrated in her commendations and empathic responses towards family members. Aggregation of these features was justified as it facilitated their numerical representation to more fully describe or interpret their meaning (Stake, 1995; Sandelowski, 2001). As the simple tally suggests in Table 6.2, commendations and empathic responses showed very little variation during both home visits. Their prevalence supported the therapeutic nature of these assessment visits and the caring response displayed by Janine. Non-verbal interactions provided further evidence.

<table>
<thead>
<tr>
<th>Relational Stance</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commendations</td>
<td>22</td>
<td>25</td>
<td>47</td>
</tr>
<tr>
<td>Empathic Responses</td>
<td>24</td>
<td>22</td>
<td>46</td>
</tr>
</tbody>
</table>

Table 6.2: Prevalence of ‘relational stance’ during home visits Case 1
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6.5.3.2 Non-verbal interactions

Inspecting the talk-in-interaction prompted analytical reflections on the observation record. Place, time, and locations were identifiable from the observation record and provided contextual information. The communication situation was compared with the interaction texts of both home visits, special attention being given to the relational stance conveyed by Janine and further inferred from the observation record. Analysis of this non-verbal interaction data proceeded systematically by

1. coding the observation record using pre-defined codes
2. entering transcript line numbers next to relevant sections of the observation record for ease of reference and comparison between text of audio recording and observation record
3. comparing observation record with text of audio recording to get a sense of the whole
4. looking for possible convergence of data from texts and recorded observations
5. counting representations of ‘building trust’ and ‘showing empathy’ in rank order of prevalence to discern further insight into the nurse’s relational stance
6. drawing inferences from the summary displays
7. interpreting results from an interactionist perspective

Janine’s predominant non verbal communication feature in support of ‘building trust’ appeared to be smiling and laughing as illustrated in Table 6.3 below. The interpersonal atmosphere between Janine, Mary and the children came across as of one of ease and openness. Although Janine maintained respect for interpersonal space by sitting on a separate settee, she also changed her position. When showing the ‘Child Development Cards’ she got up and knelt in front of Mary to explain these. In the pre-home visit interview she had explained this was an intentional gesture to reduce the perceived power balance between herself as professional and that of her client. At the time, it struck me as a symbolically meaningful gesture with which to communicate a ‘non-expert stance’. Throughout the visit, there seemed to be a climate of informality and rapport between all participants. They did not behave like strangers - one could sense a degree of acquaintance between them.
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<table>
<thead>
<tr>
<th>Primary System of Representation</th>
<th>Rank Order of Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home Visit 2</td>
</tr>
<tr>
<td>Smiles</td>
<td>7</td>
</tr>
<tr>
<td>Laughs</td>
<td>7</td>
</tr>
<tr>
<td>Keeps eye contact</td>
<td>2</td>
</tr>
<tr>
<td>Shows openness</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6.3: Prevalence of ‘building trust’ Case 1

Janine’s representation of ‘showing empathy’ summarised in Table 6.4 was dominated by *showing symmetry in facial expression and tone of voice, nodding and listening attentively*. They were suggestive only of her empathic relational stance towards Mary who was troubled by her son’s behaviour problems.

<table>
<thead>
<tr>
<th>Primary System of Representation</th>
<th>Rank Order of Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home Visit 2</td>
</tr>
<tr>
<td>Shows symmetry in facial expression and tone of voice</td>
<td>9</td>
</tr>
<tr>
<td>Nods</td>
<td>4</td>
</tr>
<tr>
<td>Listens attentively</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6.4: Prevalence of ‘showing empathy’ Case 1

The meaning given to non verbal gestures lent confirmatory support to Janine’s verbal interaction, which was rich in empathic understanding and commendations. Inferences drawn from non-verbal interactions must be treated with caution because of the method’s limited dependability, but findings from observation summarised in Table 6.3 and 6.4 complement each other, compared with Janine’s features of talk in Table 6.2. This display of an empathic, caring response was recognised and valued by Mary when she shared her account of events. Findings from the nurse and the family perspective confirmed the relational stance, the consistency of interactions, and the perceived therapeutic nature. These analytic approaches, however, did not give sufficient insight into sequences of meaning units throughout the home visits.

### 6.5.3.3 Conversational sequences

The next analytical procedure sought to gain an understanding of conversational moves by coding turn-taking sequences. To further support a process-orientated analysis, I adapted Krippendorf’s decision scheme for coding the talk-in-interaction texts (2004: 135-136). The following questions proved useful for interrogating the data:
Chapter 6 Descriptions, Analyses and Findings Case One

1. How does the HV make space for the continuation of the conversation with family members?

2. Does the utterance concern the son's health or other family members' health?

These questions helped identify sequences of talk throughout the text and differentiated them into meaning units. The first question focused on the process of interaction. Informed by theoretically and empirically grounded conceptualisations gained from the previous analysis, I was able to categorise the data by logically distinguishing between conversational moves. Themes were defined at category level and five themes extrapolated from turn-taking utterances which fitted all the data: (1) professional concerns; (2) patient health concerns; (3) family orientated health issue; (4) building relations; and (5) family talk. The second question allowed for a judgment about the focus of the conversational moves. These decision schemes offered dependability, which was necessary given the variation in home visits. As with all other themes, each was given a label, a definition, an indicator and a description (Dey, 1993). Interaction texts were interrogated based on consistent coding. Table 6.5 provides a summary of these turn taking episodes.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Talk</td>
<td>34</td>
<td>32</td>
<td>66</td>
</tr>
<tr>
<td>Family Orientated Health Issue</td>
<td>26</td>
<td>28</td>
<td>54</td>
</tr>
<tr>
<td>Professional Concern</td>
<td>21</td>
<td>23</td>
<td>44</td>
</tr>
<tr>
<td>Patient Health Concern</td>
<td>17</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>Building Relations</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>109</td>
<td>219</td>
</tr>
</tbody>
</table>

Table 6.5: Prevalence of conversational sequences across home visits Case 1

*Professional concerns* referred to turns of talk between Janine and Mary. The content reflected Janine’s *professional concerns* specific to her role. The move was initiated by her in response to an individual family member’s needs or the family as a whole. This conversational sequence had an instrumental, strategic purpose for assessment. *Patient health concerns* referred to interactions and actions about Max’s psychosocial and physical health concerns, a sequence initiated by Janine or Mary. Figure 6.13 illustrates the coding format.
Chapter 6 Descriptions, Analyses and Findings Case One

<table>
<thead>
<tr>
<th>Thematically Coded Conversational Sequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional concerns – negotiating a plan of work</strong></td>
</tr>
<tr>
<td>83 HV Well (.2) so what could we do (.2) if we do a block of say 4 visits then and if we</td>
</tr>
<tr>
<td>85 M Right [</td>
</tr>
<tr>
<td>88 you know (.2) just do a block of 4 (.3)</td>
</tr>
<tr>
<td><strong>Patient health concerns – psychosocial health issue 1: aggressive behaviour</strong></td>
</tr>
<tr>
<td>96 M It’s just the aggressiveness that really I mean just because he doesn’t see</td>
</tr>
<tr>
<td>98 “where is (.2) where is this anger in him coming from?” because I gave him a</td>
</tr>
<tr>
<td>100 was watering, it was like that you know stinging (.2)]</td>
</tr>
<tr>
<td>102 M [like when you poke yourself in the eye [ ] (C1_HV_HoV_1)</td>
</tr>
</tbody>
</table>

**Figure 6.13: Representations of professional concerns and patient health concerns Case 1**

While Janine attempted to negotiate the planned visits, she also sounded quite directive in scheduling these. Mary signalled her implicit agreement in line 85. The immediateness with which she disclosed Max’s behaviour in line 96, reveals Mary’s concern and her difficulty in coping with his behaviour. She seemed to want to bring this to Janine’s attention. In this sequence, seeking understanding was co-created between Janine and Mary: Janine listened attentively to Mary’s concerns. As the above excerpt of patient health concerns shows, themes could be differentiated according to their content. It was then possible to assign categories e.g. **psychosocial health issue 1**, and their properties e.g. aggressive behaviour, a tactic that allowed probing for the prevalence of different categories and their sub-categories. It also supported comparison between home visits and theoretical concepts, and helped with the construction of an audit trail of analytic procedures. Table 6.6 summarises the categories representing four of the most common sequences classified as professional concerns.

<table>
<thead>
<tr>
<th>Professional Concerns</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse intervention</td>
<td>8</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Reviewing progress</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Negotiating a plan of work</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Providing health information</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

**Table 6.6: Prevalence of professional concerns across home visits Case 1**
Because the Child Development Programme was an integral part of Janine’s practice, the use of ‘Child Development Cards’ and goal-setting interactions were interpreted as nurse interventions. As the sub-categories illustrate, professional concerns were closely interwoven with assessment and care giving. Reviewing progress came nearest to being fully associated with an exploration of current family health status since the previous home visit.

*Family orientated health issues* captured conversational sequences that helped address health issues arising from the impact of an individual’s health concerns on another family member. This theme took account of the assumed interrelated health concerns affecting family members or the family as a whole. *Family orientated health issues* were initiated by Janine or Mary. A range of sub-categories could be classified under this theme, summarised in Table 6.7.

<table>
<thead>
<tr>
<th>Family Orientated Health Issues</th>
<th>Home Visit 1</th>
<th>Home Visit 2 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner’s involvement</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Family member’s health</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Affirming family members-parents</td>
<td>7</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Mother’s health</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Affirming family member-child</td>
<td>6</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Family play</td>
<td>-</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Affirming parental roles</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Parental relationship</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Extended family</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

**Table 6.7: Prevalence of family orientated health issues across home visits Case 1**

These sequences could be seen as evidence of characteristic interaction in family health assessment. A striking feature was ‘partner’s involvement’, as he was absent during home visits. This finding confirmed Janine’s account concerning virtual family members. The interrelated and interdependent nature of family dynamics and relationships, and the impact on Max, was acknowledged. Thus, the sequences of *family orientated health issues* seemed to fit a family systems nursing perspective. As the excerpt in Figure 6.14, line 219 shows, Janine assumed the benefit of including the partner into their concerns; an assumption confirmed by Mary in line 221 and line 224.
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<table>
<thead>
<tr>
<th>Thematically Coded Conversational Sequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family orientated health issue 2: partner’s involvement</strong></td>
</tr>
<tr>
<td>215 HV What we’ll do, so what we’ll do then (.6) if we go through (.4) if we are</td>
</tr>
<tr>
<td>216 going to look through the development card, look at things like he’s talking</td>
</tr>
<tr>
<td>217 and he’s socialising and working things out, and then sort of move on to</td>
</tr>
<tr>
<td>218 looking at things like survival tips. I’ll give you some cartoons, some</td>
</tr>
<tr>
<td>219 of it (.2) you have seen them before (.4) but it might be quite good for</td>
</tr>
<tr>
<td>220 ((partner)), because you want some for ((partner)) to look at.</td>
</tr>
<tr>
<td>221 M Yes</td>
</tr>
<tr>
<td>222 HV And just to get him thinking a bit as well and how he is eating and you’re</td>
</tr>
<tr>
<td>223 looking after yourself as well.</td>
</tr>
<tr>
<td>224 M Yes, that’s great.</td>
</tr>
<tr>
<td><strong>Building relations</strong></td>
</tr>
<tr>
<td>227 HV ((son’s name, talking to child)), I was going to ask your mother (.2) but I can write</td>
</tr>
<tr>
<td>228 down that you can say your name ((talking to child)) =</td>
</tr>
<tr>
<td><strong>Professional concerns - reviewing progress</strong></td>
</tr>
<tr>
<td>233 = actually he is coming on now, certainly [</td>
</tr>
<tr>
<td>234 M [really, just like, it seems to be every day we’ve got something new.</td>
</tr>
<tr>
<td>(C1_HV_HoV_1)</td>
</tr>
</tbody>
</table>

**Figure 6.14: Sequence of interaction Case 1**

The partner’s appreciation was taken for granted, however, raising questions about the need for family members to be physically present for their perspective to be taken into account. From an interactionist orientation, meaning is situated and emerges in interaction.

Another turn-taking sequence featured puzzling utterances which I found difficult to classify until they were assigned a label: building relations. Once defined, these phrases seemed to take on a particular significance as they stood out almost unrelated to the preceding or following sequence. This is evident in Figure 6.14. In line 227 and 228 Janine suddenly took account of Max. Professional concerns then continued. Building relations referred to an interaction between Janine and any other family members during home visits, which could be interpreted as a means of developing a sense of trust and relationship-building. Features of building relations were also initiated by a family member. These conversational moves were not instrumental towards health maintenance or health care, although in line 227 and 228, the utterance carried an implicit association with the child’s developmental progress. Building relations represented the relational dimension between family members and Janine and emerged out of the shared situation or were related to a shared experience from a previous visit. These represented social talk.
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There was a further category of sequences that was equally puzzling: family talk. This conversational sequence referred to an interaction between family members. It also occurred as a comment directed towards an individual in the family by a family member which did not necessarily receive a response - an incomplete speech act (Habermas, 1999). These sequences were similar to building relations as they did not relate to a previous or following sequence, yet seemed to carry a significant meaning for family members. Figure 6.15 illustrates the phrases within a coded sequence of the thematically categorised sequences.

<table>
<thead>
<tr>
<th>Thematically Coded Sequence of Conversational Moves</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family orientated health issue 9: play</strong></td>
</tr>
<tr>
<td>585 M It is a good idea, but I don’t think he would be much interested in that the now,</td>
</tr>
<tr>
<td>586 because as you say, he is more interested in the noise, but she would - she would like that</td>
</tr>
<tr>
<td>588 HV But then if he saw her though, he might get actually get engaged and</td>
</tr>
<tr>
<td>589 enjoy it</td>
</tr>
<tr>
<td>590 M I just want to try and find him something (.4) because he loves Spiderman (.2) but all the</td>
</tr>
<tr>
<td>591 Spiderman stuff is too rough, do you know what I mean, there is nothing for him =</td>
</tr>
<tr>
<td><strong>Family talk</strong></td>
</tr>
<tr>
<td>596 = oh that’s lovely, wow! ((daughter walks over to mother - talking to daughter))</td>
</tr>
<tr>
<td><strong>Building relations</strong></td>
</tr>
<tr>
<td>601 HV Did you do that? ((daughter shows drawing to HV)) That is just fantastic. And did you do all</td>
</tr>
<tr>
<td>602 of this as well? Wow (.2) I bet your teacher thinks you are so clever at nursery.</td>
</tr>
<tr>
<td><strong>Compliments daughter</strong></td>
</tr>
<tr>
<td><strong>Family orientated health issue 10: daughter’s educational development</strong></td>
</tr>
<tr>
<td>607 M I have been sitting, just writing (.2) like I will write words and she copies them (.4) that’s</td>
</tr>
<tr>
<td>608 really good, she impressed me (.2) I thought ‘that’s really good’</td>
</tr>
<tr>
<td>609 HV The thing is if you are doing that with her I think he will probably start watching because</td>
</tr>
<tr>
<td>610 he has been so good over there watching her. <strong>Compliments son</strong></td>
</tr>
<tr>
<td><strong>Family talk</strong></td>
</tr>
<tr>
<td>615 M Yes, but don’t draw on any of the words, just colour in the wee people ((talking to daughter))</td>
</tr>
<tr>
<td>616 right (.2) okay</td>
</tr>
<tr>
<td><strong>Professional concerns - providing information</strong></td>
</tr>
<tr>
<td>620 HV And I don’t know if I mentioned that one before, but that was from the ‘Save the Children’</td>
</tr>
<tr>
<td>621 pack and it is just looking at sort of 10 different steps to sort of different things you could try</td>
</tr>
<tr>
<td>622 (.4) I thought that might be quite useful for ((partner)) to look at. You could just stick it on the</td>
</tr>
<tr>
<td>623 fridge and what I quite like as well (.2) it runs through all different things like you know (.2)</td>
</tr>
<tr>
<td>624 making sure it is a child friendly environment (.2) this has got lots of different points (.2) but</td>
</tr>
<tr>
<td>625 what I really like on the other side as well (.2) you have probably seen that as a poster ‘children</td>
</tr>
<tr>
<td>626 learn what they live’ (.2) have you seen that one before?</td>
</tr>
<tr>
<td>627 M No I have not (.4) that’s really good =</td>
</tr>
<tr>
<td><strong>Family talk</strong></td>
</tr>
<tr>
<td>633 = eh (.4) did you do that? ((talking to son))</td>
</tr>
<tr>
<td>634 S and ((sister))</td>
</tr>
<tr>
<td>(C1_HV_HoV_2)</td>
</tr>
</tbody>
</table>

Figure 6.15: Alternating sequence of interaction Case 1
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An alternating sequence began with family orientated health issues. There was a shared concern about developmental implications regarding the siblings’ play. Mary initiates family talk in lines 596 and 615, by interacting with Jill. It seemed mutually meaningful, because of the mother and daughter’s shared experience. Janine was a silent witness to an interaction that might have shed light on family dynamics. The conversational sequence changes to building relations, as Janine attempts to build a rapport with Jill in line 601. Jill is complimented, as highlighted in lines 602. Mary then continues the conversation, talking about Jill’s educational progress. This family orientated health issue is picked up by Janine, who interprets Mary’s action and then compliments Max in line 610. Janine responds to an observational comment regarding a one-time event rather than offering a commendation for a patterned behaviour over time. However, the sentence carries an assumption of Jill’s patterned behaviour. The compliments may have signalled to Jill and Max that both were valued in their own right by Janine. The sequence then returns to family talk in line 615, where Mary acknowledges and instructs her daughter. While family talk in line 596 is followed by building relations as a kind of social lubricant, easing the transition towards family orientated health issues, this does not happen in lines 615 and 616. On this occasion, family talk shows its distinct feature by creating a disjunction in the flow of interaction. Janine picks up the conversation with professional concerns in a purposeful manner and pursues her agenda of professional concerns. This sequence is again abruptly interrupted in line 633 with family talk. On this occasion, the shared family experience is even confirmed by Max himself in line 634.

Figure 6.15 illustrates a sequence of alternating thematically coded conversational moves that create patterned sequences, which only became meaningful once I had analysed the interaction texts in all four cases. It required further progression in the level of analysis, the relevance of which is reported in Chapter 10, Section 10.4. An audit trail was built by tallying all the thematically coded conversational sequences for each home visit, allowing me to ascertain their meaning in terms of their prevalence. Each data source was checked for accuracy of counts and consistent application of coding decisions. This supported dependability of procedures. A summary of thematic conversational sequences according to their ranked prevalence is given in Table 6.8. From this a number of inferences can be drawn.
### Table 6.8: Prevalence of thematic conversational sequences across all home visits Case 1

<table>
<thead>
<tr>
<th>Themes</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Talk</td>
<td>34</td>
<td>32</td>
<td>66</td>
</tr>
<tr>
<td>Family Orientated Health Issue</td>
<td>26</td>
<td>28</td>
<td>54</td>
</tr>
<tr>
<td>Professional Concern</td>
<td>21</td>
<td>23</td>
<td>44</td>
</tr>
<tr>
<td>Patient Health Concern</td>
<td>17</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>Building Relations</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
</tbody>
</table>

*Family talk* was influential in shaping the two home visits, which were orientated towards exploring *family orientated health issues*. Janine tried to get a sense of the collective family situation and took account of the interrelated and interdependent nature of family members, consistent with a family nursing approach. However, the partner’s absence prevented her from gaining a full understanding of the family situation. The prevailing feature of *family talk* may have been due to this unique family composition. The two pre-school children displayed a developmentally appropriate demand for attention during both home visits, and Mary responded to these frequent demands. This might have contributed to *family talk* emerging as such a striking feature of the interactions.

### 6.5.4 Nursing Documents

Prompted by questions in the document summary form, a preliminary descriptive analysis was carried out on receipt of documentation templates. Coded data referring to Janine’s account of these documents was re-inspected and compared with the received documents. The previously developed heuristic framework questions turned out to be the most helpful. Reading and re-reading of the completed document summary forms and additional notes initiated the cycle of analysis as discussed in Chapter 5, Section 5.4.4. The outcome of the analysis was a detailed report which formed a separate part of the material sent to participants for verification. Case-specific summary findings are reported below.

### Direction

The Child Development Programme directed Janine to take a behavioural-developmental perspective towards the child and a partnership approach towards the mother. Janine was
committed to a holistic family approach. The documentation, however, featured only relevancies pertaining to the mother-child dyad, which structured the exploratory process in response to family circumstances. The child rearing problem was linked with parental relationship issues and lack of paternal parenting involvement. The paper and electronic documentation system could not accommodate these complex issues, nor was there space to refer to the other sibling. Despite reference to the mother’s health, the structure and content of the document limited the integration of many of the family orientated health issues explored during visits. Similarly there was insufficient direction within the assessment framework and documentation to accommodate and integrate information about the family as a whole.

**Disclosure**

The ‘Development Card’ provided a structured assessment tool that facilitated discussion between Janine and Mary, and the charting of Max’s developmental progress. The function of this interactive tool, parent-held and reviewed at each visit, was to encourage both parents to think about parenting issues and set developmental goals for the next home visit. Although welcomed by Mary, she did not believe the assessment tool had the desired effect on her partner. Thus the documentation became symbolic of the disclosure of her maternal parenting effort and of her progress. By contrast, the ‘Children’s Progress’ was a confidential professional record held by Janine and completed in Mary’s presence during the home visit. It remained, however, in the ‘ownership’ of the health professional and represented her definition of the family situation. The ‘Children’s Progress’ document contained categories that identified health issues of the mother and child, and became symbolic for disclosing the health care system’s efforts in reviewing maternal parenting efforts and progress. Much valuable family information became apparent during home visits, especially, the parental relationship and its effect on child rearing practice. However, both modes of documentation - paper and electronic - left only the faintest traces of the co-operative efforts of a caring health visitor and a mother struggling to maintain a functional family life. Since no specific reference was made to the family in the assessment framework, documented family health information was limited to the mother-child dyad. Much was left undisclosed.

**Discretion**
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Janine approached the documentation pragmatically and with discretion. She valued it, because it was useful and reflected her professional commitment, and allowed her to view the family holistically. The documentation focused only on mother and child, yet, Janine would never just look at them in isolation. The selection of ‘Development Cards’ as an assessment tool was a matter of discretion. Documenting her assessment practice, intervention and family health gain also called for her discretion in terms of deciding where to enter information. At the end of the case study, Janine expressed her scepticism about the documentation’s relevance for her assessment practice.

Discrepancy

A family promoting assessment framework underpinned the documentation (see below Section 6.6). There was no reference to family structure, function, development or environmental aspects, however, and information gathering tools such as a Genogram or Ecomap were not included. The documentation, therefore, provided little scope for charting the inter-relational and multi-dimensional nature of family health. Space to identify the interrelationship between and among family members and their environment was also unavailable. The interactional dimension, information-rich and typical of family dynamics, focused chiefly on the role of mother and child. A more inclusive family focused perspective, acknowledging other family members’ health or related implications, was lacking. The documentation did not provide the functionality needed to support Janine’s family orientated practice. She expressed concerns about the discrepancy of a structured assessment tool and the need to understand the dynamics of family life. She favoured a more visual representation which would help capture the dimensionality of family health and the collaborative nature of its exploration. While some factual information showed up on the electronic record, the richness of therapeutic conversations between Janine and Mary became a historical event of a shared experience. The therapeutic effect of the assessment intervention was lost as an outcome, one that was necessary for the evidence of practice within a multi-disciplinary and multi-agency context. The documentation made assessment processes invisible and deprived Janine of an essential element of her practice. The process and skill with which the bio-psycho-social family issues were explored, and the expertise with which assessment informed subsequent interventions, was for the most part lost to practice.
6.6 COMPARISON OF THEORETICAL ASSESSMENT FRAMEWORKS

The study’s theoretical orientation and key concepts guided the conceptual-analytical structure by which it was approached. These concepts had provided a useful analytic leverage for the talk-in-interaction. Dimensions of the conversational sequences of family orientated health issues and patient health concerns were identified and compared with domains in Wright & Leahey’s (2000: 68) C-FAM. Figure 6.16 summaries this comparison.

<table>
<thead>
<tr>
<th>C-FAM Family Assessment Domain</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structural Domain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Categories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rank order subsystems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boundaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended family</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Larger systems</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion and spirituality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Developmental Domain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Categories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcategories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stages</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Tasks</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Attachments</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td><strong>Functional Domain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Categories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcategories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instrumental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities of living</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Expressive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional communication</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Verbal communication</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Nonverbal communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circular communication</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Problem solving</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Roles</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Influence and power</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beliefs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliances and coalitions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 6.16: Comparison of theoretical assessment framework with interaction data Case 1
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The information confirms that Janine explored health issues that fitted the structural, developmental and functional domain of Wright & Leahey’s (2000) family systems nursing assessment framework. The first and second column identifies domains with categories and sub-categories of the C-FAM. Only those relevant to the situation in each of the home visits were addressed, which showed consistency throughout. Information on the internal family structure was neither sought nor documented, however. Activities of living related largely to the youngest child. It was puzzling to see such alignment in the information gathered by Janine with the C-FAM, given that this particular assessment framework was not used in practice.

Family health assessment practice in Case 1 was informed theoretically by Barker (1987) and Orr (1992). An assessment framework was integral to the Child Development Programme. A UK-wide evaluation of the programme confirmed its value as a source of support and advice for families (Hogg & Worth, 2000; Worth & Hogg, 2000). A needs-led service, it is offered by health visitors in support of social inclusion and family policy. The underlying principles of the Child Development Programme, as summarised by Orr (1992: 147), suggest a certain amount of alignment with family nursing concepts drawn from Wright & Leahey (2000) and Friedman et al. (2003). Figure 6.17 illustrates a comparison of some of these elements.

<table>
<thead>
<tr>
<th>Child Development Programme Concepts (Orr, 1992)</th>
<th>Family Nursing Concepts (Wright &amp; Leahey, 2000; Friedman et al., 2003)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with parents</td>
<td>Shared family paradigm</td>
</tr>
<tr>
<td>Recognising parents as experts of their child</td>
<td>Avoidance of the professional expert stance</td>
</tr>
<tr>
<td>Sharing responsibility with the parents</td>
<td>Co-responsible, co-determined problems</td>
</tr>
<tr>
<td>Eliciting a more in depth response</td>
<td>Therapeutic conversation</td>
</tr>
<tr>
<td>Child as focus of attention</td>
<td>Family as context - first level in family nursing</td>
</tr>
<tr>
<td>Health &amp; self esteem of mother is also considered</td>
<td>Systems approach achieves systemic understanding</td>
</tr>
<tr>
<td>Ideas with the child are not carried out only by</td>
<td>Taking a strengths focus allows parents to find</td>
</tr>
<tr>
<td>the HV to avoid parental feelings of inadequacy</td>
<td>their solutions to problems</td>
</tr>
<tr>
<td>Reasons are always found to praise something</td>
<td>Offering commendations to build family strengths</td>
</tr>
<tr>
<td>the mother is doing</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 6.17: Comparison of family orientated concepts in assessment frameworks Case 1**

Conceptually, both orientations focus on the family and convey a relational stance that can be interpreted as therapeutic and co-operative. Although the Child Development Programme’s concepts focus specifically on the family, they remain strongly focused on the mother – child dyad, which was also borne out in the nursing documentation discussed earlier. The concepts drawn
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from Wright & Leahey (2000) and Friedman et al. (2003) are grounded in integrated family systems nursing frameworks. They take account of the mutual interactions between and among family system individuals, i.e. they go beyond a sub-system focus. Despite this difference, the similarities between these concepts may have contributed to the holistic, i.e. integrative, approach taken by Janine towards the family. This integrative stance fitted a family systems nursing approach in Janine’s assessment practice as she took account of the interaction and reciprocity between and among family members. She focused on the family as a whole and recognised the inter-dependence of multiple factors, as Figure 6.17 suggests. The case-specific assessment framework was, thus, family-derived without being an integrated family systems nursing assessment framework.

While the family as a whole was taken into account, the nurse-family interaction also had a person-centred therapeutic dimension. Bryans (2003) found that reflective-interactive turn-taking utterances promoted the assessment process and created a therapeutic interpersonal climate. Features such as circular question-answer sequences, commendations and empathic responses showed in the nurse-family interaction in this first case. They were of a reflexive-interactive nature, mirroring Bryans’ findings. Circular question-answer sequences are an interaction pattern discussed in family therapy. Circular questioning has been shown empirically to promote a therapeutic alliance (Ryan & Carr, 2001). Their usefulness in communication with family members is advocated by Wright & Leahey (1984), who integrated this approach into the C-FAM (Wright & Leahey, 2000: 133-139). Circular questioning by Janine prompted a reflexive response which helped her to learn about Mary’s concerns. Such a response has been cited in the literature as calling forth an exploratory cycle of questions and answers (Tomm, 1981; 1988; Hartrick et al., 1994; Wright & Leahey, 2000; Bell, 2000). Findings from this first case study support this claim.

Both linear and circular question-answer sequences moved the family assessment process forward. In the pre-home visit interview Janine gave an example of a circular question which suggested that she used this communication strategy to promote dialogue with parents. It is a speech act considered by linguistics as pragmatic, i.e. one that is relevant to the use of everyday language (Austin, 1975[1962]). Others describe circular questioning as an interaction that acknowledges the correspondence between content and relationship from a systems theory perspective (Watzlawick et al., 1967; Tomm, 1981; 1988; Loos & Bell, 1990).
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Whether this particular feature alone created a therapeutic experience for Mary is questionable. However, Mary perceived the home visits as building her self confidence and her trust of Janine as health visitor. Features of commendations and empathic responses added to the therapeutic climate of the family assessment visits. Commendations, as highlighted in this case study, reflected definitions given by Bohn et al. (2003). They conveyed Janine’s relational stance towards each family member, even Mary’s partner in his absence, thereby confirming the family’s overall strengths. Along with her empathic responses, Janine conveyed to Mary that she was being heard and accepted unconditionally. Such a communication can also be interpreted from a symbolic interactionist viewpoint. Feelings and personal meanings are sensed from the inside by taking account of ‘the other’ as experienced in each moment “without reservations, without evaluations” (Rogers, 1993[1961]: 62).

6.7 LESSONS LEARNED

The selected methods accommodated epistemological and methodological requirements, the emergent nature of situations and events, and were suitable for probing the research phenomenon. Procedures were robust enough to gain access to a purposive sample, generate data about multiple perceptions, experiences, actions, and interactions and combine this data. Theoretical perspectives served as useful heuristic devices for data collection and analysis, with the prospect of reaching deeper levels of analysis once a more substantial data-base was in place. Interview guides indicated a logical and plausible progression for the development of an initial thematic analytic structure. The observation guide gave insight into the unfolding events and added depth and direction to the analytic process. A first round of analysis encouraged reflection on the first data sets and the data collecting instruments, including the impact of my role and skills with a view to further enhancing the quality of the data in the next case. Analytic procedures were brought to bear on the data. Initial descriptions and tentative interpretations generated more questions. Throughout this first case, personal reflections contributed to my grasp of the research process and its requirements.

Despite the recruitment outcome of a ‘one-informant’ family perspective, which is a limitation of this first case study, I decided to go ahead with data collection. Although a preliminary case, it gave sufficient scope to test design and procedures, and also alerted me to the problem of
recruiting a family in subsequent cases. In order to fully meet theoretical and methodological intentions, it was necessary to hold at least “conjoint interviews” to represent the family experience (Racher et al., 2000: 369; Houck et al., 2005).

Given that community nurses work in teams and may share their case load, safeguarding participants’ confidentiality and privacy was a key concern. To minimise any infringement of participants’ confidentiality and privacy, I reiterated the need to adhere to ethical principles during field visits and contacts with local collaborators and gatekeepers. Findings, assembled data displays, data records and case reports, and their return to participants for member checking, had to be considered carefully due to their co-constructed nature. By the time case reports were sent out, considerable time had elapsed, which compromised participants’ verification of case reports. Although contact was maintained with the community nurse, no response was received. Contact with the family could not be re-established.

6.8 MODIFICATIONS MADE

In its earliest conceptual phase, one intention had been to integrate an exploration of the decision making process of community nurses, which was reflected in the study’s initial title submitted for ethical approval. This intention, however, was not followed through as a focus in the preliminary case or for subsequent case studies.

I regarded it useful to aim to collect data from more than just two home visits. In view of the extensive amount of documents generated for data collection, I decided to record field notes in contact summary forms for all subsequent case studies (Miles & Huberman, 1994). These forms were equally suitable for recording reflections, questions and other information.

Bold topic headings were inserted in the interview texts, representing the interview topics, which resulted in a systematic structure and eased navigation through data sets after a first round of analysis (Gibbs, 2002). Below each topic heading, the interview questions and responses appeared in chunks. These provided an initial structure based on conceptual understandings and
meanings, which helped when comparing data sets. Identification and subsequent coding of data chunks were now attributable to each data source. In this way, distinct data sources were maintained and made more identifiable in the printed coding reports (Gaskell, 2000; Gibbs, 2002).

Early analytic interrogation of the data caused me to probe more specifically into the meaning of ‘family’, by asking the nurse and the family for their views. The interview schedule was extended to incorporate this topic.

Finally, the position of this preliminary case in the overall multi-case study design required consideration, to make full use of its potential. In view of the minimal changes made to the interview schedules, the findings of the first case study were included in the cross-case synthesis.

**SUMMARY**

Conduct and procedures were described in this first case study and found to be sufficiently sensitive for the study’s aims and objectives. Data was laid out and examined and findings reported in a variety of formats. Case findings are limited as they represent a ‘one-informant’ perspective, i.e. the mother’s experience about the family instead of multiple family voices representing the family experience. Family health assessment, however, went beyond an individual focus and reflected a near family systems nursing approach to practice. Although not informed by it, the assessment practice aligned with Wright and Leahey’s (2000) C-FAM, suggesting its usefulness for recognising the interactional and interdependent nature of an integrative, i.e. holistic, family health assessment. Whether themes would justify their transferability from this case study to the next remained to be seen.

The following chapter will give an account of the second case, which would give quite a different experience and insight into the research phenomenon.
7 DESCRIPTIONS, ANALYSES AND FINDINGS CASE TWO

INTRODUCTION
This chapter reports on the second case study. Case-specific issues are identified and the gaining of research site access and the sampling of the case are described. Events surrounding the unfolding data collection are detailed. To avoid a description of methods, only necessary analytical procedures are outlined. Findings are laid out relating to case profile, interview texts and nurse-family interactions, and the nursing documents. This includes the descriptive interpretive comparison of theoretical perspectives.

7.1 ISSUE IDENTIFICATION
The assessment practice of a health visitor and the psychosocial health care needs of a mother with two young children defined the situation of the first case study. To achieve the necessary phenomenal variation for this multi-case study, family health assessment required to be examined in a contrasting context for this next case. Within this case, family health assessment was conducted in response to the needs of a child with a chronic illness and the impact on the family in terms of self-care management, adaptation and support, which forms the remit of the community children’s nurse (CCN). It was important to seek multiple voices that represented the family as a whole, to meet the study’s theoretical and methodological requirements. These requirements were satisfied in this second case study, in which pseudonyms were again used to protect participants. Considerable time had elapsed when data records and case reports were sent for member checking, but comments were not received. A follow-up phone call confirmed that participants intended to discuss the sent material.

7.2 GAINING ACCESS AND SAMPLING
Research and management approval from the host organisation was gained while the first case study proceeded. Access to the research site and the recruitment process had been initiated with the line manager of the community children’s nursing service of the relevant division. Two
community children’s nurses responded to the invitation, both of whom met the selection criteria. A separate meeting was arranged with each individual. The study’s purpose and procedures were explained. Both recruits voluntary gave their informed written consent, but one withdrew from the study shortly after (see Chapter 6, Figure 6.1.).

The participating CCN, Betty, contacted me following data collection of case study one. She had selected a potential family with three children from her case load. Family recruitment followed according to tested procedures. On visiting the family, both parents, Lena and Jim, and their youngest son were present. Jens (4 years), showed global developmental delay and had complex needs since birth. The study was explained in detail. An uncle visited briefly and left shortly after. Then the older siblings, Jack (12 years) and Lilo (11 years), joined us. By now Lena and Jim had given their informed voluntary consent and that of their three children in writing. I explained the purpose of my visit to the older siblings, to establish rapport with a view to gaining their assent to the study. Lena considered it inappropriate to gain assent in writing from Lilo because of her dyslexia. Jack took the provided information with interest before both children retreated. The parents told me about their domestic arrangements: Lena and the children lived in the same household while Jim lived along the street with his sister. By the time I left, Jack had not returned and I had not gained his assent. Recruitment of case two had taken a total of 28 weeks; eight weeks for the community children’s nurse and 20 weeks for the family.

7.3 COLLECTING THE DATA
Data collection phases followed as planned, only the occasions for home and field visits differed. Episodes of data collection, participants, and referral reason are shown in Figure 7.1.
Chapter 7 Descriptions, Analyses and Findings Case Two

### Data Collection Summary Case 2

<table>
<thead>
<tr>
<th>Phase</th>
<th>Method</th>
<th>Occasion</th>
<th>Participants</th>
<th>Referral Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pre-home-visit nurse interview</td>
<td>1</td>
<td>Community Children’s Nurse</td>
<td>Youngest child’s assessment of developmental, psychosocial &amp; physical needs. Overnight gastrostomy feeds. Ureterostomy catheter care. Family support.</td>
</tr>
<tr>
<td>2</td>
<td>Audio-recorded nurse-family interactions during home visits</td>
<td>1</td>
<td>Mother with 2 school children and 1 pre-school child</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-participant observation of nurse-family interaction during audio-recorded home visit</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Post-home-visit family interview</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-home-visit nurse interview</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Examination of nursing assessment document(s) relating to referred patient/family</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional field visit</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Figure 7.1: Data collection summary Case 2

### 7.3.1 Nurse Interview: Pre-Home Visit

Interview procedures were followed as in the previous case, with consent re-affirmed and permission gained to audio-record the interview. There was an immediate flow of conversation. Betty appeared relaxed and seemingly enjoyed the opportunity to talk about her practice. I noted some similarities in the participant’s account compared with the previous case, yet subtleties of meaning needed to be teased out (Stake, 2006). Betty answered freely and generously, and all questions were covered in about 90 minutes. Informal talk followed once the recording had stopped. Betty expressed her enjoyment of our conversation which I reciprocated, thanking her for her contribution. She regarded the interview as a welcome opportunity to reflect on her practice. The family home visit was to take place 10 days later and we agreed that I would go along as an observer. In the meantime, repeated listening to the recording before its transcription proved useful as it allowed me to immerse myself into Betty’s account of perceptions and experiences of her practice.

### 7.3.2 Home Visit 1: Audio Recorded and Observed

As negotiated, we met outside the family’s home. The whole family welcomed us as if with expectation. Audio-recording and observing commenced as planned once permission was gained. Initially, all family members were present though Jack left shortly after our arrival. Lena led the
family communications. Jim and Lilo were predominantly onlookers and made sporadic comments. While their verbal interaction was minimal, their non-verbal communication of eye contact and touch suggested emotional warmth. Jens was everyone’s focus of attention. Eventually, Lilo began moving in and out of the living room, keen to show off her pets. Observation of interaction was much more complex and challenging compared with the previous case study. At times, the richness of the unfolding activities could not be noted quickly enough.

Verbal and non-verbal communications were not the only pattern of interaction. Betty assessed Jen’s urinary function when changing his ureterostomy catheter. Although conversation continued throughout the procedure, it was an activity which did not fit into the observation scheme. The procedure upset the child and his crying affected the quality of the audio recording. However, it would have been difficult to make sense of this activity without observing this interaction that involved Betty, Lena, Jim and Jens. By then, Lilo had gone to the garden, and popped in and out seemingly to reassure herself of events in the living room. Figure 7.2 is an excerpt of the observation record.
Once we had left the family, Betty invited me to spend some time in her car and we reflected on events. She shared information about care issues which helped to put some of the observed interaction into context. A meeting was arranged to discuss the nursing documentation. Although
not given access to the ‘active’ documents, I received a blank sample copy of each official document. Much information was also shared about Jens, his family and their complex circumstances which contributed to gaining a fuller understanding of the case.

7.3.3 Home Visit 2: Audio Recorded
Two weeks had passed since the previous home visit. On this occasion, Betty agreed to audio-record the visit without my assistance. A field visit had been negotiated for the following day to receive the recording equipment and discuss data collection for the coming weeks as participants were going to embark on a summer holiday. More information was shared about the nursing care documentation and the next opportunity to collect interaction data was planned for five weeks hence. It was to be audio recorded and observed. In the meantime another member of staff visited the family as Jens required regular urostomy catheter changes.

7.3.4 Home Visit 3: Audio Recorded and Observed
On this occasion, Lena, Lilo and Jens were present. Lilo was again eager to show off her many pets as she vied for my attention. Verbal and non-verbal interactions were recorded as planned. Events unfolded in a similar pattern. The initial conversation was followed by Jens’ catheter change which was not quite as troublesome as previously. The visit involved assessment of the situation, Jens’ progress, feeding regime and hands-on care when the urostomy catheter was changed. Jack joined us towards the end of the visit. Following this third home visit, I gained much insight into the nurse-family interaction and negotiated access to the child’s ‘active’ nursing notes for the same day. During their inspection, copious notes were taken. The information collected at previous field visits now provided an orientation through the various documents.

7.3.5 Nurse Interview: Post-Home Visit
This last phase involved the post-home visit interviews. Repeated listening to recordings and reading of first transcripts afforded insight into the substantive issues and interactions relating to this case. Questions had been noted when contact summary forms were completed and further questions were generated in light of the incoming data. This interactive engagement with all data
sources made it possible to tailor the semi-structured interview guides towards the substantive issues of the case situation. The post-home visit interview with the nurse proceeded as planned.

7.3.6 Family Interview: Post-Home Visit
It took two attempts to arrange this interview due to family circumstances. Both parents and the two younger siblings were present on my arrival. After some friendly talk, Lilo left us to play with friends. Jens sought my attention to play and was fed by Betty. The grand-father came in to look after Jens. Jack was not at home as he was attending a birthday party. I had the impression that arrangements had been made for the children not to be present during the interview. Compared with previous visits, the conversation proceeded without distractions, and I had a sense that both parents wanted to give me their full attention, although I would have appreciated the older siblings’ contribution to this data collection episode. Having explained the purpose of the interview and gained their verbal consent, contextual information about the family was sought and the recording began. The family interview proceeded in a well paced manner with both parents considering their responses carefully. It was important to learn about their experience from a shared family perspective. Uncertain at the beginning how this would unfold, I presented myself as an empathic listener and gave Lena and Jim time to respond. The conversation took a natural turn-taking flow and a co-created account of their experience developed. I gave the parents an opportunity to lead on what seemed meaningful to them. Both parents spoke freely, even about sensitive relational issues. I could sense an unspoken bond, despite their chosen separate households. Occasionally, Lena answered for Jim; I was then careful to re-phrase the question and turn to him in order to probe for his perspective. At times, there was agreement in relating their family story. At other occasions, some of their accounts reflected individual perceptions. Both parents contributed as informants of the family experience, thus meeting the requirement of a family interview (Houck et al., 2005). Once the voice recorder was turned off, Lena and Jim shared some of the rather turbulent events surrounding Jen's recent emergency hospital admission which had contributed to the previously cancelled family interview. While listening and responding to their concerns over the episode, which clearly had been distressing, I regarded it as inappropriate to return to my research agenda of gaining feedback on the interview. I thanked both parents for their participation and explained that I would invite them to comment on the case report in due course, and left some biscuits for the children on their return. Once in the car and listening to the audio-recording, I realised that I had inadvertently missed asking the
Chapter 7 Descriptions, Analyses and Findings Case Two

parents for their recommendation for practice. Data collection was now completed - it had taken 18 weeks. The transcribed audio-recordings generated 51,664 words of text; seven pages of observation records, nine contact summary forms, while document summary forms relating to three nursing documents with six pages of additional information were compiled.

7.4 ANALYSING THE DATA

7.4.1 Case Profile Two

A case profile (see Figure 7.3) was developed from a variety of data sources in order to gain a first descriptive understanding about the case and its context.

<table>
<thead>
<tr>
<th>Case Profile 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Children’s Nurse Context</strong></td>
</tr>
<tr>
<td>Betty was a CCN in her mid-30s. She had triple qualified as registered general nurse, registered sick children’s nurse and registered health visitor. Her practice covered both an urban and rural conurbation. Thirty children with complex, exceptional, and 10 children with acute health needs were on her case load. She held a number of academic awards: a Bachelor of Art in Community Health Nursing, a Higher National Certificate in Child Protection and a Professional Studies 2 in Wound Management (CCN_CIID_1). The community children’s nursing service provided a key link between a tertiary service provider and local areas. The team followed a philosophy of care in which the family is offered the chance to learn about management of care so that they “can be as independent as they wish to be” (CCN_DSF_2).</td>
</tr>
<tr>
<td><strong>Community Children’s Nurse Development</strong></td>
</tr>
<tr>
<td>Betty had eight years’ primary care experience. Of these, she had worked as CCN for seven years. For her professional development she engaged with a community children’s nursing specialist forum, case management developments and policy initiatives. Co-ordination of mentorship and student supervision was a regular element of her role (CCN_CIID_1).</td>
</tr>
<tr>
<td><strong>Family Context</strong></td>
</tr>
<tr>
<td>Lena (36) and Jim (59) had separated before the birth of their youngest child. They had three children. Jim lived just along the street with his sister. Depending on his state of employment, he visited regularly and helped in some day-to-day family chores. Usually, Lena could call on him when Jens’ condition deteriorated. Jack (12) was at secondary school. He was prone to constipation and suffered from asthma. Lilo (11) was attending her last year at primary school. She had been diagnosed with dyspraxia and dyslexia and had additional needs (CCN_CIID_Fam_Int). Jens (4) suffered from global developmental delay with complex needs and a life recurring chronic illness. His fragile condition resulted in recurrent hospital admissions. Lena was a full time carer. Her father, who was of Polish origin “lives across the way” (CSF_2). Lena’s brother lived in her father’s household. (CCN_Fam_Int).</td>
</tr>
<tr>
<td><strong>Family Development</strong></td>
</tr>
<tr>
<td>This family was on a roller coaster of adapting to the burden of care and coping with recurrent crisis. Jens was born at 35 weeks’ gestation with chromosomal abnormality, a feeding problem, laryngo malacia with stridor, hearing loss, congenital hydronephrosis and microcephaly. Lena and Jim had lived through many turbulent episodes. Jack and Lilo had taken their share of having to cope with their brother’s frequent hospital admissions due to surgical interventions such as repair of nephrectomy with inguinal hernia, ureterostomy, several insertions of gastrostomies and refashioning of stoma</td>
</tr>
</tbody>
</table>
Chapter 7 Descriptions, Analyses and Findings Case Two

| Referral Reason | Betty had known the family for more than four years. A health visitor had referred Jens to the home care service for failure to thrive. Since then a continuing relationship had developed between Betty and the family. Respect and trust had grown in response to her care involvement as frequent hospital admissions required follow up and liaison between the tertiary service and the family (CCN_DSF_4). The nature of this relationship had resulted in the family to request Betty to be their key worker (C2_Fam_Int). In this advocacy role she had the additional responsibily for care co-ordination, such as calling regular meetings and liaising with professionals in the multi-agency team. One such meeting had taken place before data collection (CCN_DSF_4). The main reasons for the home visits were an assessment of the mother’s perception of the outcome of the last care co-ordination meeting, Jens’ developmental needs, his ureterostomy catheter care and the feeding regime. |
| Researcher Reflections | Given time, opportunity, and inclination Jim, Jack and Lilo tended to be around or to float in and out during home visits; to have a look rather than to speak; to see what brought whom and for what occasion through the door. The living room was spacious to accommodate all - visitors, children, uncle; the dogs, the cat, the bunnies and the hamster. Everyone was made welcomed by Lena and so Jens became enveloped in love and social banter. Yet underneath it all was a burden of care carried by all. Lena carried the joke; everyone turned to her, to keep them right, to keep them fed; above all to be there - for Jens - day in and day out. With every home visit, the slightest change in Jens was carefully inspected; talked through; considered. Efficient and skilled, Betty changed his catheter – aseptically - amid the pet hairs and a crying little boy determined to seek his share of independence. |

Figure 7.3: Case profile 2

The diagram below, Figure 7.4, shows the family composition. This Genogram was neither drawn for assessment nor for data collection purposes. However, a family Genogram drawn by Betty was part of the assessment documentation of this case study. An explanation of Genogram symbols is given in Appendix K.
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7.4.2 Nurse – Family Accounts
The analysis proceeded in several iterative cycles according to the two stages laid out in Chapter 6, Section 6.5.2 with procedures applied consistently to enhance dependability. Although the data fitted the conceptual-analytical framework which had been developed for case one, there were instances where I had to extend the coding structure to accommodate meaning units not previously found in the accounts of case one.

Data record and data reports were developed following the structure of analytic framework questions as they applied to the nurse and family perspective. Figure 7.5 is a merged illustration of one category for the purpose of this thesis. The excerpt gives the CCN’s data record entry in the left column. Its derived understanding, taken from the nurse case report, is shown in the right column.
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<table>
<thead>
<tr>
<th>Domain: Conceptualisations</th>
<th>Derived Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category: meaning of family</strong></td>
<td>For Betty ‘family’ is seen as a very personal experience. Her conceptual scheme of ‘family’ is a group of people who, depending on their relation to each other, could be positioned inside or outside “the picket fence”. Different people might put different family members inside “the picket fence” where closeness and relational stability are provided. This symbolic meaning appears to be informed by the nature of relational bonds and not necessarily by kinship, generational position or locality. Her meaning of family is not tied to normative rules but reflects her experience of working with families of different compositions.</td>
</tr>
<tr>
<td>CCN: I think it’s very personal [ ] as time’s gone on [ ] I’ve got to know more about her extended family, because even her husband, their father is a bit of an extension to that family cause he’s not quite in there, they’re like float, they’re quite transient within the family. So they drift in and out. So probably really, if I was to draw the family, as a child drawing a family, I would draw ((mother)) and the three children and a trampoline which they’re never off and then in the background, I would probably put the three men [ ] which are granddad, dad and uncle, but they definitely would be, if I’m thinking of a child’s picture [ ] they wouldn’t be in the picket fence of the house. [ ] I think different people would have different people inside the picket fence as it were. So some people would have their aunties and uncles and absolutely cousins all inside, and then other people would have them maybe. [ ] And now there is a massive move to a lot of grandparents who are actually really taking on a much more parental role within families, which is very different to how it ever was. 5</td>
<td></td>
</tr>
<tr>
<td>(C2_CCN_Post_HoV_Int)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 7.5: Co-constructions of the meaning of family Case 2

I also noted that Betty’s account did not show the range in experiences and intentions in her espoused communicative actions compared with case one. These case-specific differences were even more marked once the comparative data display of themes portraying the nurse and family perspective was constructed. This is shown in Figure 7.6.
Despite these differences, there were commonalities showing in the data and their extrapolated themes which fitted the coded meaning units. Figure 7.7 illustrates how seeking understanding was the leading theme for the CCN, suggesting a sophisticated conceptual and relational process of ‘inquiry’ with the family.

<table>
<thead>
<tr>
<th>Case 2</th>
<th>Nurse Perspective</th>
<th>Family Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betty (CCN)</td>
<td>Seeking understanding (14)</td>
<td>Advocating on behalf of family members (3)</td>
</tr>
<tr>
<td>Lena</td>
<td>Pursuing strategic action (6)</td>
<td>Being listened to (2)</td>
</tr>
<tr>
<td>Jack (12)</td>
<td>Negotiating a working relationship (3)</td>
<td>Developing family confidence (1)</td>
</tr>
<tr>
<td>Lilo (11)</td>
<td>Promoting dialogue (0)</td>
<td>Negotiating actions (1)</td>
</tr>
<tr>
<td>Jens (4)</td>
<td>Picking up cues (0)</td>
<td>Sharing health concerns (1)</td>
</tr>
<tr>
<td>Jim</td>
<td>Verifying cues (0)</td>
<td>Receiving support and advice (1)</td>
</tr>
<tr>
<td></td>
<td>Looking at all aspects around (0)</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 7.6: Case-specific themes capturing the nurse and family perspective Case 2**

<table>
<thead>
<tr>
<th>Substantive Conditions of Meaning Making and Social Order 4. What are the nurse’s experiences and intentions?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain: Role Specific Meanings</strong></td>
</tr>
<tr>
<td><strong>Category: seeking understanding</strong></td>
</tr>
<tr>
<td><strong>Derived Understanding</strong></td>
</tr>
<tr>
<td>CCN: [ ] often what you find out is that [ ] there’s other issues [ ] you’re going in to get the information, so you are trying to gain that information as much as somebody will give you that information [ ] using those assessment frameworks, trying to actually glean a picture of what that family is [ ] and the dynamics of that family as such. [ ] It is hard. [ ] it probably always starts off - as there is a purpose, you’re going out to normally to provide something [ ] it can come from a family directly, a family’s needs, they would just divulge their needs at any time [ ] and then when you’re doing your family assessment this is probably where [ ] you sort of look at the social and educational requirements of their child, so it becomes kind of on a bigger scale, [ ] you kind of know your families, those that you know well, you do know really well and you kind of know that they know their limitations and that’s all probably part of the on-going assessment[ ] it’s not time because some families you can know for years [ ] and I wouldn’t say you know them particularly well [ ] and then others it is time, you kind of grow with them and others you can know by in a very short period of time [ ] quality of the time makes the difference but if you’re just spinning</td>
</tr>
<tr>
<td>For Betty seeking understanding means collecting bits of information that could be built into a picture of what the family is and how they do things. “Gleaning this picture” is difficult and takes time because it has to be assembled from observations and conversations. It requires looking, seeing, hearing and listening. It means interacting, being fully engaged. It requires concentration to take in all these different features and impressions out of which she assembles the picture – a pattern of the family. This pattern she recognises with her senses and then matches it to some evidence. The emerging pattern has to be fitted to the initial purpose of a referral and the information given by the family. Seeking understanding requires more than looking at the form – the Gestalt. It also calls for building relations so as to glean a picture of family relations – their dynamics: how they do things together, how they are</td>
</tr>
</tbody>
</table>

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in and spinning out and don’t appear to be giving them listening time, then I would say your never really gonna get to know them if you’re not sitting in such, if you’re divulging lots and lots of information for them, but you’re actually gleaning information by listening to how their life’s been, what they’ve been doing and the siblings as well, that’s how you kind of get to know how they are getting on [ ] what you’re wanting to see [ ] is how well they are, which sounds really, really vague, but probably little about the actual child themselves, but how as a family they are accepting the situation which they are in [ ] you’re trying to look at the actual dynamics, how well they are actually all working together [ ] I think you are wanting to know that they feel well supported, [ ] there are certain questions which you’re definitely asking [ ] but they are informal, because how you ask them will be different probably every time. [ ] And when you are reassessing which you’re doing on an ongoing basis, you will [ ] go back to certain points and you’ll probably rephrase it differently or because you felt you may be didn’t get the information you needed the last time [ ]
[ ] it’s (the participating family) a very easy place to go into and sit down and relax and have a chat and find out [ ] how they’re really getting on, [ ] if you’re actually aware of what’s going on and often you may not be it just depends on how much you’ve been imparted about [ ] personal issues that might be happening. [ ] say I left and somebody was doing my job as of tomorrow [ ] may be something that just would never crop up in conversation and it may not be imparted, it may be imparted, it’s documented [ ] if someone was new it may not. [ ] in time that person [ ] would also then start to understand and unravel the family. But it’s a predicament that you’re in, because you’ve been it for a time. So you learn it, as it goes along, you’re learning about the family as they move along [ ]

Figure 7.7: Co-constructions of seeking understanding Case 2

coping, how they are caring for each other at times of adversity and living with constant additional care demands. This way of seeking understanding turns eventually into a knowing, a depth of knowledge of each other which grows out of this trust to share how things actually are – not just a front, not just at the surface. This co-effort, expended between the CCN and a family, results in a well-built structure. This nurse-familiy knowledge becomes concrete and building it depends not always on time, but rather on mutual dependence to get to know each other at a level that generates a sense of solidarity. This solidarity which grows out of seeking understanding calls for giving quality time so as to grow together for a common purpose. It means being able to relax, to sit down and have a chat.

The following example is a merged illustration relating to the family perspective. Figure 7.8 is an excerpt from the family’s data record entry in the left-hand column and its derived understanding.
Figure 7.8: Co-constructions of advocating on behalf of family members Case 2

The excerpt illustrates the family’s perspective regarding Betty’s role of advocating on behalf of family members. Since the theme was not directly associated with ‘assessment’ purposes, it was not taken forward as a theme that directly represented the assessment process in this multi-case study. Nonetheless, it featured as an experience that was regarded as worthy to be shared by the family in each case study.
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7.4.3 Nurse – Family Interactions

7.4.3.1 Features of talk

Question-answer sequences

The interaction texts were systematically interrogated for features of talk. Each home visit showed linear question-answer sequences which facilitated the gathering of necessary information. Jens’ fragile condition, complex needs and his care demands that needed to be met by Lena gave these home visits a functional rather than a therapeutic care focus. While these linear question-answer sequences supported assessment purposes, they also had an interventive thrust, as the example illustrates.

53 CCN Okay (1.0) his last antibiotics for a chest infection weren’t they or was it his urinary tract?
54 M His urine.
55 CCN It was his urine as well (.2) when did he finish those?
56 M Em [ 
57 CCN [a week ago? 
59 M No about three weeks ago [ 
60 CCN [is it as long as that already? 
61 M Oh aye (.2) cos when he got better then he got another bad cold [ 
62 CCN [right and he didn’t get antibiotics for his cold? 
63 M No no [ ]
(C2_CCN_HoV_3)

The focused intention of ascertaining Jens’ recent medication in response to a urinary tract infection shows up in these three sequences of linear questions. An exploration of the effect and meaning of these recurring infections on Lena, or its impact on other family members, does not feature. This instrumental steer was further highlighted by the lack of circular question-answer sequences in the first and second home visit. During the third home visit there were few occasions when a circular question was formulated by Betty. The opportunity of more reflexive responses was not taken up by Lena, or they were arrested as Betty pre-empted possible reflexive comments, as in the following example. The dialogue shows that a reflexive-interactive sequence may not always lead to an exploratory exchange as it requires skilled communication, relevance and readiness to reflect and engage in such a manner. This excerpt illustrates where a circular answer-question is attempted in line 551 and 553.

551 CCN [ ] do Lilo and Jack play a lot with him outside as well then?
552 M Not at all ((Jens still crying))
553 CCN Do they not (.2) so if they want to play they leave him? They are at that age
554 where they want to play properly and he’s obviously just wanting to be a bit exploring which is just his way of learning ((Jens still crying))

161
The summary of these question-answer sequences across the three home visits in Table 7.1 highlights the instrumental, investigative and consistent nature of these conversational features.

### Table 7.1: Question-answer sequences during home visits Case 2

<table>
<thead>
<tr>
<th>Question-Answer Sequences</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
<th>Home Visit 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear Questioning</td>
<td>60</td>
<td>57</td>
<td>68</td>
<td>185</td>
</tr>
<tr>
<td>Circular Questioning</td>
<td>-</td>
<td>-</td>
<td>5*</td>
<td>5</td>
</tr>
</tbody>
</table>

*questionable due to arrested response

**Commendations**

During the three home visits Betty did not offer many commendations. None could be found in the first visit and just a few in the following two. Here is one such commendation:

In line 339 and 340 Betty commended Lena for her judgment in evaluating Jens’ condition, when being febrile. The importance of receiving such affirmation was mentioned by Betty during the family interview. This appeared to have a therapeutic effect as Lena was still missing her mother who had given her much reassurance and support. Now Lena had to learn to trust her own judgment. Betty appeared to have sensed this as significant in promoting Lena’s strength in caring for Jens. Betty reinforced her commendation in line 343 and 344 to help develop Lena’s confidence.
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**Empathic responses**

Empathic responses showed up more in all home visits, which seemed to provide the therapeutic effect Lena and Jim valued about these visits. These features of talk seemed to create a caring climate despite the visits’ instrumental focus and strategic questioning. Below is an example of one such response.

160  CCN  How are you finding it? ((nursery visits))
161  M    I liked it (.2) I’ve met well somebody from the village [ ]
163  CCN  Good [  
164  M    [ she knew me (.2) it was her first day so she knew me so [  
165  CCN  [ aha that’s nice you actually found somebody to have a chat with and [  
166  M    [ aya (.2)  
167  CCN  because before you found it quite a lonely experience sitting there when  
168  Everyone else was doing music therapy (.2) oh that’s good I’m really pleased

(CC2_CCN_HoV_2)

On this occasion Betty empathised with Lena’s feelings of loneliness, such as missing out on social contacts. Her remarks show a time dimension which allowed Lena to reflect on the progress she and Jens had been making. Socialising seemed to be getting easier compared with earlier nursery visits, and meeting parents in a similar situation from her local community could help to develop alliances for support in the long term.

I regarded commendations and empathic responses as giving insight into Betty’s relational stance towards the family. Table 7.2 summarises these features of talk. Both reflect the extent to which a therapeutic climate shaped the interactions in this second case study.

<table>
<thead>
<tr>
<th>Relational Stance</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed</th>
<th>Home Visit 3 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commendations</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Empathic responses</td>
<td>10</td>
<td>11</td>
<td>9</td>
<td>30</td>
</tr>
</tbody>
</table>

**Table 7.2: Prevalence of ‘relational stance’ during home visits Case 2**

Their difference in magnitude suggests that commendations were not part of Betty’s regular communication during these home visits. While her relational stance showed a caring concern which was evident from her empathic responses, offering commendations appeared to be under-utilised as a means of building family strengths and interacting more therapeutically.
7.4.3.2 Non-verbal interactions

Betty’s main non-verbal communication feature in support of ‘building trust’ appeared to be *keeping eye contact* with family members, *smiling, showing openness* and *respecting interpersonal space*, as illustrated in Table 7.3 below. There was a climate of ease and openness between her, Lena, Jim and the children. Betty showed openness by keeping the documentation open in front of her, and sitting next to Lena with notes accessible for her to view. Although the documentation was not kept in the family’s home, its content relating to Jens’ health care needs was actively shared with and made accessible to Lena. The documentation thus became a symbol of their meaningful and shared encounter. At times, though, she spoke quickly which appeared to make it difficult for Lena to take her turn. Verbal and non-verbal communications were not the only pattern of interaction for exploring health needs. Betty assessed Jens’ urinary function when changing his catheter. Betty and Lena talked to each other throughout the procedure. The catheter change was a purposive activity accompanied by linguistic utterances which helped coordinate their action (Habermas, 1999: 220). Due to the complexity of activity, I sensed that Betty’s speech, which focused little on the action itself, represented the binding and bonding energies of language described by Habermas (1999).

<table>
<thead>
<tr>
<th>Primary System of Representation</th>
<th>Rank Order of Prevalence Home Visit 1</th>
<th>Rank Order of Prevalence Home Visit 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeps eye contact</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Smiles</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Laughs</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Shows openness</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Respecting interpersonal space</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

**Table 7.3: Prevalence of ‘building trust’ Case 2**

Betty displayed expressive behaviours that seemed to contribute to an interpersonal climate of respect, acceptance and appreciation between all participants. Her relaxed manner conveyed a distinct air of competence. She showed ease and composure, despite Jens’ challenging physical assessment and care needs. Non-verbal communication was perceived as contributing to ‘building trust’ - a concept already identified in case study one and widely described in the literature as essential to the nurse-patient relationship. ‘Building trust’ is also generated within a reciprocal process, demanding engagement and the willingness of those involved in the relationship (Niven &
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Scott, 2003). Maintaining eye contact is fundamental in encouraging trust to flourish as it signals recognition of the other’s presence (Porritt, 1990).

Showing symmetry in facial expression and tone of voice between Betty and Lena was the most frequently recorded expressive behaviour associated with ‘showing empathy’. This was followed by listening attentively, nodding and showing patience. See Table 7.4 for a summary of observations.

<table>
<thead>
<tr>
<th>Primary System of Representation</th>
<th>Rank Order of Prevalence Home Visit 1</th>
<th>Rank Order of Prevalence Home Visit 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shows symmetry in facial expression and tone of voice</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Listens attentively</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Nods</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Shows patience</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 7.4: Prevalence of ‘showing empathy’ Case 2

Based on the recorded observations, Betty appeared to communicate an empathic understanding, unconditional commitment, and an acceptance of Lena’s goals, a caring, non-judgmental stance and a positive regard towards the family. Betty’s non verbal cues of symmetry in facial expression and tone of voice and her attentive listening during the observed visits could be interpreted as ‘showing empathy’. It was a mode whereby she related to them and communicated presence (Porritt, 1990; Demetriou et al., 1998; Egan, 2002). The observations suggested that this relational effort involved Lena and Jens predominantly, however, and the other family members to a much lesser degree. The gravity of health needs experienced by Lena in caring for her youngest child might have been a reason for Betty’s full attention to be directed towards them.

7.4.3.3 Conversational sequences

As in the previous case study, turn-taking sequences were coded-guided by the questions:

- How does the CCN make space for the continuation of the conversation with family members?
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Does the utterance concern the youngest child’s health or other family members’ health?

The five themes extrapolated in case one fitted all the talk-in-interaction text data. The main conversational partners were Betty and Lena. Professional concerns was the most common sequence across the home visits, followed by family orientated health issues, building relations and patient health concerns. Family talk was the least widespread conversational sequence. Table 7.5 gives information on the prevalence of the five themes.

<table>
<thead>
<tr>
<th>Conversational Sequences</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed</th>
<th>Home Visit 3 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Concerns</td>
<td>16</td>
<td>22</td>
<td>26</td>
<td>64</td>
</tr>
<tr>
<td>Family Orientated Health Issues</td>
<td>22</td>
<td>13</td>
<td>14</td>
<td>49</td>
</tr>
<tr>
<td>Building Relations</td>
<td>17</td>
<td>8</td>
<td>14</td>
<td>39</td>
</tr>
<tr>
<td>Patient Health Concerns</td>
<td>14</td>
<td>11</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>Family Talk</td>
<td>13</td>
<td>3</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>57</td>
<td>66</td>
<td>205</td>
</tr>
</tbody>
</table>

Table 7.5: Prevalence of conversational sequences across home visits Case 2

Professional concerns featured strongly throughout the home visits. Family orientated health issues were predominantly orientated towards issues of importance to Lena as the main carer of Jens. Such moves were therefore closely linked with a co-exploration of issues with Betty. Building relations often involved exchanges between Betty and Jens as she strove to build rapport with him in preparation for the catheter change. The urgency of focusing on his needs varied depending on his condition. For example, at the first visit he was quite unwell compared with the third visit when he was much brighter. Interestingly, family talk featured much less in this case study, despite family members’ presence in the first and the third visit. This might have been due to the family’s ‘normal’ communication patterns. Alternatively, the dearth of family talk might have been the result of participation in the study.

A summary of professional concerns highlights the content of these sequences in Table 7.6. The sub-categories show that conversational content relating to assessment and intervention were interwoven throughout the home visit. Both functional care-giving and health promotion were responses used to meet the needs of this family.
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<table>
<thead>
<tr>
<th>Professional Concerns</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
<th>Home Visit 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse intervention</td>
<td>8</td>
<td>4</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Offering health care advice</td>
<td>-</td>
<td>6</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Reviewing progress</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Negotiating a plan of work</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 7.6: Prevalence of professional concerns across home visits Case 2

The content of family orientated health issues is detailed in Table 7.7. This information confirms the strong influence of Lena’s role demands and associated concerns on her family and the home visits. Consideration of the interrelated and interdependent family issues during home visits would support the claim that in this case a family orientated approach was taken. From a family nursing perspective, it represented a ‘family as client’ rather than a ‘family as a system’ focus. While Betty inquired about family members, her interactions did not display concern about the reciprocal nature of family dynamics between and among family members.

<table>
<thead>
<tr>
<th>Family Orientated Health Issues</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
<th>Home Visit 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s concern for patient</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Environmental issues/transport</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Home care supplies</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Mother’s concern for siblings</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Daughter’s development</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Concern about father’s role</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Mother’s concern for father</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Affirming paternal role (mother)</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Siblings’ education</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Siblings’ play/relations</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Siblings’ health</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Family communication</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Extended family</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Financial concerns</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 7.7: Prevalence of family orientated health issues across home visits Case 2

The following excerpt of conversational sequences gives a flavour of the interaction between Betty, Lena and Lilo; Jim helped to hold Jens for the procedure. The interaction illustrates the regular activity of catheter change occurring at each home visit. During this procedure the conversation continued at multiple levels and with different family members. This conversational
flow created a distinct alternating pattern of sequences as displayed in Figure 7.9. Betty’s communication and procedural skill, showed in line 648 to 651. While changing the catheter, she took account of Lena and Jens and attempted building relations with Lilo. A short passage of family talk between Lena and Jens followed, grounded in a shared family experience that was unrelated to the preceding or following sequences. Betty continued with securing the catheter, followed by Lilo signalling her intention, but her speech act is left incomplete in line 654.

<table>
<thead>
<tr>
<th>Thematically Coded Sequence of Conversational Moves</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional concerns: nurse intervention – catheter change</strong></td>
</tr>
<tr>
<td>648 CCN Right Lena (.2) give him a big cuddle and then we fix the tubing on the leg</td>
</tr>
<tr>
<td>649 M There might be the older one at ((nursery)) but they’ll know</td>
</tr>
<tr>
<td>650 CCN well he’s tall (.2) he’s a lot taller that he was before Christmas [</td>
</tr>
<tr>
<td><strong>Building relations</strong></td>
</tr>
<tr>
<td>651 [ you were nearly touching the moon there Lilo ((talking to daughter))</td>
</tr>
<tr>
<td><strong>Family talk</strong></td>
</tr>
<tr>
<td>652 M Mummy’s boy ((talking to Jens))</td>
</tr>
<tr>
<td><strong>Professional concerns: nurse intervention – securing catheter</strong></td>
</tr>
<tr>
<td>653 CCN Okay (.2) are we ready here we go ((inaudible, child crying))</td>
</tr>
<tr>
<td><strong>Family talk</strong></td>
</tr>
<tr>
<td>654 Daughter I’m gonna back on the trampoline.</td>
</tr>
<tr>
<td><strong>Building relations</strong></td>
</tr>
<tr>
<td>655 CCN Right Jens (.2) well done ((inaudible, child crying)) what’s that? That’s all you need (.2)</td>
</tr>
<tr>
<td>656 something to look at [</td>
</tr>
<tr>
<td><strong>Patient health concern: physical – eliminating</strong></td>
</tr>
<tr>
<td>657 [ his urine doesn’t smell too bad to be honest [ ]</td>
</tr>
<tr>
<td>(C2_CCN_HoV_1)</td>
</tr>
</tbody>
</table>

**Figure 7.9: Alternating sequence of interaction Case 2**

While building relations, Betty praised Jens. She then moved on to patient health concern where she communicated an evaluative judgment on Jens’ urine. Like a recurrent circular pattern, conversational sequences moved from professional concerns to building relations to family talk and back to professional concerns, only again to feature family talk and building relations, which culminated in the assessment of patient health concerns. The only missing sequence in this excerpt is family orientated health issues. Statements were not usually as brief as in this excerpt; they were selected to show the alternating patterned regularity of turn-taking episodes.
7.4.4 Nursing Documents

Various documents had been received as templates. The ‘active’ assessment documents had been inspected on site with hand written notes transferred into electronic files. Analytical procedures were followed as outlined in Chapter 6, Section 6.5.3. A detailed report was compiled of which a summary is given below.

Direction

A systematic and integrated family systems nursing framework gave much direction for assessment practice and its documentation in this case study (see also below Section 7.6). Professional requirements aligned with those of the health care system. A ‘Family Assessment’ sheet for the whole family complemented one for Jens, the referred family member. The Genogram had been drawn some time ago to identify family composition. The interrelation of family and environmental systems was captured in the documentation. Although Betty valued the direction given, she regarded the integration of the assessment framework into the documentation as somewhat static. Capturing information content from a dynamic and interaction-rich encounter such as the home visit was problematic, even with a relevant theoretical framework. While ‘Family Interaction’ was an identified assessment category, the documentation did not include an Ecomap. Family information was recorded following home visits, but it entered the ‘Continuation Sheet’ - a repository that displayed a chronology but lacked any other structure. Only the Genogram made it possible to interactively engage with the “Family Assessment” sheet. It was drawn by pencil to allow its reconfiguration, as a family might reconfigure in composition - a not uncommon experience for Betty.

Disclosure

Betty focused on Jens’ safety and how his care was maintained by Lena. How this constant care giving might have affected the family as a whole over time was more difficult to discern from the documentation. The pinpointing of potential difficulties Lena might experience in caring for her ‘fragile’ child mattered most; these required action and resulted in their disclosure. Personal family matters were treated by Betty in a variety of ways. Information was either “jotted in your memory”, where it remained undisclosed to the public gaze, or it was “jotted in your diary”. Here
personal family information remained in ‘transit’ until it was formalised and recorded in the ‘Continuation Sheet’. Once formalised, it was shared with Lena during home visits. Disclosure was a two-way process which was much appreciated by Lena and Jim. Betty regarded the formalised information gained by drawing a Genogram as “a good reference point”. In its pictorial image, it could be symbolically significant for family relations while potentially disclosing intimate relationships. Betty, therefore, treated its use and revealing information with caution -“some people don’t know who’s their half sister or half brother or not. So, it’s really how they see their family”.

**Discretion**

For Betty, discretion was also bounded by ethical judgment and a commitment to protect the family’s privacy “that they’re not lying open raw on a piece of paper”. While for Betty avoidance of unnecessary disclosure meant maintaining family integrity, it also called for vigilance in assessing potential risks to the child. Although each home visit was documented, she too used her discretion in the transfer of information into its formalised structure. This appeared to be influenced by the extent of the information that was obtained, and the nature of interaction and relationship with the family. Since information was recorded in the ‘Continuation Sheet’, it was no longer guided by a standardised framework. As much as it was characterised by its imprecision in structural display, it was current and factual in content. It was also open to scrutiny. Despite this pragmatic approach to documentation, the displayed information remained meaningful at multiple layers, especially to Betty. While information was not always formally recorded, family knowledge was maintained in a transient and temporal basis. These implicit layers of meaningful content were considered with discretion. They corresponded with the relational dimension which Betty and the family had established over time. After all, family talk and building relations were part of “gleaning this picture” of the family. Although personal family knowledge may not feature as an institutional display, it appeared to be critical for an understanding of family health concerns.
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**Discrepancy**

While the documentation suggested a ‘family as a system’ perspective, the extent to which such a family systems nursing approach was taken in practice and in the documentation was less discernable. The documentation provided a structured format based on theoretical and empirical work. However, there was a discrepancy in terms of the lack of documentation of the family’s interrelationships and how these were affected by Jens’ complex and life-limiting needs. It was necessary to infer much of the complexity of care needs and the range of input from other services. For example, there was minimal information which may have provided some insight into the family’s development, and their expressive behaviour in terms of affectional ties. The complex, technological dimension of care needs and the child’s educational and developmental challenges were clearly communicated within the nursing notes. Less evident was information relating to the psychosocial dimensions between and amongst family members. While some direct pointers to the family’s experience could be traced, the family’s burden of having to continually adapt to the child’s ‘fragile’ health status with its associated needs remained largely hidden. An ongoing assessment of Lena’s competence in Jens’ complex care was evident from entries in the continuation sheet that was completed after home visits. Lena’s self-care management ability of her ‘fragile’ child was assessed from a ‘family as client’ perspective, reflecting a family nursing approach. It met the social practice of the CCN, her colleagues and the service.

7.5 COMPARISON OF THEORETICAL ASSESSMENT FRAMEWORKS

The nursing documentation was grounded in an integrated framework of family systems nursing. Ownership had been taken by the community children’s nursing team for their document developments during an action research project (Whyte et al., 1998). The framework drew on the C-FAM (Wright & Leahey, 1994), Whyte’s (1997a) Family Systems Nursing Assessment Model, the McGill Model (Gottlieb & Rowat, 1987), and the Activities of Living (Roper et al., 1996). Headings in the family assessment sheet provided prompts such as ‘Family Composition’ (Genogram), ‘Family Context’ and ‘Family Development’. One page was given over to ‘Family Assessment’ with headings such as ‘Family Interaction’ (communication and roles), ‘Informal Support Network’, ‘Formal Support Network’, ‘Family Concerns’, ‘Family Expectations’ and ‘Agreed Priorities’. ‘Activities of Living’ were the focus in the separate assessment sheet for the referred child.
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The collaborative nature of nursing work with families, the coping process and corresponding problem-solving which required developmental progress in learning were also identifiable elements from the McGill model (Gottlieb & Rowat, 1987; Allen, 1999). The central focus of this model is on health, family, collaboration, learning and family strengths. The dynamic and multi-dimensional construct of health includes coping as problem-solving process that is interrelated to development as a process towards reaching life goals (Gottlieb & Rowat, 1987; Allen, 1999) - a perspective that was seen to be relevant by community children’s nurses in their efforts to support families forced to adapt to the long-term needs of a chronically ill child (Whyte et al., 1998). The headings such as ‘Family Concerns’, ‘Family Expectations’ and ‘Agreed Priorities’ on the family assessment page are indicative of the McGill model’s emphasis on the collaborative nature of nursing work with families. The concept of ‘learning’ was addressed by integrating instructions for care activities such as guidelines based on the principles of best practice, which were then adopted by the parent. Figure 7.10 gives a comparative display of the C-FAM domains with their categories and sub-categories, and the family concerns that featured during the home visits.
Wright & Leahey’s (2000) three assessment domains were embedded in the conversational sequences of both *family orientated health issues* and *patient health concerns*. The above figure illustrates their constitutive elements which demonstrate a consistent focus, in line with the C-FAM, and underline the suitability of this model in the CCN’s assessment practice. Although family composition was not addressed during the home visits, the internal family structure was identified as a Genogram in the assessment documentation.

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**Figure 7.10: Comparison of theoretical assessment framework with interaction data Case 2**

<table>
<thead>
<tr>
<th>C-FAM Family Assessment Domain</th>
<th>Home Visit 1</th>
<th>Home Visit 2</th>
<th>Home Visit 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structural Domain</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Categories</td>
<td>Subcategories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>Composition</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rank order subsystems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Boundaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External</td>
<td>Extended family</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Larger systems</td>
<td>✓  ✓</td>
<td></td>
</tr>
<tr>
<td>Context</td>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social class</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Religion and spirituality</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Environment</td>
<td>✓  ✓  ✓</td>
<td></td>
</tr>
<tr>
<td><strong>Developmental Domain</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>Subcategories</td>
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<td></td>
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<tr>
<td></td>
<td>Stages</td>
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</tr>
<tr>
<td></td>
<td>Tasks</td>
<td>✓  ✓  ✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attachments</td>
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<tr>
<td><strong>Functional Domain</strong></td>
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<tr>
<td>Instrumental</td>
<td>Activities of living</td>
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</tr>
<tr>
<td>Expressive</td>
<td>Emotional communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Verbal communication</td>
<td>✓  ✓  ✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nonverbal communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Circular communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problem solving</td>
<td>✓  ✓  ✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roles</td>
<td>✓  ✓  ✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Influence and power</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beliefs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alliances and coalitions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chapter 7 Descriptions, Analyses and Findings Case Two

SUMMARY
An account of the second case study was presented. This included its conduct, procedures and findings. A more prolonged engagement in the field supported credibility. Case-specific features that brought out differences were laid out and examined, but also some commonalities compared with the first case. The prevailing sequence of professional concerns reflected the functional nature of the assessment visit in this case study. Nonetheless, family orientated health issues impacted strongly on the home visits even when the emphasis was on functional care needs. Family orientated health issues and building relations shaped the interaction process, even when professional concerns were so prevalent. Home visits were orientated towards an exploration of family health concerns rather than patient health concerns. Family talk also featured as one of the relevant themes, although its meaning had a markedly different impact compared with the previous case. Family members may have felt discouraged due to participation in the study. Alternatively, they may have displayed their common pattern of interaction, or perhaps wanted to show courtesy towards their visitors. Theoretical and methodological requirements were met as both parents co-constructed an account of the family experience.

While the assessment as practised can be described as ‘family nursing’, the documentation reflected a ‘family systems nursing’ conceptualisation. The metaphor of ‘family as client’ rather than ‘family as system’ fitted the approach taken by the community nurse. The concerns voiced by the community nurse about documenting family information raised new questions. While an integrated family systems nursing assessment framework guided practice and documentation, findings highlighted the delicate nature of issues, with the ethical ramifications that surround the documentation of family information.

The next chapter will focus on the third case, in which I sought to gain a better understanding of this dilemma.
8 DESCRIPTIONS, ANALYSES AND FINDINGS CASE THREE

INTRODUCTION
An account is given of the third case study. Particular issues associated with recruitment and sampling, including member verification, are noted first. Field events during data collection are reported and findings are laid out following the sequence in the previous case studies.

8.1 ISSUE IDENTIFICATION
For this third case, variation of a family health assessment was sought where health and long-term care needs were of family concern in order to add phenomenal richness. The assessment was to be orientated towards the whole family from the time of referral. This generic type of family health care practice is offered by the family health nurse (FHN). The Scottish FHN pilot initiative was introduced in the North of Scotland in 2001 (Macduff & West, 2003) and had been completed by the time this case study began, making this geographic area available for this enquiry. I anticipated being able to examine a family health assessment informed by a family-derived theoretical framework such as Wright & Leahey’s C-FAM (Macduff & West, 2004). While my understanding of the research phenomenon had developed with the previous cases, I was keen to find out how this third case might deepen my insight and provide a more comprehensive clarification of issues. Again, all participants’ names were changed to protect their privacy and avoid attribution. In response to the verification process, the FHN confirmed descriptions and interpretations and raised no questions or concerns, suggesting that the co-constructed accounts were meaningful for her. No comments were received from the family.

8.2 GAINING ACCESS AND SAMPLING
Access to the research site called for the relevant health board to be approached, from which recruitment of an FHN would be possible. Seeking research and management approval from the host organisation proceeded with the assistance of the Assistant Director of Nursing. She distributed 11 invitations, to which four FHNs responded. All met the selection criteria. Two nurses did not wish to go ahead once the study was explained. One nurse withdrew after having
given her consent. Recruitment of a family took place with the co-operation of Margaret, the remaining FHN. Selecting a potentially suitable family turned out to be difficult, however, because her role had changed. Family health care practice was no longer her only remit. After a year, she informed me about a potential family which had been referred to her by the general practitioner. During this time, I maintained regular contact with Margaret to signal my appreciation for her co-operation and not to lose her from the study. The recruitment process for the potential family was eventually initiated according to agreed procedures. A suitable time to visit was negotiated by phone and it was agreed that Margaret would introduce me to the family - a married couple in their early 50s – and then leave. Bob was full-time carer for Nicky, his wife, who had suffered a stroke several years previously. At the recruitment visit, I explained the study in detail. Permission was sought and gained to approach their GP, and both gave their voluntary, informed written consent. Recruitment of case three took a total of 56 weeks; eight weeks for the FHN and 48 weeks for the family. See Chapter 6, Figure 6.1 for the recruitment and data collection time line.

8.3 COLLECTING THE DATA
Data collection was to proceed as scheduled. However, an equipment error resulted in the loss of recordings of the second home visit, which was later compensated for by an additional home visit (see also Section 8.3.3 and 8.3.4). With the participants’ support, field visits were arranged in such a way as to maximise data collection time, as it took three hours by car to get to the research site. Figure 8.1 details episodes of data collection, participants, and referral reason.
**Chapter 8 Descriptions, Analyses and Findings Case Three**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Method</th>
<th>Occasion</th>
<th>Participants</th>
<th>Referral Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pre-home-visit nurse interview</td>
<td>1</td>
<td>Family Health Nurse</td>
<td>Married couple in late adulthood. Husband full time carer. Spouse suffered stroke 12 years ago. Long standing family stress. Lack of independence for carer and spouse who suffered from chronic constipation, incontinence and impaired mobility.</td>
</tr>
<tr>
<td>2</td>
<td>Audio-recorded nurse-family interactions during home visits</td>
<td>1</td>
<td>Non-participant observation of nurse-family interaction during audio-recorded home visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-participant observation of nurse-family interaction during audio-recorded home visit</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Post-home-visit family interview</td>
<td>1</td>
<td>Post-home-visit nurse interview</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Examination of nursing assessment document(s) relating to referred patient/family</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional field visit</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 8.1: Data collection summary Case 3**

### 8.3.1 Nurse Interview: Pre-Home Visit

The interview was held in a quiet room in the local medical centre. Due to the long break between previous interviews, the ‘Reflexive Interview Flow Chart’ (see Appendix E) was useful for preparation. Once verbal consent was gained and general information collected, the interview got under way. Initial prompting was necessary to elicit more elaborate accounts, and questions lacked a conversational tone perhaps due to a degree of mutual nervousness. Eventually, the initial awkwardness was overcome and a co-created account evolved with ease. Margaret’s responses reflected her assumptions and abstractions based on her experiences that alternated with lengthy descriptions of personal, subjective views. Some responses were elaborated upon so that they covered items on the interview guide prior to being raised. I had noted this phenomenon in the nurse interviews of the previous case studies. It suggested dependability of the interview guide to tap into the community nurses’ experience. In this case, however, informal talk following the interview brought to light that Margaret and I had a strong sense of sharing a perspective. I surmised that this was due to her assessment practice being grounded in a family-derived framework which had informed the study. The interview lasted 95 minutes. Margaret then gave me some background information about the family as the first observed home visit was scheduled for the afternoon.
8.3.2 Home Visit 1: Audio Recorded and Observed

On arrival at the family home, informal conversation between participants helped to ease and ‘normalise’ the situation. Humorous teasing among the couple and Margaret carried on for a little while. The small living room was filled out with four people taking up the available seats making for a close circle of conversation. Audio recording commenced, after verbal consent from all participants. I felt a little uneasy about everyone’s close proximity as it precluded me from taking a more background role. Moreover, it was difficult for me to keep a full view of Margaret as we had to sit next to each other. Judging by the social banter between Margaret, Nicky and Bob, a well established relationship had been formed between them. Everyone was soon engrossed in developing a Genogram. Nicky and Bob gave an account of their family history with much emotional involvement, such as laughter and reflective silences. By now I had also settled into my observer role. None of the participants made much eye contact with me which suggested that I had been successful in adopting a background role. The home visit lasted much longer than previous case studies. Figure 8.2 shows a segment of the observation record.
### Observation Record Case 3

<table>
<thead>
<tr>
<th>Time</th>
<th>Participants’ Behaviour</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.00</td>
<td>N looks at H and W</td>
<td>EC</td>
</tr>
<tr>
<td></td>
<td>laughs with W</td>
<td>L, SE &amp; TV</td>
</tr>
<tr>
<td></td>
<td>introduces genogram</td>
<td></td>
</tr>
<tr>
<td></td>
<td>moves hands whilst explaining</td>
<td></td>
</tr>
<tr>
<td></td>
<td>looks at both alternating</td>
<td>EC</td>
</tr>
<tr>
<td></td>
<td>nods to both and confirms</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>nods and attends to W</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>looks concerned hand under chin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>looks at H and confirms</td>
<td>EC</td>
</tr>
<tr>
<td></td>
<td>listens folding hands in lap concerned look</td>
<td>LA</td>
</tr>
<tr>
<td></td>
<td>nods confirms to H</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>nods confirms to W</td>
<td>N</td>
</tr>
<tr>
<td>W &amp; H</td>
<td>both smile</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All laugh</td>
<td>L, SE &amp; TV</td>
</tr>
<tr>
<td>W &amp; H</td>
<td>both nod</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All smile and confirm</td>
<td>S, SE &amp; TV</td>
</tr>
<tr>
<td>N</td>
<td>folds hands in lap</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>speaks stretches out legs</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>nods</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>listens and nods</td>
<td>LA, N</td>
</tr>
<tr>
<td></td>
<td>gets out notes from folder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>nods and confirms to both</td>
<td>N</td>
</tr>
</tbody>
</table>

Note: Drawing is not to scale

**Figure 8.2: Excerpt of observation record Case 3**

### 8.3.3 Home Visit 2: Audio Recorded and Observed

The next home visit took place some 10 days later. Audio recording and observation proceeded as on the previous visit. The couple seemed initially subdued and made more eye contact with me.
Chapter 8 Descriptions, Analyses and Findings Case Three

Margaret had drawn the Genogram, explained it and sought verification of information that had been noted previously. Towards the end of the home visit, a visitor arrived and before their entry to the room, I quickly stopped the recording and put the equipment into my bag. Margaret brought the visit to an end and we left the family with the agreement that I would not attend the next home visit.

On our return to her office, Margaret openly invited me to review the nursing documentation. There was no trace of the hesitancy or delay which I had detected in previous cases when I sought access to the documentation. While reviewing the documents, I took notes and any questions about the nursing records which Margaret had explained. Procedures were discussed for the next home visit, and I left an audio-tape recorder. She was happy to use the equipment as she had experience of recording her interaction from the time of her family health nurse studies. Audio-tape and equipment was to be returned at a next site visit.

On return to my car I jotted down field notes and, as on all other occasions, listened to the recording. About 14 minutes in, everything went silent. It was a distressing moment, and I never found a convincing explanation for why this had happened. Although not having concentrated on the content of the conversation at the time, I did take some prompts alongside the recording schedule, which allowed verification with Margaret at the next field visit. After seeking guidance from my supervisor, I decided to negotiate an additional home visit, depending on the quality and content of the next home visit audio recording.

8.3.4 Home Visit 3: Audio Recorded
Margaret visited the family about four weeks later. At my field visit on the same day, I received the audio recordings. During this third home visit, the couple had requested not to record all of the conversation. Margaret noted “it would have been good for the study” (FHN_CSF_4). She wanted to listen to her audio recording, which then opened up further discussion about her practice. As previously noted I commented on the length of the home visit and Margaret confirmed that her visits tended to last well over an hour. At that point, I regarded it as important to compensate for the loss of data by collecting a further set of interaction and observation data.
Chapter 8 Descriptions, Analyses and Findings Case Three

Margaret sought agreement from the couple by phone and the next home visit was negotiated there and then. The rest of the site visit was spent reviewing the nursing documentation and taking notes. I also learned that one section of the documentation, the ‘Family Health Plan,’ was usually kept by the family. It had been made specially available for my access.

8.3.5 Home Visit 4: Audio Recorded and Observed

About four weeks had passed since the last home visit. As on previous occasions, I met up with Margaret and we arrived at the family home together. After some informal talk Bob took us up to the bedroom. Margaret carried out a Doppler Ultrasound assessment, for which she had asked Nicky to remain on bed rest before her arrival. I was invited along. The observation schedule did not fit this type of interaction, however, and I took notes to capture the situation as a whole. After about 30 minutes, proceedings continued in the living room. Apart from conversational interaction, the visit focused on further diagnostic assessments such as monitoring of blood pressure and blood glucose levels of both partners. Once the visit drew to a close, times for the post-home visit interviews were negotiated. These were planned for the same day of the following week.

8.3.6 Nurse Interview: Post-Home Visit

On this occasion the interview was conducted in the nurse’s office. Verbal consent was sought and before starting, I noted background information according to the prepared interview documentation sheet. Margaret had been excited about the study because “it gave an opportunity to look at various disciplines, documentation and how it works” (FHN_CIID_2). She did not think that my observations had any influence on her interaction with the family. Once the interview got under way, an account evolved from an immediate flow in conversation. Clarification was sought on outstanding issues which had emerged during field visits and in response to the preliminary analysis of the collected data. Questions elicited detailed responses which showed depth and reflection of the issues explored. The interview lasted 55 minutes. We both took our time to feedback on proceedings. Margaret reflected at length on being an FHN and on family health nursing in general. I confirmed that she would receive the case report with an invitation to comment on factual issues, descriptions and interpretations.
8.3.7 Family Interview: Post-Home Visit

As in the previous case studies, this family interview focused less on a narrative account and more on contextual and specific issues relating to the home visits and the family’s experience and perceptions of them. Verbal consent and permission to record was confirmed. Procedures then followed as set out previously. Questions touched on issues that were meaningful to the family experience as identified from previous home visits. The conversation flowed with ease. Both partners were open and responsive, and the data rich in reflections on their chronic illness and carer experience. At times the conversation drifted off, but I regarded it as important to give the couple time and space to tell their story and for a co-constructed account to unfold. At one point Nicky was overcome by emotions, but not to the extent of abandoning the interview. On other occasions, questions touched on relevant aspects of the subjective meanings for either Nicky or Bob, which led meaningfully to my next question. Once the recording stopped, informal conversation followed, during which I invited the couple to reflect on their participation in the study. Both emphasised that they were happy to be able to contribute to helping improve services and were looking forward to receiving the promised report. I thanked both for their contribution and as a small token of appreciation I left a box of biscuits. The interview lasted 65 minutes. Data collection took 18 weeks and comprised 86,647 words of text once audio recordings were transcribed. Additional material contained 20 pages of observation records, seven contact summary forms and document summary forms relating to six examined nursing documents.

8.4 ANALYSING THE DATA

8.4.1 Case Profile Three

The case profile was built from biographical data, field notes, information collected before or after interviews and the family interview (Flick, 2002). The case descriptor provides a contextual ‘frame’ for subsequent reporting. It gives contextual and developmental information about the FHN, information on family context and development, and reasons for referral. My reflections on the case add a further nuance on events. The case profile presented in Figure 8.3 draws on the C-FAM discussed in Chapter 2, Section 2.3 and Chapter 5, Section 5.7.
### Case Profile 3

| Family Health Nurse Context | Margaret was a FHN in her mid-30s. She was qualified as a registered general nurse and held a specialist practitioner qualification in family health nursing. She worked in the capacity of family health nurse, health visitor and school nurse while sharing a full time post with another colleague. Margaret described the locality as rural with high unemployment and a culture of dependency (FHN_CIID_1). Instead of holding a case load, she covered a population from age nought to death within the geographical area attached to the medical centre. Margaret worked actively with 17 families, many of whom were vulnerable families in the midst of crises (FHN_CIID_1 & 2). Although feeling somewhat isolated, she was enthusiastic about her role as FHN “it just feels the right thing to do – working as a FHN” (FHN_CSF_1). |
| Family Health Nurse Development | Margaret had qualified with a Diploma of Nursing. She had worked for about two years as a community staff nurse before undertaking the Bachelor of Nursing in Community Studies (Family Health Nurse) programme. She had been a FHN for almost five years, held an additional qualification in Independent Nurse Describing and Supplementary Nurse Prescribing and kept abreast of developments by attending study days. She accessed public health journals, publications on cardiac rehabilitation, the NHS E-Library and had also started an online Masters in Public Health programme (FHN_CIID_1 & 2). |
| Family Context | The couple had been married for about 21 years with no children between them. Nicky (S2) had two children from her previous marriage. She had suffered a stroke 12 years ago followed by cerebral thrombosis and hypertension. She had missed out on rehabilitation in the early post-stroke years. She was mobile independently at home using a stick. Arrangements had just been made for a scooter to improve her independence. Bob (S1) had four children from a previous marriage. Both kept contact with their children and grand-children, especially Bob. Bob suffered from asthma and his knee continued to bother him. And there was Skye, their trusted, much loved, furry friend (C3_Fam_Int). |
| Family Development | Nicky and Bob were in their late adulthood. Their independence had suddenly been compromised by Nicky’s onset of disability. Bob had struggled to keep a full-time job as a mechanic, while also caring for Nicky. Eventually he had to give up his work due to his own deteriorating health. He was now Nicky’s full time carer. Both had managed for many years, but gradually they were overtaken by events. Bob described the impact of Nicky’s disability: “its driven us apart but its brought us closer together [ … ] I never ever thought like i at thirty-eight years of age I’d be looking after a disabled wife” (C3_Fam_Int). Nicky commented on their situation as “I think we’d have benefited having Margaret 14 years ago” (C3_Fam_Int). |
| Referral Reason | Margaret had known the couple for about eight months (FHN_CIID_2). Five home visits had taken place during which Nicky and Bob had been “leading the way” in making known their concerns (FHN_CIID). Nicky had experienced little support, and suffered from lack of independence and chronic constipation. During the initial home visits, the immediate problem of her long standing incontinence had been dealt with. The planned home visit was the first ‘proper’ family health assessment (FHN_CIID_2). |
| Researcher Reflections | Nicky and Bob were keen to tell their story. Home visits were cathartic as both were at last being listened to; and there was much to tell. Spiced with wit and humour they gave an account of their ups and down while trying to make the most of their situation, despite the burden each carried – Nicky with a sense of loss for her independence, Bob with a sense of entrapment in a situation not of his choosing. Or was it the other way round? Were both carrying each other’s burden? The relief of being offered alternatives and that there was hope of becoming unstuck was palpable. Their eagerness for self-care so as to turn things round was apparent. So was the astuteness and skill of Margaret in facilitating their change. |

**Figure 8.3: Case profile 3**
Chapter 8 Descriptions, Analyses and Findings Case Three

The family composition is shown as family Genogram in Figure 8.4. An explanation of Genogram symbols is given in Appendix K. It was initially drawn by Margaret in conversation with the family during one of the home visits. Permission was granted by Margaret and both family members to use the diagram for the purpose of this study. The hand-drawn diagram was transferred to an electronic copy. The initials of all family members entered into the original copy have been excluded for ethical reasons.

![Image of Family Composition](image_url)

Figure 8.4: Family composition Case 3
Chapter 8 Descriptions, Analyses and Findings Case Three

8.4.2 Nurse – Family Accounts

The analysis proceeded in several iterative cycles according to the two stages laid out in Chapter 6, Section 6.5.2. As in previous case studies, the data fitted the conceptual-analytical framework developed so far. *Data record* and *data reports* were compiled, guided by the analytic framework questions as they applied to the nurse and family perspective. One category as an illustration is merged in Figure 8.5. The excerpt displays the family’s *data record* entry in the left-hand column and the derived understanding taken from the family’s *case report* is shown in the right-hand column.

<table>
<thead>
<tr>
<th>THE FAMILY PERSPECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantive Conditions of Meaning Making and Social Order</td>
</tr>
<tr>
<td>1. How does the family see their role?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain: Role specific meanings</th>
<th>Derived Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category: meaning of family</td>
<td></td>
</tr>
</tbody>
</table>
| Nicky: I think family means a lot [ ] Bob: Family is not just your brothers and sisters Nicky: Oh no Bob: family is your kids Nicky: oh aye [ ] Bob: Family to me is like a business because family is what you are Nicky: oh definitely aye Bob: it’s your family that’s made you [ ] and family to me is close I like family close, I have photographs of relatives going back like five, six generations because it’s important to me, it’s history it’s and I love going to see them and I love getting the crack with them and because I have interests one day I hope to be able to go and take them ((grand children)) doing the same thing [ ] you’ve got to show family what they mean to you and what love is and that’s what I think - family is love. Nicky: And I think you know I mean even though Bob wasn’t there bringing his up I mean. Bob: oh, I was for the first wee bit like and then [ ] we didn’t see them and then by pure chance I got a letter from the eldest girl ((daughter)) and she eh asked if she could start seeing us again which is what we did and ever since then we never really looked back have we [ ]
| (C3_Fam_Int) | For Nicky and Bob family is a relational experience across generations defined by affectional bonds of companionship, love and commitment to relational work. Family provides individual and collective identity through time and circumstances. |

*Figure 8.5: Co-constructions of the meaning of family Case 3*

As shown in Figure 8.6, all themes capturing the nurse and the family perspective fitted the interview data in this case study.
Chapter 8 Descriptions, Analyses and Findings Case Three

<table>
<thead>
<tr>
<th>Case 3</th>
<th>Nurse Perspective</th>
<th>Family Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Margaret (FHN)</td>
<td>Promoting dialogue (9)</td>
<td>Advocating on behalf of family members (4)</td>
</tr>
<tr>
<td>Bob</td>
<td>Picking up cues (9)</td>
<td>Developing family confidence (4)</td>
</tr>
<tr>
<td>Nicky</td>
<td>Seeking understanding (8)</td>
<td>Being listened to (3)</td>
</tr>
<tr>
<td></td>
<td>Verifying cues (7)</td>
<td>Negotiating actions (3)</td>
</tr>
<tr>
<td></td>
<td>Looking at all aspects around (6)</td>
<td>Receiving support and advice (2)</td>
</tr>
<tr>
<td></td>
<td>Pursuing strategic action (5)</td>
<td>Sharing health concerns (1)</td>
</tr>
<tr>
<td></td>
<td>Negotiating a working relationship (3)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 8.6: Case specific themes capturing the nurse and family perspective Case 3

The illustration in Figure 8.7 is an interesting account of the FHN’s perspective relating to her experience and intentions. Her account alludes to a form of pattern recognition, a conceptual scheme based on the use of her perceptual skills. If the pieces fitted together, it was very pleasing because she found family work, if it worked out, very rewarding. The theme picking up cues as a distinct conceptual process echoes findings in Bryan’s (1998) study. In this study, however, it also suggests a perceptual process.

<table>
<thead>
<tr>
<th>Domain: Role Specific Meanings</th>
<th>Derived Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category: picking up cues 9</td>
<td>For Margaret picking up cues means she “might pick up little bits and pieces along the way”. She uses these ‘bits’ to build up a picture. It alludes to a tactile activity which suggests that sometimes she might pick up the wrong ‘bits’ or miss a ‘bit’. These ‘bits’ become the key for her to know what she can use as relevant information. The ‘bits’ are not necessarily the information she might need. The ‘bits’ are the cues which help her to get that information. Picking up “little bits and pieces along the way”. ‘Bits’ are like hooks needed to fish for the relevant information. It takes effort and patience to find them, sometimes weeks. It requires listening, teasing them out with certain communication techniques and informal chatting. Watching the family communicate with each other helps teasing bits out. These “little bits and pieces along the way” give her a flavour of the family.</td>
</tr>
</tbody>
</table>

The Nurse Perspective

Substantive Conditions of Meaning Making and Social Order
4. What are the nurse’s experiences and intentions?

FHN: I don’t often formally sit down and do a big assessment with them I might pick little bits and pieces along the way and use that to kind of build a picture so you tend to kind of just build on these bits and they are key to know that you can use to get that information and get a good flavour from that this didn’t happen on the first visit you know it took a few weeks to find the basic bits of this information where you’re really just sitting back listening to people and pulling out what their motivators are and using that to help them set their goals to make their achievements you’re building up this picture of the family so you need to know about everything really then there might be points that I will pick up that they might say parts of this are sort of hooks so that I can see - would maybe tease them out and get them to talk about it more in a very kind of in a chat way so it looks like we are just having a normal - but actually I’m trying to gain the information about
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that family and how I can [ ] relate to them and
work with them. [ ] to watch them
communicating together to kind of see their - the
dynamic from their point of view as well as of
what they’re saying but you’re also observing that
communication between the two of them just to
see if there is any other bits and pieces which they
may be saying but they might be doing something
different [ ].
(C3_FHN_Pre_HoV_Int)

Figure 8.7: Co-constructions of picking up cues Case 3.

A theme that captures the family perspective is illustrated in Figure 8.8. The couple were keen to
talk about their sense of relief being listened to and being heard.

THE NURSE PERSPECTIVE

Substantive Conditions of Meaning Making and Social Order
4. What is the family’s definition of the situation?

| Domain: Conceptualisations and Experiences |
| Category: being listened to |
| Derived Understanding |
| Bob: [ ] she’s found it out ((health concerns)) by - |
| Nicky: well she listens doesn’t she Bob: by listening to |
| us understanding what we’re telling her and what |
| she’s not been too sure about she’s been able to go |
| back to the doctors and check it through details on the |
| computer so that she’s got the full picture and knows |
| which course of action to take and it’s only by [ ] |
| speaking to us and understanding and listening that |
| she’s been able to do that [ ] she listens to you so that |
| she knows she’s got the full facts and the history [ ] |
| because she does that I’ve got a hell of a lot of |
| confidence in her [ ] because you know that she’s |
| listening to you, you just gain confidence because you |
| know she’s taking an interest.viii |
| (C3_Fam_Int) |

Figure 8.8: Co-constructions of being listened to Case 3

While an understanding of their situation with its individual and collective relevance appeared to
be generated through dialogue and reflection, being listened to featured as a meaningful
experience of the assessment visits in this and the other case studies.
8.4.3 Nurse - Family Interactions

8.4.3.1 Features of talk

Question-answer sequences

Procedures as detailed in Chapter 6, Section 6.5.2.1 were followed for the analysis. By now the different features of talk stood out such as linear question-answer sequences. A sequence is shown below which related to the time of gathering information for drawing the Genogram.

657 FHN And do any of them have any significant sort of health –
659 W Em ((brother)) is diabetic plus he had a heart attack he had a
660 heart attack.
661 FHN And is it Type 2 is it – does he inject with insulin?
662 W Yes aye.
663 FHN And has he been a diabetic for some time?
664 W No it was only – [ ]
(C3_FHN_HoV_1)

Gathering this information was time-consuming for Margaret as she had to draw and document and continue with the conversation. While Nicky and Bob responded with direct and factual information, they also reflected on their past family composition and health history. This resulted in interaction that seemed to meander, alternating between focused questioning like the sequence above and more exploratory sequences.

The following piece of dialogue is an interesting example of a circular question-answer sequence. It occurred during the early stage of the home visit.

66 FHN [ ] That’s really good and do you (.2) you know helping them has
67 that been useful for yourselves (.2) has that helped you kind of
68 focus on?
69 H Definitely definitely because what’s happened with that is
70 instead of like just sort of sitting I mean like when this house is
71 done you know you sort of like you cannæ do anything
72 because of the rain you know I’ve gotta cut the grass but I
73 cannæ cut that until the rain so it’s giving us a chance to go
74 down the road to see them [
75 FHN [ yeah [
76 H [and I mean [ ]
(C3_FHN_HoV_1)

In line 66 to 68 Margaret’s intention of being inclusive incorporated the couples’ friends into the systemic cycle of reflection. Engaging and supporting friends appeared to have a health-
promoting influence on Bob due to the relational involvement in their community. This type of circular question *expanded horizons* for Nicky and Bob to look beyond their sense of entrapment in their situation. Through seeing friends again, who offered their support, the couple may have experienced a new sense of meaning and this also may have been beneficial for their friends. Awareness was thus generated by Margaret in this circular question-answer sequence that drew all participants and the couple’s friends into an *act of solidarity* for the promotion of health in their community.

The prevalence of these features are summarised in Table 8.1. As indicated by the shaded column, the available 14-minute audio recording of the second home visit was analysed. However, because of the largely lost data set, findings were not included in the summary. I applied this decision to all other analytic procedures of the second home visit, to achieve consistency and dependability of the interaction analysis in this case study.

<table>
<thead>
<tr>
<th>Question-Answer Sequences</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed*</th>
<th>Home Visit 3</th>
<th>Home Visit 4 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear Questioning</td>
<td>68</td>
<td>3</td>
<td>23</td>
<td>45</td>
<td>136</td>
</tr>
<tr>
<td>Circular Questioning</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

*excluded from total

**Table 8.1: Question-answer sequences during home visits Case 3**

As the above table shows, the main question-answer sequences comprised linear questioning. They reflected an instrumental and investigative rather than a reflexive-exploratory climate of interaction. Since I was particularly interested in finding out whether circular questions appeared in the data, it was useful to detect them. However, in the post-home visit interview it came to light that Margaret was not familiar with this particular type of questioning. Instead, she spoke of motivational interviewing (Shinitzky & Kub, 2001; Britt et al., 2003; Knight et al., 2006), as a specific strategy which she used to promote change.

**Commendations**

Commending the family was a common feature in Margaret’s communicative behaviour, as the following example illustrates.
The excerpt confirms the couple’s collective effort which Margaret had noticed. Her observation can be corroborated with data from her account of experience and intention of picking up cues. Her remarks are evidence of her assessment practice based on her perceptual skills. Commending as a therapeutic intervention is an interwoven feature of talk. Confirmation of its therapeutic impact was found in the family account as developing family confidence.

**Empathic responses**

Further features of talk which suggested they had therapeutic impact were empathic responses. These responses demonstrated that Margaret could take the role of the family – not as individuals but as a whole, as illustrated in the following thematic sequence of family orientated health issue – carer’s concern for spouse.
Bob voiced his concerns about the treatment Nicky received by their general practitioner in lines 239 to 243, while in line 258 also appreciating the doctor’s difficulty in offering an immediate resolution. Margaret’s response is not just empathic in lines 259, 260 and 264, yet she also paraphrased the situation by offering an interpretive explanation in lines 262 and 263. This is followed by a realistic assessment and an encouragement to persevere in line 265 to 266. This sequence displays skilled communication and can be described as family therapeutic interaction that is embedded in a family health assessment.

The summary of commendations and empathic responses displayed in Table 8.2 confirms the consistent family therapeutic climate of home visits in this case study. These features of conversation were also reflective of the relational stance with which Margaret approached this family. She took account of their interdependence as individuals and the inter-related nature of their health problems.

<table>
<thead>
<tr>
<th>Relational Stance</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed*</th>
<th>Home Visit 3</th>
<th>Home Visit 4 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commendations</td>
<td>16</td>
<td>4</td>
<td>30</td>
<td>24</td>
<td>70</td>
</tr>
<tr>
<td>Empathic Responses</td>
<td>35</td>
<td>9</td>
<td>16</td>
<td>54</td>
<td>105</td>
</tr>
</tbody>
</table>

*excluded from total

Table 8.2: Prevalence of ‘relational stance’ during home visits Case 3

**8.4.3.2 Non-verbal interactions**

Confirmatory evidence of Margaret’s relational stance was found in her non-verbal interactions, which were interpreted as ‘building trust’. Data in all observed home visits showed *keeping eye contact* as her prevalent representation to signal her attention and recognition of Nicky and Bob. The ease with which communications evolved is supported by the prevalence of three following representations such as *laughs, shows openness* and *smiles* (see Table 8.3). Margaret confirmed this observation in the post-home visit, when she described the home visits of this family as particularly easy compared with some other family situations.
Data from accounts and interactions could also be corroborated with observational representations of ‘showing empathy’ as summarised in Table 8.4. Margaret’s striking non-verbal communication was nodding. She displayed this signal of confirmation towards both family members. While representations showed a fair amount of consistency in the first two home visits, a different pattern was displayed in the fourth home visit. This visit involved diagnostic nursing interventions which defined lengthy spells of Margaret’s communicative behaviour.

### Table 8.4: Prevalence of ‘showing empathy’ Case 3

<table>
<thead>
<tr>
<th>Primary System of Representation</th>
<th>Rank Order of Prevalence Home Visit 1</th>
<th>Rank Order of Prevalence Home Visit 2*</th>
<th>Rank Order of Prevalence Home Visit 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nods</td>
<td>33</td>
<td>35</td>
<td>9</td>
</tr>
<tr>
<td>Listens attentively</td>
<td>23</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Shows symmetry in facial expression and tone of voice</td>
<td>20</td>
<td>8</td>
<td>2</td>
</tr>
</tbody>
</table>

*excluded from cross case synthesis

### 8.4.3.3 Conversational sequences

Turn-taking sequences were coded-guided by the following questions:

- How does the FHN make space for the continuation of the conversation with family members?
- Does the utterance concern one family member’s or both family members’ health?

As in the previous case studies, the five thematic conversational sequences fitted all the talk-in-interaction text data. The conversational partners were Margaret, Nicky and Bob. Family orientated health issues were the most common sequences across the home visits, followed by professional concerns, family talk and building relations. Patient health concerns were the least
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A widespread conversational sequence across the three home visits. That said, each home visit shows variation in the most prevalent conversational sequence. While *family orientated health issues* featured strongly in the first home visit, in the third and fourth visit *professional concerns* prevailed. Table 8.5 summarises this information.

<table>
<thead>
<tr>
<th>Conversational Sequences</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed (14minutes)*</th>
<th>Home Visit 3</th>
<th>Home Visit 4 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Orientated Health Issues</td>
<td>65</td>
<td>6</td>
<td>23</td>
<td>19</td>
<td>107</td>
</tr>
<tr>
<td>Professional Concerns</td>
<td>25</td>
<td>4</td>
<td>43</td>
<td>35</td>
<td>103</td>
</tr>
<tr>
<td>Family Talk</td>
<td>33</td>
<td>_</td>
<td>21</td>
<td>23</td>
<td>77</td>
</tr>
<tr>
<td>Building Relations</td>
<td>28</td>
<td>4</td>
<td>10</td>
<td>19</td>
<td>57</td>
</tr>
<tr>
<td>Patient Health Concerns</td>
<td>2</td>
<td>_</td>
<td>8</td>
<td>18</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>153</td>
<td>14</td>
<td>105</td>
<td>114</td>
<td>372</td>
</tr>
</tbody>
</table>

*excluded from total

**Table 8.5: Prevalence of conversational sequences across home visits Case 3**

The main categories of *professional concerns* across the home visits are identified in Table 8.6. Margaret’s concerns were orientated towards health promotion rather than functional care-giving, especially in the third and fourth home visit. This focus was a response to Nicky and Bob’s need to develop their self-care more effectively.

<table>
<thead>
<tr>
<th>Professional Concerns</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 3</th>
<th>Home Visit 4 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing health information</td>
<td>9</td>
<td>26</td>
<td>17</td>
<td>52</td>
</tr>
<tr>
<td>Negotiating a plan of work</td>
<td>4</td>
<td>9</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Offering health care advice</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Summarizing</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

**Table 8.6: Prevalence of professional concerns across home visits Case 3**

I was particularly curious about the extent to which content of *family orientated health issues* might perhaps reflect the C-FAM domains. The coding of categories had been inductively analysed in the previous cases. Categories and sub-categories were thus grounded in the data before any comparison was made with the C-FAM domains, a principle which was also followed in this case. This proved useful as interaction in the first home visit had revolved around drawing the
Genogram, and I saw it as important to differentiate its use with the help of sub-categories. Table 8.7 displays the outcome of this analysis.

<table>
<thead>
<tr>
<th>Family Orientated Health Issues</th>
<th>Home Visit 1 (Observed)</th>
<th>Home Visit 3 (Observed)</th>
<th>Home Visit 4 (Observed)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer’s concern for spouse</td>
<td>12</td>
<td>13</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>Genogram-introduction</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Genogram-patient’s family of origin</td>
<td>11</td>
<td>-</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Genogram-patient’s health history</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Affirming family members</td>
<td>7</td>
<td>9</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Genogram-couple’s family composition</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Genogram-carer’s health history</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Genogram-patient’s children</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Genogram-carer’s family of origin</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Environmental issues</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Genogram-carer’s children</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Genogram-couple’s relational history</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Genogram-couple’s grand children</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Equipment/home care supplies</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Carer’s psychosocial health</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Carer’s physical health</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Family diet</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Extended family’s diet</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 8.7: Prevalence of family orientated health issues across home visits Case 3

The data shows the interrelated nature of family orientated health issues that featured in these home visits. The prevalence of Bob’s concern for Nicky confirms the interdependence of their health concerns of family members. An exploration of health issues also involved the couple’s family of origin and their extended family, which was promoted through the drawing of the Genogram. While concerns about Nicky featured strongly in home visits one and three, Bob’s physical health became the prevalent focus in these thematic sequences in the third home visit. The reciprocal nature of content captured as family orientated health issues during these visits supports the inference that the family as a whole was the principle focus for assessment and intervention. Thus Margaret took a family orientated approach which can be interpreted as family systems nursing. There was a consistent weaving of both family members’ concerns during these interactions, which seemed to have therapeutic meaning. The consistent use of documentation (see below Section 8.5) also confirms the approach taken by Margaret as one of family systems nursing.
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A further corroborating example of the centre-stage position given to ‘family’ combined within a therapeutic assessment practice is illustrated in Figure 8.9. This alternating sequence of conversational themes highlights the importance of family talk to my growing understanding that ‘family’ is not only placed centre-stage, but ‘family’ also takes up this position.

<table>
<thead>
<tr>
<th>Thematically Coded Sequence of Conversational Moves</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional concerns - reviewing progress</strong></td>
</tr>
<tr>
<td>332 FHN Right (.2) so real progress all round then.</td>
</tr>
<tr>
<td>333 H Absolutely all round.</td>
</tr>
<tr>
<td>334 FHN Fantastic (.2)</td>
</tr>
<tr>
<td><strong>Building relations</strong></td>
</tr>
<tr>
<td>335 H As I say I mean like (.2) I mean although we went away as I say</td>
</tr>
<tr>
<td>336 ((neighbour)) has been in a few times and Nicky was on</td>
</tr>
<tr>
<td>337 the phone for her and the big fellow took him for her dinner</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
<tr>
<td>344 W We actually went to a funeral on Thursday I mean ((name))</td>
</tr>
<tr>
<td>345 couldn’t make it cos he took the ferry and I said to</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
<tr>
<td><strong>Family talk</strong></td>
</tr>
<tr>
<td>353 H Who?</td>
</tr>
<tr>
<td>354 W Guess who Bob get hold of her ((name)) ((talking to husband))</td>
</tr>
<tr>
<td>355 H Oh you dancer (.2) you dancer ((laughter))</td>
</tr>
<tr>
<td><strong>Building relations</strong></td>
</tr>
<tr>
<td>356 W And we’re coming out and linking him and we’re coming out of</td>
</tr>
<tr>
<td>357 the graveyard and ((name)) and ((name)) said eh hang on you</td>
</tr>
<tr>
<td>358 two what’s going on [</td>
</tr>
<tr>
<td>359 FHN [ laughing [</td>
</tr>
<tr>
<td>360 W [ I said it was perfectly alright (.2)</td>
</tr>
<tr>
<td>361 FHN That will be the talk now ((laughing))</td>
</tr>
<tr>
<td>362 W Blackmailing me she said ( ) looked after (.2)</td>
</tr>
<tr>
<td><strong>Family talk</strong></td>
</tr>
<tr>
<td>363 H And you’ve got the dentist.</td>
</tr>
<tr>
<td>364 W I’ve got the dentist September [</td>
</tr>
<tr>
<td>365 H [ September the dentist the last dental appointment to come</td>
</tr>
<tr>
<td>366 through and we’ll see what’s going to happen then (.2) do you</td>
</tr>
<tr>
<td>367 think they might wheek them out?</td>
</tr>
<tr>
<td>368 W I want him to I hope he does.</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
<tr>
<td><strong>Family orientated health issue - affirming family members</strong></td>
</tr>
<tr>
<td>373 FHN And that will be that finished as well. Empathic response</td>
</tr>
<tr>
<td>374 W We’re just getting super, super organised all of a sudden.</td>
</tr>
<tr>
<td>375 FHN Aha that’s really good (.2) that’s great. Compliment [ ]</td>
</tr>
</tbody>
</table>

Figure 8.9: Alternating sequence of interaction Case 3

195
Margaret confirmed the progress made by Nicky and Bob in line 332, followed by dialogue of building relations. This social “chat” then alternates with family talk in line 353 reflecting the couple’s shared experience to which Margaret is silent witness, only to be drawn into a further sequence of building relations in line 356. Again dialogue between Nicky and Bob in line 363 shapes the interaction from which Margaret is excluded. She eventually intervenes in line 373. Interestingly she enters the conversation, not with her own agenda of professional concerns, but with a therapeutic intervention directed to both family members which is meaningful for them, given Nicky’s response in line 374. These sequences provide evidence to support the time-consuming nature of these home visits, as family members appear to exercise their influence on the unfolding events. Margaret recognised this family influence, as her account of events confirmed.

8.4.4 Nursing Documents
The nursing documents were received as templates. The ‘live’ documents were examined on site. Copious hand written notes were taken and then transferred to electronic files for further inspection. Analytical procedures were followed as outlined in Chapter 5, Section 5.4.4. A summary of the detailed report that was compiled is given below.

Direction
Margaret used a fully integrated family-derived assessment framework to help her organise her thoughts. Genogram and Ecomap were information tools integrated into the documentation. Margaret emphasised that ownership of their story remained with the family rather than - as is often the case - the health professional. Therefore, both tools could help to redress the power imbalance, as it was the family’s and not the nurse’s perception that was being considered. Margaret found the assessment tools easy to use; both helped to synthesise much information which otherwise would have proved difficult to request and document. It offered a good fit with the model. Combined assessment framework and tools provided a standard for her assessment practice, not in a prescriptive manner, but in response to the family situation. The ‘Family Health Summary’ as the assessment document contained family information of both family members. Completion was incremental with information added as it became known. The Summary was used in parallel with the ‘Family Health Plan’, which integrated the care given and evaluation of
individual and collective health issues. Both were interactively used and complemented each other, and gave much direction. They captured not only family information systematically and meaningfully, but also Margaret’s professional values and intentions. The demands of health care systems, however, also exerted their influence. In response to these, the nursing assessment documentation was supplemented by a 14-page ‘Single Shared Assessment’ document, a ‘Carer Support Plan’, a 10-page ‘Community Nursing Documentation’ and an ‘Individual Health Profile’. This indicated a very thorough process in terms of capturing family health information. Margaret, however, was firmly committed to the ‘Family Health Summary’ and ‘Family Health Plan’ because “it works”.

**Disclosure**

The integration of Nicky and Bob’s family information into the two complementary nursing documents appeared to be problem-free disclosure. The ‘Family Health Summary’, the foundational assessment document from which interventions were planned, contained an Ecomap that had been completed before data collection and showed both spouses’ relational connections within their social environment. The connection lines indicated strong as well as stressful relationships. The nature of social integration and the differences between each spouse could easily be inferred from the drawing. The Genogram, drawn during one of the observed home visits, portrayed the family health patterns across generations of each spouse’s family of origin and their own situation. Margaret had introduced the information tools to the couple, which then turned their disclosure of personal information into a co-constructed and meaningful reality of their family situation. The ‘Family Health Plan’ was a ‘stand alone’ document and remained in the family’s home. Collective and individual problems that affected the couple and their goals were recorded in this one document. Actions were identified from both spouses’ perspective to give a comprehensive portrayal of family needs as a whole and for each individual. The ongoing nature of assessment and the negotiated interventions were captured. The reciprocal interaction of bio-psycho-social and contextual phenomena, the interrelationship between family members, and the environment were evident from what was disclosed in the document.
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**Discretion**

For Margaret the ‘Family Health Summary’ and the ‘Family Health Plan’ were regarded as unproblematic in terms of recording information pertaining to both spouses in each of these documents. It seemed similarly problem-freee for Nicky and Bob as both had made their document available for data collection. In this case *discretion* was involved more subtly with the other documents which also contained family information, albeit with different criteria. These were the ‘Single Shared Assessment’, used for the referred patient, and the ‘Carer Support Plan’, focusing on the carer. The latter document was based on Nolan et al.’s assessment instruments (1998). Both documents provided an additional layer of information and placed the family squarely within the multi-professional gaze. Margaret also used her *discretion* when recording information in the ‘Community Nursing Documentation’ which had been used for assessment purposes before the family health assessment. It met health care system requirements and justified local management structures. A further document, the ‘Individual Health Profile’, had been designed by Margaret and referred to ill-health preventative work or assessment of physical health over a short episode. The need to navigate through a maze of documents raises questions about the equality and trust placed on professional practice; in this case that of family health nursing. Alternatively, confidence in assessment practice can be demonstrated by the use of documentation that is grounded in an experiential, theoretical and empirical body of professional nursing knowledge.

**Discrepancy**

The assessment framework was reflected in the structured documentation that was developed and piloted during the Family Health Nurse Policy Pilot Initiative of the Scottish Executive in 2001 (SEHD, 2003b). The document attempted to capture the reciprocal interaction of bio-psycho-social and contextual phenomena, the interrelationship between family members as the family system and the environment (Hanson & Kaakinen, 2005). The recorded information was brief and succinct. It provided details about the ongoing care needs of both spouses and was aligned with the interaction patterns of *family orientated health issues* and *patient health concerns* identified from home visits. While professional obligations and needs were fulfilled, the documentation lacked evidence of the therapeutic conversation that took place. The extent to which the family as a whole was assessed in its documentary form was considerable; yet it failed to convey the
Chapter 8 Descriptions, Analyses and Findings Case Three

magnitude of conversational sequences relating to family orientated health issues examined during three audio-recorded home visits. The necessary therapeutic dimension in nursing work with this family was not accommodated within any theoretical assessment framework that informed the documentation in this case.

8.5 COMPARISION OF THEORETICAL ASSESSMENT FRAMEWORKS

The integrated family-derived assessment framework was based on Wright and Leahey’s (2000) C-FAM. An aide-memoire was available which listed the C-FAM’s elements. The Genogram provided a generational focus and the Ecomap gave a social network focus. Both functioned as an assessment tool with which to seek the family’s interpretation of their situation. Each element of the assessment framework contributed to the assessment practice in case three by giving purpose to the role of family health nurse and family health care practice.

As in the previous case studies, Wright & Leahey’s (2000) three assessment domains could be identified in the conversational sequences of family orientated health issues and patient health concerns. As is evident from Figure 8.10, there was a consistent focus that showed variations according to need and the progressive understanding of family health issues at each visit.

<table>
<thead>
<tr>
<th>C-FAM Family Assessment Domain</th>
<th>Home Visit 1</th>
<th>Home Visit 2*</th>
<th>Home Visit 3</th>
<th>Home Visit 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structural Domain</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Categories</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcategories</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composition</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rank order subsystems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boundaries</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended family</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Larger systems</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Context</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social class</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion and spirituality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Developmental Domain</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Categories</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcategories</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stages</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 8.10: Comparison of theoretical assessment framework with interaction data Case 3

To find this fit of theory and practice is not surprising, given that the documentation had been based on a family systems nursing model. However, it is interesting to note the fit between the conversational sequences of *family orientated health issues* with this integrated family systems assessment framework.

**SUMMARY**

This third case study supported the relative value of Wright & Leahey’s theoretical assessment framework and the credibility of *family orientated health issues* as a thematically grounded theme in the interaction. While the data of the naturally occurring talk and the documentation offered strong support for using the metaphor of ‘family as system’ as the approach in this case, data from the nurse and family accounts did not fully uphold this perspective. Instead, ‘family’ was perceived as a relational experience. It was described by participants as dependent on a context and meaning that was assigned depending on the situation. Data from participants’ accounts reflected a symbolic interactionist perspective. In light of this disconfirming evidence, I began to question the fit and usefulness of the ‘family as system’ metaphor, and the distinguishing characteristics of a symbolic interactionist and a family systems nursing perspective.
Chapter 8 Descriptions, Analyses and Findings Case Three

The next case study was to provide a further variation in assessment practice, which is the focus of the following chapter.
Chapter 9 Descriptions, Analyses and Findings Case Four

9 DESCRIPTIONS, ANALYSES AND FINDINGS CASE FOUR

INTRODUCTION
This chapter reports on the last case study of this enquiry. Issues relevant to the case are identified followed by a description of how access was gained, the case found and data collected. Findings are presented based on the descriptive-interpretive within-case analysis. A comparison of theoretical perspectives follows.

9.1 ISSUE IDENTIFICATION
A comparative field of practice to the previous cases is that of the district nurse (DN). The DN has a long established role in providing community care especially to the sick adult in a home care environment. Referral to the community nursing service commonly involves an individual and is often an older person with an illness need who may depend on another carer. A case in this field of practice further extended variations in experience, perspectives and features of the research phenomenon. Moreover, I was keen to find out whether the themes and pattern would still fit the data where I expected the integrative family focus emphasis.

Once participants were recruited, family circumstances required modification of the sequence of data collection episodes. To maintain consistency, the modified sequence is not reflected in the reporting. Authentication and feedback from data records and case reports were received from both the DN and the widow. As in previous case studies, different names have been used to protect participants.

9.2 GAINING ACCESS AND SAMPLING
The protracted recruitment in this case study was reported in Chapter 6, Section 6.1. This process took place while data collection for case study three was ongoing. Four health boards were approached before a DN and family were recruited. Susan, the DN, met the selection criteria. A meeting was arranged to explain the study in detail and she gave her informed voluntary consent.
Chapter 9 Descriptions, Analyses and Findings Case Four

Recruitment of the family followed according to procedures and some two months later Susan informed me about the selected family, an elderly couple. Joe had long-term conditions. He also suffered from a terminal illness, diagnosed two months previously, and his wife, Lisa, cared for him at home. The appropriateness of recruiting this family was discussed in detail with Susan. Approval was sought and secured from Joe’s general practitioner. A few days later, Susan introduced me to the couple and then left. During a lengthy informal talk rapport developed. I reassured myself that both spouses felt comfortable about the study and understood its implications. Both expressed an interest in participating. To give the couple plenty of time to make up their mind, however, we agreed that I would call later in the day after both had given their participation further consideration. On my return visit, both had completed the consent form. Recruitment of case four took 76 weeks in total. Within the host organisation, it had taken eight weeks to recruit the DN and 10 weeks for the family. See Chapter 6, Section 6.1 for the time line of recruitment and data collection.

9.3 COLLECTING THE DATA

Compared with the previous case studies, data collection proceeded swiftly, thanks largely to Susan’s frequent home visits. She responded to the fluctuations in Joe’s health state which in turn impacted on the timing of data collection. Figure 9.1 summarises information on data collection.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Method</th>
<th>Occasion</th>
<th>Participants</th>
<th>Referral Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pre-home-visit nurse interview</td>
<td>1</td>
<td>District Nurse</td>
<td>Elderly married couple</td>
</tr>
<tr>
<td>3</td>
<td>Post-home-visit family interview</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audio-recorded nurse-family interactions during home visits</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-home-visit nurse interview</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Examination of nursing assessment document (s) relating to referred patient/family</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional field visit as required</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 9.1: Data collection summary Case 4
9.3.1 Nurse Interview: Pre-Home Visit

Procedures were followed as in the previous cases with consent re-confirmed and permission gained to audio-record the interview. While seeking biographical details I learned that seven years previously Susan had been involved in a research project which had explored the use of an Ecomap, with 20 families in her case load. This family assessment tool had not been integrated into the nursing documentation and literature about the project could not be located. Once recording began it took a little while to establish a conversational tone and to overcome an initial constraint in the flow of the interview. I had to gently probe to elicit episodic accounts of specific experiences. Some responses indicated that Susan felt nervous and I thought it important to reassure her so she could feel more at ease. I found this much easier in this fourth case study as I recognised that my interviewing skills had developed since the first interview. A mutually meaningful conversation eventually unfolded. The interview lasted 75 minutes and time was allowed for informal conversation once the audio recorder was switched off. The home visit was scheduled to take place two days later.

9.3.2 Home Visit 1: Audio Recorded and Observed

Susan and I met at the family’s home. On arrival we were welcomed by Lisa. Joe was sitting in the living room. After permission was gained, audio recording began. Although I was part of what looked like a conversational circle, I had a sense of fading into the background from the beginning while also having a good view of Susan. The home visit was calm and well paced, with little distraction and was relatively easy to record. It lasted 35 minutes. It was one of Joe’s “bad days” - he felt poorly. Figure 9.2 gives a situational sketch and a five-minute sampling sequence of the interaction.
9.3.3 Home Visit 2: Audio Recorded

Only three days had passed since the previous home visit. Before visiting, Susan and I discussed the timing of the family interview as I had raised my concerns about whether this would be
possible if Joe’s condition deteriorated sooner than anticipated. Ethically, it would have been indefensible to proceed with the family interview unless Joe was having one of his “good days”. These were unpredictable. I had to adopt a flexible approach in response to this family situation which was in keeping with the methodology. We agreed that I would explore the possibility of the family interview with Lisa and Joe, depending on how he felt on the day of the visit. Lisa looked more relaxed on our arrival; as did Joe. Audio-recording and observation commenced as usual. Towards the end of the visit, Susan took some blood samples. Once this intervention was completed, Susan signalled me non-verbally as if awaiting my decision regarding the family interview. Since Joe had talked about having one of his “good days”, we agreed to hold the family interview that afternoon.

Following this home visit we discussed the proceedings so far. Susan was keen to plan subsequent field visits as far as this was possible. She was to visit the family again in three days and agreed to audio-record the visit in my absence, under the proviso that this was acceptable to the couple. I explained the audio recording equipment and left it with her until the day of the next nurse interview, which we planned for the following week.

9.3.4 Home Visit 3: Audio Recorded and Observed
Three days had passed since the last home visit and Susan successfully audio-recorded the interaction. She returned the recording and the equipment to me on the day of the post-home visit nurse interview.

9.3.5 Nurse Interview: Post-Home Visit
Due to the change in sequence, this interview was actually the last data collection episode. The interview followed the set procedures. By now, we had got to know each other and there was a flow to the conversation. Case-specific issues were clarified and once the recorder was turned off the conversation continued. The interview had lasted 90 minutes and I still had to review the documentation. We agreed however that I would receive a photocopy later, due to time constraints. Data collection had taken just over two weeks.
9.3.6 Family Interview: Post-Home Visit

The family interview took place in the afternoon of the day following the second home visit, a decision taken in response to Joe’s volatile condition. With data from a third home visit outstanding, I took the opportunity to listen to the audio recording of the morning visit. This allowed me to reflect on case-specific issues and, combined with field notes, I felt prepared for the family interview. On my arrival Joe and Lisa were very welcoming. Lisa directed me where to sit and where to place the equipment and she pulled over a chair. Consent and permission to record was re-negotiated and informal background questions soon encouraged the couple to share some of their life stories and their meaning of ‘family’. Once the interview commenced rapport was well established. Joe and Lisa shared what was meaningful to them individually and as a couple. Sometimes I felt drawn into their account and was touched by both their emotional warmth and their worries. Towards the end of the 45-minute interview both looked tired. Joe was dozing off in his chair. It was time to go without seeking much further feedback about the interview. On leaving, I thanked Lisa and explained again about the case report; “he wants to read about it next year” she said. I left her with a bunch of flowers. She smiled and waved when I drove off. Sadly, when I spoke to her again, Joe was no longer with her. Data collection had resulted in 34,753 words of text of transcribed audio-recordings. Six pages of observation records, six contact summary forms and three nursing documents attached to their respective document summary forms were collected.

9.4 ANALYSING THE DATA

9.4.1 Case Profile Four

Biographical data, field notes, information collected before or after interviews and the family interview contributed to the case profile. It provides a contextual ‘frame’, gives developmental information about the DN, information on family context and development, reasons for referral and my reflections on the home visits. The case profile presented in Figure 9.3 draws on the C-FAM discussed in Chapter 2, Section 2.3 and Chapter 5, Section 5.7.
Chapter 9 Descriptions, Analyses and Findings Case Four

### Case Profile 4

| District Nurse Context | Susan was a registered adult nurse with a specialist practitioner qualification in community nursing. She was in her mid-40s. Since working as a district nurse she thought that "you can’t just treat the person on their own" (DN_CIID_1). As community nursing sister she was in charge of a team of three community nurses in a small, semi-rural town with a stable population of around 6,000 where “lots of patients live alone or have carers”. Her case load comprised 55 to 60 patients. (DN_DSF_1). |
| District Nurse Development | For 17 years she had been working in primary care and for about six years before that in acute care settings. She held a number of academic awards such as a Bachelor of Science in Community Nursing, a Certificate in Diabetic Care and a Diploma in Marie Curie Nursing (DN_CIID_1). As part of her professional development she was a member of the Non-Medical Prescribing Forum. She used the NHS E-Library and on a monthly basis consulted the British Journal of Community Nursing and the Journal of Community Nursing (DN_CIID_2). |
| Family Context | Joe (73) suffered from pancreatic carcinoma, hypertension and diabetes mellitus. He had also experienced a cerebrovascular accident in the past (DN_DSF_1). Following a protracted period of “suffering the pain for 15 months”, “losing weight” and “a bag full of tablets” (DN_CSF_5) the diagnosis had been finally confirmed four months ago. He was of Irish origin. Lisa (72) had always lived in their home town and cared for him. She had a son (49) from a previous relationship. He visited occasionally. Lisa’s mother, who had lived in the same household, had died four years previously and although Joe had some extended family, there were no immediate family members living in the neighbourhood (DN_CIID_F). “Unfortunately” the dog was no longer keeping them company (DN_CSF_1). |
| Family Development | Joe and Lisa were in their final stage of life. Joe described having good days and bad days and noted “being able to talk to people – it’s better than treatment” (DN_CSF_5). Lisa described their situation as “if he is better I can face any challenge” and “if he is knowing that help is round the corner, he is feeling better” and it was the “biggest challenge discovering what was wrong with him (.2) it was a shock to both of us. We are frightened” (DN_CSF_5). Now Joe and Lisa had to face their final transition from years of companionship towards the looming terminal outcome of Joe’s illness. |
| Referral Reason | Susan had known the couple from a previous care episode four years ago when providing care for Lisa’s mother (DN_CSF_5). There was a bond between Susan, Lisa and Joe because of this previous care involvement. His profound circumstances had led to the family being referred to the community nursing service for palliative care by their general practitioner (DN_DSF_1). They also received fortnightly visits from the hospice nurse (C4_Fam_Int). Susan saw the couple frequently depending on Joe’s circumstances and how Lisa was coping. |
| Researcher Reflections | As Joe and Lisa were trying to come to terms with their situation, I could sense their resilience, their affection and their care towards each other. Kindness was shared with those who visited. Although certain in its outcome, the unfolding illness created uncertainty for Susan and the couple. Joe’s condition was unpredictable and gradual deterioration was evident which influenced the frequency and timing of Susan’s visits. “To talk to Susan and to get answers” (DN_CSF_5) was therefore a profound need, not just for Joe, but also for Lisa to which Susan responded. I felt privileged to have been allowed to accompany them for a short spell on their difficult journey. Joe’s kindness, humour and above all, his generosity for taking part in this case study, are valued within it. |

**Figure 9.3: Case profile 4**
The family composition is shown in Figure 9.4. The Genogram was drawn for illustrative reasons and was based on the information gathered. Genogram symbols are explained in Appendix K.

![Figure 9.4: Family composition Case 4](image)

**9.4.2 Nurse – Family Accounts**

The analysis proceeded in several iterative cycles according to the two stages laid out in Chapter 6, Section 6.5.2. *Data record* and *data reports* were compiled, guided by the analytic framework questions as they applied to the nurse and family perspective. Figure 9.8 is a merged case-specific illustration of one category. The excerpt displays the family’s *data record* entry in the left-hand column and its derived understanding taken from the family’s *case report* is in the right-hand column. The excerpt captures the couple’s definition of their situation and its meaning. The data also shows Joe and Lisa’s experience and perceptions of becoming involved addressing this situation together with Susan. The couple’s account confirms the data from talk-in-interaction, where a sense of solidarity appeared to emerge among the participants in identifying concerns at each home visit and to find a solution in order to alleviate problems.
### THE FAMILY PERSPECTIVE

#### Substantive Conditions of Meaning Making and Social Order
3. What is the family’s definition of the situation?

<table>
<thead>
<tr>
<th>Domain: Espoused communicative action</th>
<th>Derived Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category: family perceptions of home visits</strong></td>
<td>Spiritual strength became mobilised and dispersed among the couple and Susan through listening, hearing, questioning, answering and thus understanding the meaning of the situation.</td>
</tr>
<tr>
<td>Lisa: Sometimes you have wee grievances that are no even connected with the illness but I would say little things in our position little things are big things, you know like sometimes I go through there and there’s two cups lying and I think I’ve got a mountain of dishes [ ] what I mean, everything’s hard work and it’s no really but you just feel that sometimes, I feel sometimes when I get up oh it’s just I don’t want to get up really sometimes. [ ] see it is trivial to somebody else Joe: oh, aye Lisa: but in our position it’s hard [ ] I just speak to her about it. [ ] aye and I ken it’s trivial but she doesnae say a thing Joe: aye, she’s a good listener and she’s a good talker when she answers your questions she makes you feel at ease Lisa: she doesnae make you feel as if you’re wasting your time, we’re maybe wasting her time (laughing)) Joe: aye it’s not that it’s just the way that’s the way life is at the moment Lisa: and another thing as well we dinnae get much company and it’s a wee bit company for him and I think you can take advantage of that ((laughing)) Joe: aye, I can have a little laugh too. vi (C4_Fam_Int)</td>
<td></td>
</tr>
</tbody>
</table>

---

**Figure 9.5: Co-constructions of the family perceptions of home visits Case 4**

Figure 9.6 is a summary of all the themes which fitted the interview data and captured the nurse and family perspective. The occurrence of data units representing a particular theme is given in brackets.

<table>
<thead>
<tr>
<th>Case 4</th>
<th>Nurse Perspective</th>
<th>Family Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susan (DN)</td>
<td>Picking up cues (12)</td>
<td>Receiving support and advice (5)</td>
</tr>
<tr>
<td>Joe</td>
<td>Seeking understanding (7)</td>
<td>Advocating on behalf of family members (4)</td>
</tr>
<tr>
<td>Lisa</td>
<td>Promoting dialogue (7)</td>
<td>Developing family confidence (2)</td>
</tr>
<tr>
<td></td>
<td>Verifying cues (6)</td>
<td>Being listened to (2)</td>
</tr>
<tr>
<td></td>
<td>Pursuing strategic action (5)</td>
<td>Negotiating actions (2)</td>
</tr>
<tr>
<td></td>
<td>Looking at all aspects around (4)</td>
<td>Sharing health concerns (1)</td>
</tr>
<tr>
<td></td>
<td>Negotiating a working relationship (3)</td>
<td></td>
</tr>
</tbody>
</table>

---

**Figure 9.6: Case specific themes capturing the nurse and family perspective Case 4**
Chapter 9 Descriptions, Analyses and Findings Case Four

A data excerpt with its derived understanding is shown in Figure 9.7. The coded meaning unit in the left-hand column is an account which captures the interwoven nature of conceptual and perceptual skills used by the DN all of which seemed to contribute to an integrative approach towards a family’s needs.

<table>
<thead>
<tr>
<th>Domain: Role Specific Meanings</th>
<th>Derived Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category: looking at all the aspects around</td>
<td>For looking at all the aspects around Susan uses her senses. She looks at the relationship between family members, their capacity to support the individual with a health care need, their coping mechanisms, and their emotional bonds. She looks for gestures and signs from which to infer family members’ ability to find their own solution to their problems. She tries to discern their attitude to care from a physical, social and mental perspective. She looks at home circumstances, environmental factors and “who else is going to have some kind of influence on the way they manage” and “the difficulties they might have”. She takes a good look at a range of factors, influences, attitudes and relations. With her senses she tries to embrace the multidimensionality of family health. She aims to take a holistic, an integrative look.</td>
</tr>
</tbody>
</table>

(C4_DN_Pre_HoV_Int)

Figure 9.7: Co-constructions of looking at all the aspects around Case 4

A family’s profound sense of sharing health concerns could also be detected in this case study as the example in Figure 9.8 demonstrates. From the family perspective, health needs appeared to be associated with a collective and relational dimension that extended well beyond an individual’s concern.
THE FAMILY PERSPECTIVE

Substantive Conditions of Meaning Making and Social Order

4. What is the family’s definition of the situation?

<table>
<thead>
<tr>
<th>Domain: Conceptualisations and Experiences</th>
<th>Category: sharing health concerns 1</th>
<th>Derived Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe: [ ] again you’re coming back to that information might help somebody else, all this business with what I’m going through at the moment it’s all being documented and someone at some time it might do somebody a lot of good in a few years time I don’t know, if it does well any good [ ].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(C4_Fam_Int)</td>
<td>Joe showed a benevolent response with regard to his terminal illness. He shared his experience and hoped lessons could be learned from his needs. The couple’s participation in the study was an act of solidarity to generate knowledge for the social good.</td>
<td></td>
</tr>
</tbody>
</table>

Figure 9.8: Co-constructions of sharing health concerns Case 4

9.4.3 Nurse – Family Interactions

9.4.3.1 Features of talk

Question-answer sequences

For the analysis, procedures as detailed in Chapter 6, Section 6.5.2.1 were followed. As in the previous case studies, I recognised the differences in features of talk. As the example illustrates, the investigative purpose of linear question-answer sequences was easily located in conversations in this case study.

350 DN What about your urine? Remember you were saying it was awful dark.
351 H It’s still dark.
352 DN Is it still the same?
353 H Aye.
354 DN Are you drinking well?
355 H I drink plenty of water and stuff you know. [ ]
(C4_DN_HoV_2)

By comparison the following excerpt shows a circular question in line 235 which confirms its relational nature as Joe is brought into Susan and Lisa’s shared concern. This sequence occurred when Joe had left the room to go to the toilet. Susan adopted a slow paced interaction which is evident from the long pause before she asked Lisa about her feelings regarding Joe. The circular question is embedded in a thematic conversational sequence of family orientated health issue –
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carer’s psychosocial health. The many empathic responses were also identified during the analysis.

<table>
<thead>
<tr>
<th>Line</th>
<th>DN</th>
<th>W</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>235</td>
<td>Hmm (.6) you’ll be quite worried about him are you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>236</td>
<td>I ken (.4) sometimes I get in my own road though</td>
<td></td>
<td></td>
</tr>
<tr>
<td>237</td>
<td>I dinnae ken what I am doing (.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>238</td>
<td>It’s difficult when you’re just kind of (.2) watching and you feel a bit helpless. <strong>Empathic response</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>240</td>
<td>Aye it’s hard (.4) oh aye (1.) but you just have to (.6) you get the strength</td>
<td></td>
<td></td>
</tr>
<tr>
<td>242</td>
<td>I know aye you get amazed (.4) what you’ve got within you</td>
<td></td>
<td></td>
</tr>
<tr>
<td>243</td>
<td>kind of thing to cope with things (1.) = <strong>Empathic response</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Her exploratory question appeared to be aimed at gaining information on how Lisa was coping with the situation. Although Lisa did not reply at length, her remarks suggest she was pondering nonetheless, because she took her time to respond in line 236. It is as if Susan gave her space to be heard as her response was equally delayed, as the pause in line 237 confirms. Susan listened to Lisa’s experience sensitively and with an almost palpable presence. This caring presence encouraged identification with Lisa’s experience, which was amplified further by Susan’s empathic statements in line 238 and 243. While these moves supported an exploration of Lisa’s psychosocial health, they highlighted the therapeutic dimension that can be intertwined with a family assessment interaction as has been found in the previous cases. Although circular-question answer sequences did not occur often, their impact stood out. As Table 9.1 shows, Susan’s main form of inquiry was based on linear questioning, in order to gain discrete elements of information.

<table>
<thead>
<tr>
<th>Question-Answer Sequences</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed</th>
<th>Home Visit 3 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear Questioning</td>
<td>19</td>
<td>19</td>
<td>38</td>
<td>76</td>
</tr>
<tr>
<td>Circular Questioning</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 9.1: Question-answer sequences during home visits Case 4

**Commendations**

An interesting sequence is given below where Susan offered commendations. Despite the humorous manner in which this dialogue was exchanged, it also appeared to be of profound meaning for all concerned. The commendations in line 337, 339 and 341 provided a strong
Chapter 9 Descriptions, Analyses and Findings Case Four

affirmation of Lisa’s caring concern for Joe. Its therapeutic impact on the couple’s relationship and their coping mechanisms can only be inferred, however.

<table>
<thead>
<tr>
<th>Line</th>
<th>H</th>
<th>( ) when I ( ) eat, “you’ve left a carrot there’s two peas there” ((laughter))</th>
</tr>
</thead>
<tbody>
<tr>
<td>336</td>
<td></td>
<td></td>
</tr>
<tr>
<td>337</td>
<td>DN</td>
<td>She’s not a nag really [ <strong>Commendation</strong> ]</td>
</tr>
<tr>
<td>338</td>
<td>W</td>
<td>[ we’ve had broccoli</td>
</tr>
<tr>
<td>339</td>
<td>DN</td>
<td>She’s just thinking of your better interests ((laughter)) <strong>Commendation</strong></td>
</tr>
<tr>
<td>340</td>
<td>H</td>
<td>Aye this is where it goes up -</td>
</tr>
<tr>
<td>341</td>
<td>DN</td>
<td>She’s caring for you (.2) <strong>Commendation</strong></td>
</tr>
<tr>
<td>342</td>
<td>H</td>
<td>Oh I ken that (.2) don’t I know it I don’t know how she does it if I</td>
</tr>
<tr>
<td>343</td>
<td></td>
<td>was her I would be up the shed.</td>
</tr>
<tr>
<td>344</td>
<td>W</td>
<td>Listen that’s where his bed’s going ((laughter))</td>
</tr>
<tr>
<td>345</td>
<td>H</td>
<td>And two new walls for my outside [ ]</td>
</tr>
<tr>
<td></td>
<td>(C4_DN_HoV_2)</td>
<td></td>
</tr>
</tbody>
</table>

**Empathic responses**

Susan’s interaction was rich in empathic responses, which indicated her ability to imagine Joe and Lisa’s experience as individuals and as a family. As is evident from this feature of talk demonstrated from line 447, 454, 460 and 462, Susan interpreted their experience with compassion, which was appreciated by both spouses in their account. Indeed, Joe and Lisa talked about Susan listening to their concerns:

**Family orientated health issue – carer’s concern for spouse**

<table>
<thead>
<tr>
<th>Line</th>
<th>H</th>
<th>He couldnæ stand the diarrhoea</th>
</tr>
</thead>
<tbody>
<tr>
<td>445</td>
<td></td>
<td></td>
</tr>
<tr>
<td>446</td>
<td>DN</td>
<td>I know that was terrible wasn’t it, what a shame. It takes a lot</td>
</tr>
<tr>
<td>447</td>
<td></td>
<td>out of you too eh? <strong>Empathic response</strong></td>
</tr>
<tr>
<td>448</td>
<td>W</td>
<td></td>
</tr>
</tbody>
</table>

**Family orientated health issue – couple’s reflection/review of progress**

<table>
<thead>
<tr>
<th>Line</th>
<th>H</th>
<th>I think – still the hospital ((laughs)) oh that was a week that,</th>
</tr>
</thead>
<tbody>
<tr>
<td>451</td>
<td></td>
<td></td>
</tr>
<tr>
<td>452</td>
<td></td>
<td>that was a week that was, I think it done me more harm in that</td>
</tr>
<tr>
<td>453</td>
<td></td>
<td>week the endoscopy and things.</td>
</tr>
<tr>
<td>454</td>
<td>DN</td>
<td>You had a time of it right enough. <strong>Empathic response</strong></td>
</tr>
<tr>
<td>455</td>
<td>W</td>
<td>And the thing is you’ve no got, you’d nothing to eat and I mean</td>
</tr>
<tr>
<td>456</td>
<td></td>
<td></td>
</tr>
<tr>
<td>457</td>
<td></td>
<td></td>
</tr>
<tr>
<td>458</td>
<td>H</td>
<td>I couldn’t except drink that rotten stuff they send you, drink</td>
</tr>
<tr>
<td>459</td>
<td></td>
<td></td>
</tr>
<tr>
<td>460</td>
<td>DN</td>
<td>Hmm (.4) however that’s all past <strong>Empathic response</strong></td>
</tr>
<tr>
<td>461</td>
<td>W</td>
<td>We’ve, we’ve got over that hurdle</td>
</tr>
<tr>
<td>462</td>
<td>DN</td>
<td>Yeah that’s right. <strong>Empathic response</strong></td>
</tr>
<tr>
<td>463</td>
<td>H</td>
<td>Aye that’s that one gone (.4) [ ]</td>
</tr>
<tr>
<td></td>
<td>(C4_DN_HoV_2)</td>
<td></td>
</tr>
</tbody>
</table>

Compared with commendations, empathic responses featured much more strongly in Susan’s communicative behaviour. Table 9.2 summarises these features of talk which were interpreted as symbolic of Susan’s relational stance towards the family.
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<table>
<thead>
<tr>
<th>Relational Stance</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed</th>
<th>Home Visit 3 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commendations</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Empathic Responses</td>
<td>36</td>
<td>28</td>
<td>19</td>
<td>83</td>
</tr>
</tbody>
</table>

Table 9.2: Prevalence of ‘relational stance’ during home visits Case 4

9.4.3.2 Non-verbal interactions

Susan’s communicative behaviours reflected the representational function of her interaction. Her non-verbal communication appeared to support the rapport between participants. The data showed congruence between Susan’s verbal and non-verbal behaviours. Her main non-verbal communication feature was *keeping eye contact*. She also *smiled* and *laughed* and *showed openness* towards the couple. She *respected interpersonal space* by sitting at a distance from each family member, yet remained able to maintain good eye contact. These communicative behaviours may have contributed to “building trust” in the nurse-family relationship.

<table>
<thead>
<tr>
<th>Primary System of Representation</th>
<th>Rank Order of Prevalence Home Visit 1</th>
<th>Rank Order of Prevalence Home Visit 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeps eye contact</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Smiles</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Laughs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Shows openness</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Respecting interpersonal space</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 9.3: Prevalence of ‘building trust’ Case 4

*Nodding* featured as Susan’s main representation of “showing empathy”. There were occasions of a striking *symmetry in facial expression and tone of voice* between her, Joe and Lisa. A further non-verbal communication feature was that she *listened attentively, showed a depth of interest* in Joe and Lisa’s concerns and she *gave time* for both to communicate these. An additional behavioural feature which did not fit into the coding structure was her forward and backward body movements when she turned to either Joe or Lisa. These non-verbal cues emphasised her attentiveness towards the couple’s concerns and represented empathic understanding which was described by Joe in the family interview as “*showing a real interest*”.

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<table>
<thead>
<tr>
<th>Primary System of Representation</th>
<th>Rank Order of Prevalence Home Visit 1</th>
<th>Rank Order of Prevalence Home Visit 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nods</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Shows symmetry in facial expression and tone of voice</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Listens attentively</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Shows depth of interest</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Gives time</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 9.4: Prevalence of ‘showing empathy’ Case 4

9.4.3.3 Conversational sequences

Turn-taking sequences were coded-guided by the following questions:

- How does the DN make space for the continuation of the conversation with family members?
- Does the utterance concern the husband’s health or other family members’ health?

The five themes extrapolated in the previous case studies also fitted all the talk-in-interaction text data. Family orientated health issues were the most common sequences across the home visits, followed by patient health concerns, family talk, professional concerns and building relations. Although differing in magnitude, this patterned sequence recurred, except in the third home visit. Table 9.5 summarises this information.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed</th>
<th>Home Visit 3 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Orientated Health Issue</td>
<td>24</td>
<td>23</td>
<td>23</td>
<td>70</td>
</tr>
<tr>
<td>Patient Health Concern</td>
<td>27</td>
<td>19</td>
<td>21</td>
<td>67</td>
</tr>
<tr>
<td>Family Talk</td>
<td>12</td>
<td>13</td>
<td>23</td>
<td>48</td>
</tr>
<tr>
<td>Professional Concern</td>
<td>6</td>
<td>13</td>
<td>17</td>
<td>36</td>
</tr>
<tr>
<td>Building Relations</td>
<td>3</td>
<td>8</td>
<td>8</td>
<td>19</td>
</tr>
</tbody>
</table>

Table 9.5: Prevalence of conversational sequences across home visits Case 4

The main categories of professional concerns across the home visits are identified in Table 9.6. The sub-category nurse intervention was largely a response to Joe’s needs which in turn required frequent reviewing progress. The couple’s needs for health information were also met by Susan.
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### Table 9.6: Prevalence of professional concerns across home visits Case 4

<table>
<thead>
<tr>
<th>Professional Concerns</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed</th>
<th>Home Visit 3 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse intervention</td>
<td>-</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Reviewing progress</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Providing health information</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Summarising</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

The content of *family orientated health issues* are detailed in Table 9.7. This information confirms the strong influence which role demands had on Lisa. Interestingly, in these conversational sequences the couple’s collective psychosocial health needs also featured as did financial concerns that affected both. Given the consideration of the interrelated and interdependent family issues, the interaction and approach taken by Susan was family orientated. It fitted a ‘family nursing’ approach. Susan displayed concern about the interaction and reciprocal nature of family dynamics between both family members and the impact of Joe’s condition on their individual and collective health. The data however fitted a relational and interactional perspective rather than a systems perspective.

### Table 9.7: Prevalence of *family orientated health issues* across home visits Case 4

<table>
<thead>
<tr>
<th>Family Orientated Health Issues</th>
<th>Home Visit 1 Observed</th>
<th>Home Visit 2 Observed</th>
<th>Home Visit 3 Observed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer’s concern for spouse</td>
<td>22</td>
<td>17</td>
<td>15</td>
<td>54</td>
</tr>
<tr>
<td>Couple’s psychosocial health</td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Financial concerns</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Carer’s physical health</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Patient’s concern for spouse</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Carer’s psychosocial health</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

Despite *family orientated health issues* featuring strongly, *patient health concerns* were also a main focus of interaction because of Joe’s ill health. These two conversational themes showed an interesting patterned regularity. By now I was able to recognise these patterns more easily and I began to make comparisons across the data sets of the previous case studies. These evolving insights and their analytic implications are discussed in Chapter 10.
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An excerpt of case-specific alternating sequences is given in Figure 9.9 where family orientated health issues focused on Lisa’s concerns for Joe in line 38. Susan offered a tentative confirmation and then probed further. The conversation then turned to Joe’s deteriorating physical health. He described how he felt, which Susan then interpreted in line 47. However, Joe challenged her interpretation and raised further concerns to which Susan signalled listening in line 58. Joe tried to explain his worries further and Susan continued to listen. Lisa then explained the underlying anxiety about Joe’s deterioration in line 66. Since an operation seemed to be their real concern at this time, the conversational moves returned to Joe’s physical health in lines 71 to 76. While Susan continued listening, in line 75 she attempted to alleviate the couple’s anxiety. The conversation then shifted once more to the next sequence of family orientated health issues, again initiated by Lisa in line 80.

<table>
<thead>
<tr>
<th>Thematics Coded Sequence of Conversational Moves</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family orientated health issues – carer’s concern for spouse</strong></td>
</tr>
<tr>
<td>38  W  See in a certain light when you look at him I thought he was a</td>
</tr>
<tr>
<td>39  W  wee bit yellow.</td>
</tr>
<tr>
<td>40  DN  I do notice a wee difference today – I don’t know whether</td>
</tr>
<tr>
<td>41  DN  cause it’s em brighter today so I maybe notice it more (.2) do you</td>
</tr>
<tr>
<td>42  W  feel more unwell or -</td>
</tr>
<tr>
<td><strong>Patient health concerns: physical - deterioration</strong></td>
</tr>
<tr>
<td>46  H  Just feel useless and tired</td>
</tr>
<tr>
<td>47  DN  No energy</td>
</tr>
<tr>
<td>48  H  No (.4) it’s just that (.4) em they said that might happen [</td>
</tr>
<tr>
<td>58  DN  [right (.4)</td>
</tr>
<tr>
<td>59  H  Cause this one apparently can get blocked [</td>
</tr>
<tr>
<td>60  DN  [hmm</td>
</tr>
<tr>
<td><strong>Family orientated health issues – carer’s concern for spouse</strong></td>
</tr>
<tr>
<td>64  W  And that’s a temporary one anyway.</td>
</tr>
<tr>
<td>65  DN  Ah right, right.</td>
</tr>
<tr>
<td>66  W  They put the temporary one in thinking if he needed an operation [</td>
</tr>
<tr>
<td><strong>Patient health concerns: physical - deterioration</strong></td>
</tr>
<tr>
<td>71  H  [ so I’ll have to get - it looks very much like I’d have to get</td>
</tr>
<tr>
<td>72  H  ((doctor)) again and another blood test [</td>
</tr>
<tr>
<td>73  DN  [ hmm (.6)</td>
</tr>
<tr>
<td>74  H  = and see if it is - try and get something done about it -</td>
</tr>
<tr>
<td>75  DN  well remember we did the blood tests before - so maybe he’s</td>
</tr>
<tr>
<td>76  DN  got the results of them.</td>
</tr>
<tr>
<td><strong>Family orientated health issues – carer’s concern for spouse</strong></td>
</tr>
<tr>
<td>80  W  The doctor phoned up.</td>
</tr>
<tr>
<td>81  H  The blood tests come back - said it was a bit anaemic [</td>
</tr>
<tr>
<td>82  W  [ when (.4) eh he phoned up and said he is a bit anaemic (.2)</td>
</tr>
<tr>
<td>83  DN  Right [</td>
</tr>
<tr>
<td>84  W  [ and he has, has had an infection [</td>
</tr>
<tr>
<td>85  DN  [right [</td>
</tr>
</tbody>
</table>
While Joe and Lisa experienced being listened to, Susan appeared to continue with seeking understanding of the situation. Conversational moves then culminated in her sentence in line 88 where she offered a further resolution. Her question, however, allowed the couple, in this case Lisa, to take the lead in the decision-making process. Susan refrained from a directive professional expert response. Therefore, the family remained ‘centre-stage’ in their collective concerns. Susan, Joe and Lisa collaborated to arrive at a solution to the problem. The excerpt suggests that a listening, non-expert approach may be of therapeutic benefit as family members were respected in their experience of anxiety and in its alleviation.

### 9.4.4 Nursing Documents

The nursing documents had been received as templates at the start of data collection. The ‘live’ assessment documents were received as photocopies during the last field visit. A document summary form was completed for each of these. Analytical procedures were followed as outlined in Chapter 5, Section 5.4.4. A detailed report was compiled; a summary of which is given below.

**Direction**

Susan had taken direction from the Activities of Living (Roper et al., 2000) and Orem’s self care model (Orem, 2001), both of which she had developed into an assessment framework to guide her practice. The combination of a ranking across Roper et al.’s ‘dependence/independence continuum’ and Orem’s ‘component of self care capacity’ made it possible for Susan to accommodate “whoever is in the household”. This was displayed in the ‘District Nursing Assessment Tool’ which gave direction, with some minimal entries made at the start of a referral. The ‘Continuation Sheet’ integrated any further documentary requirements and was designed for individualised assessment and care-giving. Susan navigated through various structural demands pragmatically, as was evident from entries in the ‘Continuation Sheet’. Family information was
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integrated from Joe and Lisa, including responses to their assessed needs, thereby accommodating what mattered to Susan professionally. Nonetheless, the ‘Continuation Sheet’ functioned as a repository. On the face of it, the documentation met the system’s requirements as it was used health board-wide. Transition to an electronic documentation had started, however, and a ‘Single Shared Assessment’ document was completed whenever social care requirements were identified by Susan.

Disclosure

The documentation was not shared with Joe or Lisa. This limited their direct involvement in the decision-making processes relating to the documentation of their health care needs. However, this was not an issue for either of them. Joe put it bluntly: “who cares what people put on a piece of paper - I don’t” (C4_Fam_Int). While disclosure was not problematic from the family perspective, as an administrative tool the ‘District Nursing Assessment Tool’ and the ‘Continuation Sheet’ were the legal record of Susan’s assessment and nursing care. As in the other cases, the documents functioned as a communication tool so other community nurses could continue with all aspects of care in Susan’s absence. In this context, disclosed family information assumed an influential meaning due to the exposure to the professional gaze. It was therefore relevant whether or not interrelated psychosocial health concerns were documented following the home visit. As Susan confirmed, however, not everything was documented. For example, the dynamic interrelationship of health concerns on the couple and their expressive behaviour in terms of affectional ties were minimal. The regular home visits created a pattern of continuity, and not only in the documentation. They also contributed to the co-constructed meanings and mutual knowledge that accumulated between Susan, Joe and Lisa, which created dynamic patterns of family orientated health issues, patient health concerns, family talk, professional concerns and building relations. This required a degree of discretion regarding certain aspects of disclosure.

Discretion

Susan used her discretion around the sharing of family information, knowledge and the evolving relationship which was not documented. She was aware of the nature and significance of the assessment document in terms of its institutional display. This included Joe and Lisa’s situation
which carried an element of social isolation with all its subsequent implications. Informed by her experience of working with families, Susan had learned to distinguish between their private and public spheres and would simultaneously navigate through the structural demands of the documentation. Some family information was only communicated verbally to community nurses who also visited Joe and Lisa. While Susan exercised discretion in sharing her family knowledge, the documented family information inevitably showed some discrepancy.

Discrepancy
The combined components from two nursing models provided a structure for the assessment process and the documentation. However, the feedback loop between identified health needs, decisions taken and nursing care given was difficult to discern from entries recorded. The initially completed ‘District Nursing Assessment Tool’ did not appear to be linked with the ongoing assessment process documented in the ‘Continuation Sheet’. Concepts of Orem’s conceptual framework were integrated into the assessment tool in terms of the person’s health status, requirements for self-care and capacity to perform self-care. Limited systematic reference was made to the assessed individual’s knowledge, skills, motivation and orientation towards their self-care. The tool did not incorporate the requirement to identify and individually assess a family member or carer’s situation, nor their capacity to provide the implied self-care. Despite this deficit, information relating to the health needs and concerns of both spouses was evident. While some direct pointers to the family experience could be traced, the couple’s burden of having continually to face the impending terminal outcome of the husband’s illness remained largely undiscovered as documented reality. The extent to which the family as a whole was assessed in its documentary form was minimal despite the range of family orientated health issues that interaction during home visits displayed.

9.5 COMPARISION OF THEORETICAL ASSESSMENT FRAMEWORKS
Components of two nursing models were integrated into the assessment framework used by the DN. The first was Orem’s conceptual framework. It is constructed out of three interrelated theories drawing from systems and behavioural theories: the theory of self-care, self-care deficit, nursing systems and basic conditioning factors. The framework focuses on underlining the
Chapter 9 Descriptions, Analyses and Findings Case Four

requirement for the nurse to have expert agency and to take a medical problem-based approach. Assessment is orientated towards an individual’s self-care needs and the patient’s capability to perform self-care activities (Coldwell Foster & Bennett, 2002). In her later work Orem (2001) uses the concept of ‘multi-person unit’. Friedmann (1989: 212) conceptualised this rather objectifying term “as subsystems of the total family system”. Orem’s framework emphasises a dependency on the nursing system while promoting a functional and somewhat rigid systems perspective. The lack of focus on the interdependent and interrelated dimensions of relationships and their emotional nature can be regarded as a limitation of Orem’s framework for nursing work with families. The assumption is that continuous self-care is compromised and nursing care requires to be given. The concept of self-care requisites is associated with activities of living and assessment is linked with nursing diagnosis based on self-care deficits.

The other component informing the assessment tool was Roper, Logan and Tierney’s activities of living (Roper et al., 2000). However, a systematic integration was limited with some important activities omitted. These omissions showed up when information recorded in the ‘Continuation Sheet’ was inspected. Since this particular assessment framework is concerned with the individual, health concerns which are assessed as they related to both family members were not accommodated in the tool. Moreover, a lifespan dimension was difficult to identify from the documentation, and potential or actual problems were not differentiated. There is an assumption in the Roper et al. model that nurses regard patients or clients as autonomous, decision-makers who support partnership working (Holland, 2003). This assumption could only be made based on some of the language used to record information following the home visits. The documentation was not shared with the patient or his carer, which limited their direct involvement in the decision-making processes relating to the documentation of their health care needs. However, the parallel use of the Single Shared Assessment acknowledged the multi-agency context in which the DN operated; a context also assumed to apply in the Roper et al. model (Holland, 2003).

Wright & Leahy’s (2000) three assessment domains could be extrapolated in the conversational sequences of family orientated health issues as illustrated in Figure 9.10. As in the previous case studies, these included Actitivies of Living relating to patient health concerns.
Relevant issues varied according to need and the progressive understanding of family health issues at each visit. While developmental and functional factors were considered during home visits, the obvious and defining structural information on the composition of the family did not feature in the interaction or in the assessment tool. Only in the ‘Single Shared Assessment’ document was a reference made to the patient’s next of kin. As in the previous case studies, the data from talk-in-interaction supported the utility of Wright & Leahey’s family systems assessment framework. Congruence with the documentation was missing, however. Moreover, from an experiential perspective, the accounts of the community nurse and the family were more meaningful from a
symbolic interactional point of view. ‘Family’ and ‘family health assessment’ were revealed by the data to be a relational affair. Both concepts reflected and fitted Hartrick Doanne and Varcoe’s conceptualisation of family nursing as “relational inquiry” (2005).

As in the previous case studies, data records and data reports were sent to participants for their feedback on findings. Susan confirmed the co-constructed descriptions and interpretations and returned the prepared forms with comments which were treated as additional data. Lisa confirmed some sections of the family case report (see Appendix L for participants’ feedback). The received authentication of findings from the community nurse in Case 3 and Case 4 further provided an additional rationale to go ahead with a systematic search for similarities and differences across the four cases.

SUMMARY
This case study contributed significantly to the confirmation of regularities in the data. These initial patterns became even more meaningful when first comparisons were tested with findings from the previous cases. By now I had gained an in-depth and case-specific understanding of community nurse-family interaction in family health assessment. This understanding related to varying fields of practice and assessment contexts. Given the range of experiences, perceptions, interactions, observations and nursing documents, and the recurring regularity in themes and patterns across four case studies, selection of cases had been achieved to the point of redundancy. No new themes or patterns were forthcoming with this fourth case. Therefore, I took the decision not to sample further cases.

Findings in this case showed that although linear question-answer sequences were the prevalent features of talk to gain health information, circular question-answer sequences supported the reflexive and therapeutic nature of interaction. This therapeutic climate was further supported by the prevalence of empathic responses. Commendations, however, were not a common mode of communicative behaviour displayed by the DN. Non-verbal interactions appeared to confirm both the features of talk and the nurse’s account of intentions. This was notable in the wish to take
account of family members individually and collectively. The metaphor ‘family as system’ was not supported by the data grounded in the community nurse and family experiences. While interaction data implied a ‘family as unit’ perspective, the differentiated and contextual issues that related to both spouses featured strongly. The approach taken by the DN resembled a person-centred focus in which she attended to each family member as an interrelated social group rather than ‘a unit’. The community nurse and family’s perceptions fitted a symbolic interactionist interpretation of ‘family’ and ‘family assessment’. While the concerns of both family members were documented, the adapted assessment framework used by the DN was not family-derived. However, family orientated health issues explored in conversation did reflect the domains in Wright and Leahey’s C-FAM. Much therapeutic work was interwoven throughout the assessment practice in this case, but was not evident from the documentation.

Although the analysis had shown the profound uniqueness of each single case, comparison across cases remained the analytic goal. Therefore, the recurring patterns in the data offered justification for systematically commencing on the defining stage of this multi-case study.

The next chapter provides evidence of how I approached this challenge.
10 THE CROSS-CASE ANALYSIS AND SYNTHESIS OF FINDINGS

“there is no single reality we can capture ”
(Stake, 2006: 87)

INTRODUCTION

Cross-case analysis synthesises the findings from the four cases of this multi-case study. Synthesis is justified using a constructionist approach, where pooled case findings can generate a deeper understanding of underlying patterns and phenomena. There is limited literature that describes how to achieve this, and much of what is written is presented at a high level of abstraction rather than offering procedural detail. Stake’s (2005; 2006) writings have been the main influence in shaping my approach towards cross-case analysis. An identification of issues sets the scene for this final procedural stage, followed by brief narratives of each case. From these case-specific, descriptive findings, a progressive development of the central research phenomenon is achieved through analytic shifts in focus and an integrative inferential scheme in support of explanatory knowledge unfolds. The synthesis of findings is then presented.

10.1 ISSUE IDENTIFICATION

Stake (2006: vi) uses the analogy of “quintain” to represent the whole - “the entity having cases or examples”; the binding concept that is studied in a number of cases. “Quintain” is a European medieval term for a post or target used by mounted knights for tilting exercises (English Collins Dictionary, 2000). According to Stake, the binding concept becomes the target. Stake claims that “[m]ulticase studies are sometimes created at least partly to promote the quintain or to advocate the spread of its policies and practices” (2006: 84). A similar intention brought me to this enquiry. Therefore, this multi-case study is not value-free. It reflects my professional interest in understanding the ‘quintain’ of ‘community nurse-family interaction in family health assessment’.

The reviewed literature was a further incentive, which shaped the aims of this comparative multi-case study, namely to gain an in-depth understanding of family health assessment, the perceptions, experiences and interactions of community nurses and families, and the usefulness of a family-derived theoretical assessment framework. Achieving these aims required explicit assumptions to be made around philosophical, theoretical and methodological choices, and measures had to put in place to limit bias and facilitate scrutiny of the research process. These are
Chapter 10 The Cross-Case Analysis and Synthesis of Findings

key criteria to justify the study’s credibility and utility in order to make a useful contribution to knowledge.

The cross-case analysis and synthesis were approached from a theoretically informed position grounded in symbolic interactionism and family systems theory. As Stake notes, “the methods of instrumental case study draw the researcher toward illustrating how concerns of researchers and theorists are manifest in the case” (Stake, 2005: 450). This helped to make sense of the ‘quintain’ within this study. Stake’s notion of the case as a bounded system aligned well with the systems theory perspective, where constituent parts form independent relationships and also form a whole. The situated, interactive and emergent nature of phenomena which the data revealed also fitted a symbolic interactions perspective. The data from the four cases were examined from multiple perspectives, interaction situations and contexts. The following narratives give a descriptive account of how interaction in family health assessment in different fields of practice was perceived and experienced by the community nurse and the family.

10.2 AS THE CASE MAY BE: FOUR NARRATIVES

These narratives aim to provide the reader with a vicarious experience of the uniqueness of each case, without which a composite picture of the ‘case quintain’ could not have been built. These versions of reality emphasise the differences between the four cases while recognising some of their subtle similarities. Each narrative is a synopsis of the case report. The reader is invited to enter into the interactional chain and continue its construction to discern the transferability of meaning and the relevance of assertions.

10.2.1 Narrative One

Janine, a health visitor, defined her practice as holistic because she tried to take into account all aspects that impacted on the family. ‘Family’ was meaningful to her irrespective of whether or not all members were present during her home visits. She was aware of a family’s multi-generational dimension and preferred to build her own conceptual map for a family health assessment. Janine considered maintaining role clarity within a multi-professional context as posing potentially problems due to the possible blurring of role boundaries. She was concerned that families might find it difficult to comprehend changing professional roles and remits.
Chapter 10 The Cross-Case Analysis and Synthesis of Findings

Janine thought *promoting dialogue* was a useful way to get to know the family. She was keen for parents to “get this conversation going, their dialogue going between the two of them”. It meant asking question to promote talking, exploring and reflecting to “build up a picture”. She used her senses such as looking, seeing and listening for the purpose of seeking understanding. She then built up a picture to enable her to see the connections between family members, their dynamics and their health issues. As **seeking understanding** was difficult, it needed to be managed by **pursuing strategic action**. Clear boundaries required to be set in order to deal with certain situations. Cues needed to be given to parents that the visit was coming to an end. **Pursuing strategic action** thus became a means of protecting herself and the family. Visits, after all, were resource intensive and needed to be time managed. To **build up a picture** involved much more than simply asking questions. It also meant **picking up cues** from behavioural and environmental signs. At times there was nothing specific – perhaps just a hunch. To better take in the different family aspects Janine would be **looking at all the aspects around** during her visits. “Like a spider web”, a patterned construction, looking around enabled her to see the interconnections within family dimensions and to pick up on health issues.

Following the home visits, Janine had become more aware of her role and her assessment practice. Participation in the study had posed more questions for her about the limiting documentation she used. She now recognised tensions between theoretical, experiential and educational demands in her assessment practice. Mary, the mother, had experienced role strain due to maternal parenting demands and lack of perceived paternal support. Although she saw Janine as a friend, Mary approached her with a sense of neediness and expectation, but Janine’s continuity in home visits helped create a stable environment which promoted confidence and competence. She appreciated Janine’s acceptance and non-judgemental approach, which helped to build trust between them. Mary had experienced growth in self care; she had learned to accept her parental responsibility. She experienced unconditional regard of herself and her family which she valued most.

10.2.2 Narrative Two

As a community children’s nurse, Betty saw her role as a risk assessor, a protector of a child’s safety and a provider of nursing requirements. For her, family life was maintained within a boundary of intimacy and privacy defined by “who is inside the picket fence”. To meet family
Chapter 10 The Cross-Case Analysis and Synthesis of Findings

needs, Betty sought a shared approach with professionals in health and social care as well as an understanding of each others’ roles. She was sceptical about the amount of duplication that her assessment practice involved.

For Betty it was important “to get a full picture of that particular family situation as possible” but without “prying” or “being too familiar”. She focused not just on the child, but on the whole family situation. She needed to be confident about the family’s competence to provide the demanding level of care to their fragile child. To achieve this reassurance required a degree of intrusion into family life that also needed protection. She was aware of the difficulties in using a Genogram as a tool for gathering family information and saw that it required a careful approach. The visual representation of parental relationships outside the household, with its potential impact on kinship patterns and the symbolic meaning of slashed connector lines, can highlight painful life events such as bereavement or a family member’s unexpected conduct.

Betty was seeking understanding which meant getting to know the family and collecting information. “Gleaning this picture” was difficult and took time. It required understanding family relations: how they did things together, how they coped, how they cared for each other at times of adversity and living with constant additional care demands. For Betty, inclusiveness did not extend to virtual family members. She regarded a problem focus as relevant for inclusion in family health assessment. Betty had “a list of priorities” which had to be covered, and a busy home visiting schedule. While having a specific goal for each visit, she “could be swayed in other directions”. She had her professional concerns in mind, yet the family situation could easily see her overrun her allocated time frame. She had to respond strategically, yet humanise the process of functional assessment and care provision. Since the family also had their own agenda, pursuing strategic action generated at times a dilemma for Betty which required negotiating a working relationship. She was open to the negotiation of changes as the situation arose. As long as the child’s safety was ensured, she allowed the needs of the family some flexibility. She found it easy and also necessary to adjust to family circumstances as this avoided compromising trust and information sharing.
Chapter 10 The Cross-Case Analysis and Synthesis of Findings

Following the home visits, Betty spoke about how worthwhile it had been to have met all family members at more regular intervals, especially the siblings. Participation in the study had raised her awareness of her role and assessment practice. She reflected that siblings might get a sense of purpose from her visits, in that she was coming to see the family and not just their youngest brother. To get a sense of the whole family would require meeting all the members at regular intervals. For Lena and Jim, the continuity of her home visits built their confidence and competence. Their experience of unconditional regard and professional competence helped build their trust in Betty. Lena and Jim spoke of feelings of reassurance, stability and a sense of security that helped to underline the importance of these home visits.

10.2.3 Narrative Three

Margaret, a family health nurse, practiced looking at “the bigger, the whole kind of picture” and its impact on people and families. Her aim was for the family to have a different health experience and to regain their autonomy and independence in self-care. Margaret worked closely with other colleagues from other disciplines, facilitated by joint assessments, joint home visits or other consultative negotiations. Good relationships were in place with each discipline focusing on its professional perspective.

Margaret preferred to include all family members in communication. She aimed for everyone to be involved so that a full picture could be gained - although inclusiveness did not mean virtual family members. She adopted a problem focus in her family health assessment practice. For Margaret picking up cues meant she “might pick up little bits and pieces along the way”. Finding these took effort and patience. Margaret talked about interpreting cues and using her senses of observing and listening which complemented asking questions for promoting dialogue, assisted by assessment tools such as the Genogram and Ecomap. Talking, exploring and reflecting or “chatting” required time. She regarded this tactic as an “intervention”. For Margaret, seeking understanding meant being open to the family’s side of the story. Verifying cues would be a way of getting to the heart of an issue though it required a closer examination of the situation as she did not just want “one slice of family life”. This required an effort to not only listen but to achieve a real understanding, not only of surface-level facts: looking at all the aspects around to consider all possible factors comprehensively. It would include those perceived by the family and any barriers which might get in the way of their achieving their health goals. This required focusing
Chapter 10 The Cross-Case Analysis and Synthesis of Findings

initially on priorities by pursuing strategic action. Margaret tried to gain an incremental depth in assessing family needs and concerns. It was “a tricky process” which could not be rushed. It required negotiating a working relationship. Margaret would negotiate her home visits and the degree to which family members might be involved in a particular visit. Her preferred option was to meet all family members at a visit so that everyone could have their say.

Following the home visits, Margaret emphasised the shared effort that had been required in the rebuilding of trust and the regaining of confidence in Nicky and Bob’s self-care. Participation in the study had confirmed her role, her values and her assessment practice. From Nicky and Bob’s perspective, Margaret was appreciated for her wealth of knowledge which had benefited them personally and as a couple. Much affirmation and confirmation was received which gave Nicky and Bob a new orientation. Despite the longstanding health challenges, Nicky and Bob talked about their determination to remain self-reliant. Nicky expressed her solidarity for those who might be affected by stroke and how sharing her experience might be of help to others.

10.2.4 Narrative Four

Susan, a district nurse, looked beyond the individual and included all family members in her assessment practice, based on the principle “whoever is there” and involved everyone “if they want to be”. For Susan ‘family’ encompassed those who cared most for each other, such as the immediate family and those who lived in the same household, as well as those who were not necessarily related by blood ties. She recognised their actual and ‘virtual’ presence. Based on her experience, the Single Shared Assessment was an effective means of avoiding duplication in assessing the care needs of both the individual and the family. Liaison between health and social care made it possible to look at every aspect of this family’s life, with each service focusing on its specific provision.

Susan used all her senses - seeing, hearing, feeling, grasping and thinking - as a means of picking up cues during her home visits. She regarded listening as the most important skill, one that required her undivided attention. For Susan seeking understanding represented being attuned to the meanings and experiences of family members. Although Susan preferred to listen, she initiated conversations. Promoting dialogue helped open up conversation. First, “an ordinary
Chapter 10 The Cross-Case Analysis and Synthesis of Findings

"chat" helped to create a supportive atmosphere. This was to encourage family members to share their concerns and experiences. Such dialogue gave Susan an opportunity to revise her understanding. She tried not to assume things; she did not want to judge. She wanted to find support for the cues she picked up on. This meant verifying cues as she wanted to establish some facts. Before taking any action she wanted to hear from family members to find out whether her interpretation matched the family story. For Susan pursuing strategic action meant that she had some kind of plan in place before she found out what needed to be done based on some common professional reference. However, she bracketed these intentions during her conversations with family members. She tried to gain as much information as possible “before” she assessed. Assessment meant for her reaching a distinct point where everything came to a head “before” she took action. Her action was thus based on looking at all the aspects around. She would take a good look at a range of family factors, influences, attitudes, relations and home circumstances the better to recognise family health needs. Before taking any action, Susan would seek agreement from all family members. When this was not possible she tried to “come to some kind of compromise”. So negotiating a working relationship depended on further discussion. Sometimes there were different options available and together they would look for “the best solution”.

Following the home visits, Susan had an increased awareness of her role and assessment practice. Participation in the study gave her the incentive to promote family health care more purposefully with her team. She now appreciated more fully the extent of her family-orientated practice. At the same time she felt frustrated at not being able to provide evidence of the extent to which she provided family health care, due to the limitations of the documentation. For Joe and Lisa, the continuity of Susan’s home visits fostered a sense of alliance, while their experience of affirmation and confirmation was a source of support through difficult times. Each day presented different problems. Finding at least some answers with Susan’s help was clearly appreciated. For Joe and Lisa, the home visits were important for receiving reassurance and support - an experience of a caring concern.

While these narratives confirm that at this stage the four cases were still in the foreground of my conceptual attention, this focus would gradually shift. How this shift came about is now explained.
10.3 THE CASES AS FOREGROUND

As each of the case studies progressed, my analytic reflections deepened along with my growing understanding about the relevance of the selected theoretical orientations. During these developments, I devised the diagram shown in Figure 10.1. This helped me to conceptualise and unify the variety of components, processes and early analytic insights associated with the research phenomenon.

![Diagram](image.png)

**Figure 10.1: Initial conceptualisation of ‘circularity’ of the research phenomena**

Each curved arrow symbolises part of an open and dynamic circle. Each part of the circle complements the other to create a dynamic, yet balanced, pattern. The nurse and the family perspective are equally valuable for achieving a deeper insight into their interactions and actions, which evolved within a circle of interrelation and interdependence. Each perspective carries meanings in respect of subjective perceptions, conceptualisations, relations, experiences and intentions as the above narratives demonstrate. Examples that captured these perspectives were given as coded data units and their derived meanings in Chapter 6, Figure 6.8, Chapter 7, Figure 7.5, Chapter 8, Figure 8.5 and Chapter 9, Figure 9.5. Interactions, actions and documentation, although situated in context, offer a more objective source of evidence. Both health and illness require consideration in family health assessment. The health-illness dimension was approached from a different role-bound perspective in each case. These multiple perspectives shaped the interactions and actions in the four case studies. The diagram represents first conceptualisations of the sequential flow of phenomena as they emerged in Case One (see Chapter 6, Figure 6.10).
and shows a repeating occurrence in subsequent case studies. The circular nature in flow and sequences reflects the emergent and dynamic nature of interaction in symbolic interactionism, and the flow of interconnected phenomena in family systems theory. Circularity, in terms of sequences and interrelationships of phenomena, was indicative of the central meaning within each case and for the study as a whole.

This conceptual scheme helped me grasp the analytic interrelationships, which was required for the cross-case analysis. It was also useful when I struggled to comprehend Stake’s approach to multiple case study analysis. According to Stake (2006), the single case allows a holistic and bounded view of the ‘quintain’ to be formed, a view that becomes constrained when attempts are made to integrate several cases into the analytic focus. However, each case must still contribute to the deeper understanding that is sought of the binding concept; it requires a shift in focus. The single cases in their specific entities will recede from the ‘foreground’ to the ‘background’ so that the ‘quintain’ comes into the analytic focus. This shift in focus creates a different conceptual plane similar to that used as a perceptual device and metaphor of ‘family’ in family nursing, as discussed in Chapter 2 Section 2.3.3 and displayed in Figure 2.1. Stake refers to this phenomenon as “the case-quintain dilemma” (2006: 7 & 29). Accommodating the particular and the general in a cross-case analysis also mirrors this dilemma, as illustrated in Figure 10.2.
The figure depicts the four cases, although with less detail compared with Figure 10.1. The research question shaped the issues and the analytic framework questions. Each half of the four circles contributed to the findings, which must be brought into the binding concept via a shift in the analytic focus. This shift in a multi-case study is guided by the question: “What helps us to understand the quintain?” (Stake, 2006: 6). As Figure 10.2 shows, the single cases are still in the foreground, while the ‘quintain’ forms the circle in the background. The diagram also demonstrates that not all findings from the four cases can be integrated, even when the focus is shifted. A counter-argument would be that integration of findings may be dependent on the size of the ‘case quintain’. Boundaries must be set for the quintain to make it manageable, however.

From a systems perspective, permeability – as illustrated by the broken line of the circle - should be maintained across the ‘case-quintain boundary’. As the diagram shows, the relationship between cases and the binding concept can be explained from a systems perspective. I viewed this interpretation of perceptual planes as helpful when approaching the cross-case analysis. Incidentally, Stake further notes that this shift in focus means looking for correspondences of...
patterns and/or cases. Looking for correspondences or associations is an interactive pursuit between the researcher’s intentions and the data. Therefore, the approach to answering the ‘case quintain question’ will be unique for each multi-case study. Each case will contribute uniquely to an understanding of the ‘case quintain’. This may explain the lack of procedural guidance for multi-case study research, as interaction requires interpretation of the situation as it presents itself (Charon, 2007). The circularity of this dynamic process also becomes evident in this analytic task. Insights continued to emerge through the symbolic interactionist-constructionist pursuit of association. According to Stake, it is important to anticipate such “late-emerging issues” (2005: 452). Understanding Stake’s reasoning is a challenge, however. Although some of his procedural descriptions became more accessible using a systems theory ‘lens’, Stake himself is not explicit about this systemic influence in his writings. My interpretation of distinguishing between ‘foreground’ and ‘background’ for the cross-case analysis helped me tackle this final analytic challenge. As shown in Figure 10.2, attention is first directed to the four cases as the initial analytic task in this cross-case analysis.

Once within-case analysis was completed, the following material was available from each of the four cases with which to start the cross-case analysis:

- Case profile / description including family Genogram
- Nurse data record giving raw categorical data structured, using the heuristic framework questions as headings to portray the nurse perspective
- Nurse case report giving interpretations of the nurse data record using the same format as above
- Family data record giving raw categorical data structured using the heuristic framework questions as headings to portray the family perspective
- Family case report giving interpretations of the family data record using the same format
- Memos of each category in the nurse data record/report
- Memos of each category in the family data record/report
- Summaries of talk-in-interaction of the home visits
- Summaries of thematic conversational moves from talk-in-interaction of the home visits
Chapter 10 The Cross-Case Analysis and Synthesis of Findings

- Summaries of types of question, commendations and empathic response identified in the home visits
- Matrices displaying thematic conversational moves of home visit interactions extrapolated from talk-in-interaction
- Matrices displaying question-answer sequences, commendations and empathic responses identified in talk-in-interaction
- Summaries from observational analysis of home visits
- Descriptive-interpretive case report of nursing assessment documents
- Field notes in the form of contact summary forms

As suggested by Stake (2006: 47), a number of worksheets were prepared for the cross-case analysis, to aid the analytic process. Their choice was selective, based on what I perceived to be the most helpful for the task at hand. Stake’s conventions do not include the presentations of worksheets; for the purpose of this thesis, however, one modified worksheet is shown in Figure 10.3 to enable a fuller understanding of the dynamics of this process. To some extent this table shows the analytic progression made up to this point. The issue sub-questions formulated before data collection and case analysis are shown in the left-hand column. These were introduced in Chapter 4, Figure 4.1, as part of the case study features and elements. As explained in Chapter 6, heuristic analytic framework questions had been developed for the analysis of the individual cases. As my understanding grew, these questions were further refined as shown in the right-hand column of the table. They were then used as thematic research questions to guide the cross-case analysis.
# Chapter 10 The Cross-Case Analysis and Synthesis of Findings

<table>
<thead>
<tr>
<th>Central Question</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How is family health assessment in different fields of practice conducted, perceived and experienced by the community nurse and the family?</strong></td>
</tr>
</tbody>
</table>

### Before within-case analysis

<table>
<thead>
<tr>
<th>Issue Sub Questions</th>
<th>After within-case analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is involved in the interaction process?</td>
<td>Thematic research questions</td>
</tr>
<tr>
<td>Which family health assessment constructs might help to understand the interaction process?</td>
<td>Who is involved in the interaction process?</td>
</tr>
<tr>
<td>How might the situation of family health assessment be described?</td>
<td>Are the health needs of the family as a whole considered by the community nurse when the reason of referral focuses on an individual family member?</td>
</tr>
<tr>
<td>How might the interaction process between the community nurse and the family in different fields of practice be explained?</td>
<td>a) Now that the community nurse is a HV/CCN/FH/DN, how does the nurse see her role in working with families?</td>
</tr>
<tr>
<td>What themes may emerge from gathering information about the nurse and the family’s perceptions and experiences?</td>
<td>b) Now that the community nurse is a HV/CCN/FH/DN, how does the family see their role in working with the nurse?</td>
</tr>
<tr>
<td></td>
<td>a) Now that the health focus is different for each nurse and family, what is the nurse’s definition of the situation i.e. assessing family concerns/needs?</td>
</tr>
<tr>
<td></td>
<td>b) Now that the family has a specific health need/concern and family life cycle, what is their definition of the situation?</td>
</tr>
<tr>
<td></td>
<td>a) What is the nurse’s orientation towards the family?</td>
</tr>
<tr>
<td></td>
<td>b) What is the family’s orientation towards the nurse?</td>
</tr>
<tr>
<td></td>
<td>How can the interaction process between the community nursing and the family in different fields of practice be explained?</td>
</tr>
<tr>
<td></td>
<td>Which assessment framework is being used by the nurse in her field of practice?</td>
</tr>
<tr>
<td></td>
<td>What type of information is being sought?</td>
</tr>
<tr>
<td></td>
<td>What use is being made of the information?</td>
</tr>
<tr>
<td></td>
<td>In what way does the assessment framework in use enable the nurse to assess the family as a whole?</td>
</tr>
<tr>
<td></td>
<td>Does the family have a specific view about the documentation?</td>
</tr>
<tr>
<td></td>
<td>a) What has been of particular importance about the home visits for the nurse?</td>
</tr>
<tr>
<td></td>
<td>b) What has been of particular importance about the home visits for the family?</td>
</tr>
<tr>
<td></td>
<td>What has been the impact of participation in the study on the community nurse?</td>
</tr>
<tr>
<td></td>
<td>Which recommendation would the family like to make for nursing work with families?</td>
</tr>
</tbody>
</table>

### Figure 10.3: Display of questions guiding within-case and across-case analysis

The thematic research questions were borne in mind when reading the collected reports from each of the cases (Stake, 2006). As Stake recommends, situational constraints, uniqueness among cases and theoretical issues were noted from the case material. To help uncover key issues, case specific characteristics were collated in matrices. For example, Figure 10.4 below gives a summary
answer to the first thematic research question “Who is involved in the interaction process?” A descriptive case profile was given in each respective case study chapter.

<table>
<thead>
<tr>
<th>Case</th>
<th>Community Nurse</th>
<th>Predominant Professional Role Focus</th>
<th>Referred Family Member</th>
<th>Referral Reason</th>
<th>Family Composition</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Health Visitor</td>
<td>Health</td>
<td>Youngest child</td>
<td>Behavioural problem.</td>
<td>Mother with 2 young children*</td>
</tr>
<tr>
<td>Two</td>
<td>Community Nurse</td>
<td>Illness</td>
<td>Youngest child</td>
<td>Complex long term care needs.</td>
<td>Mother with 3 children &amp; partner**</td>
</tr>
<tr>
<td>Three</td>
<td>Family Health Nurse</td>
<td>Health &amp; Illness</td>
<td>Wife &amp; husband</td>
<td>Wife’s impaired mobility due to stroke, incontinence, chronic constipation. Carer’s stress &amp; compromised coping.</td>
<td>Married couple</td>
</tr>
<tr>
<td>Four</td>
<td>District Nurse</td>
<td>Illness</td>
<td>Husband</td>
<td>Husband’s terminal stage of pancreatic carcinoma.</td>
<td>Married couple</td>
</tr>
</tbody>
</table>

*Partner declined to take part in study  **Partner not living in household

**Figure 10.4: Comparative display of participants’ characteristics**

Once a thorough grasp of the issues had been gained, it was helpful to construct a meta-matrix to collate all findings into a four-page document (Miles & Huberman, 1994). An electronic poster template file was used for each perspective, which could be reduced to scale and each page displayed showing the nurse perspective, family perspective, interaction perspective and the documentation. This meta-matrix was built from the thematic analytic structure. Entries were extrapolated rather than copied from case reports as suggested by Stake (2006); a process also mentioned by Miles & Huberman. This process uncovered the underlying phenomena in terms of similarities and differences. In vivo codes or metaphors used by participants were sometimes added, to provide further richness to these grounded themes. Guided by thematic research questions (see Figure 10.3), correspondences could be interrogated as regularities appeared. Entries could be traced to case-specific matrices, descriptions and interpretations. In one column, I identified the need for triangulation, guided by Stake’s advice to differentiate between a “little” and a “critical” need for corroboration (Stake, 2006: 36). This multi-case study design presented opportunities to identify a level of corroboration within and across the four cases, as a range of perspectives were explored and various methods employed. Appendix M is an example of the meta-matrix relating to the nurse and the family perspective in support of the cross-case analysis. The selected themes portray perceptions, conceptualisations and relations across the four cases.
While pooling the case-specific findings in matrices, I became increasingly aware of underlying patterns. These became noticeable when considering the interaction data as they became the central focus of data. Therefore, the cross-case analysis will continue with the talk-in-interaction.

10.4 SHIFTING THE FOCUS: FROM THE PROCEDURAL TO THE INTERACTION PERSPECTIVE

The analysis of interaction proceeded through identification of question-answer sequences, commendations, empathic responses and categorical aggregation of thematic conversational sequences. Data excerpts and initial interpretations of these findings were presented in Chapters 6, 7, 8 and 9. The aggregation of question-answer sequences was justified to achieve a more informed interpretation about their meaning within a comparative context. Table 10.1 summarises the two question-answer types that were identified in the talk-in-interaction during home visits.

<table>
<thead>
<tr>
<th>Question Answer Sequences</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear questioning</td>
<td>82</td>
<td>185</td>
<td>136</td>
<td>76</td>
<td>479</td>
</tr>
<tr>
<td>Circular questioning</td>
<td>10</td>
<td>5*</td>
<td>4</td>
<td>7</td>
<td>26</td>
</tr>
</tbody>
</table>

*arrested response

Table 10.1: Prevalence of questioning type across all cases

In all cases linear question-answer sequences were a prevailing feature of talk in the community nurse-family interaction. This type of questioning had an instrumental purpose as it enabled the nurse to gather specific, factual family information. Margaret, in Case 3, put it quite bluntly:

“It’s basically you really need to ask them [ ] it’s as straightforward as that” (C3_FHN_Pre_HoV_Int).

Her account suggests that questioning family members is key to obtaining information to evaluate their needs and plan care. The prevalence of linear questioning appears to confirm this across all cases. While numerically this is of interpretive impact, it was the pragmatic use of language in terms of the circular questions that I regarded as more revealing. From an interactionist and family systems theory perspective, it matters not just ‘what’, but ‘how’, understanding and information is being sought, because of the conversational sequences that may follow. Responses to a circular question tended to reveal a dimension of the family experience which went beyond mere fact-gathering. Therefore, I regarded finding evidence of circular question-answer
sequences in all four cases, despite its limited magnitude, as important and meaningful. An example from each case is presented within a comparative context in Figure 10.5.

<table>
<thead>
<tr>
<th>Case</th>
<th>Cross Case Interaction Excerpts: circular question-answer sequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>158 Janine And are you surprised at the fact that he would actually sit quietly and do it?</td>
</tr>
<tr>
<td>1</td>
<td>159 Mary Uh uh aye (.2) he likes to sit and draw now.</td>
</tr>
<tr>
<td>1</td>
<td>160 Janine That is a huge step forward for him. Empathic response.</td>
</tr>
<tr>
<td>1</td>
<td>161 Mary Hmm because before he would do it for 5 minutes and then be bored and start throwing it about or drawing on the furniture or drawing on himself whereas now he is quite happy if its they two (.2) if you put all the pen –</td>
</tr>
<tr>
<td>1</td>
<td>162 Mary because I got card making kits with glue and wee sparkly bits and beads and all of that (.2) so he sits and glues that and glues himself like but he sits and does all that.</td>
</tr>
<tr>
<td>1</td>
<td>163 Janine It is a lovely way to get his Mum’s attention though isn’t it (.2) and it is really nice attention. Commending mother.</td>
</tr>
<tr>
<td>1</td>
<td>168 Janine (C1_HV_HoV_2)</td>
</tr>
<tr>
<td>2</td>
<td>74 Betty [ ] What does Jack think of him?</td>
</tr>
<tr>
<td>2</td>
<td>76 Lilo He doesnae.</td>
</tr>
<tr>
<td>2</td>
<td>77 Lena He’s not really that bothered.</td>
</tr>
<tr>
<td>2</td>
<td>78 Betty He’s not (.2) so is he really just your rabbit?</td>
</tr>
<tr>
<td>2</td>
<td>79 Lilo Aha.</td>
</tr>
<tr>
<td>2</td>
<td>80 (C2_CCN_HoV_1)</td>
</tr>
<tr>
<td>3</td>
<td>1882 Margaret Has talking through it yourselves has that helped you kind of think about things with your family?</td>
</tr>
<tr>
<td>3</td>
<td>1883 Bob I look on the side as I say (.2) I look on the side of my father and I say he’s seventy-five he’ll probably still be going for another fifteen, twenty years and he’s got a full head of hair and I look on the side of my mothers’ I’ve got flaming no hair and I’ve only got three years to go and you go down the same as she did.</td>
</tr>
<tr>
<td>3</td>
<td>1885 Nicky But you see I mean Bob always had this thing he’s always said you know I’ll be sensible [ ]</td>
</tr>
<tr>
<td>3</td>
<td>1886 Bob (C3_FHN_HoV_1)</td>
</tr>
<tr>
<td>4</td>
<td>256 Susan [ ] do you think he’s having any pain?</td>
</tr>
<tr>
<td>4</td>
<td>257 Lisa Aye I’ve been giving him eh well see it’s (.2) he doesnae ken whether it was constipation and he’s got the sore back (.4)</td>
</tr>
<tr>
<td>4</td>
<td>258 Susan [right]</td>
</tr>
<tr>
<td>4</td>
<td>259 Lisa [so but he doesnae seem to be in a lot of pain ken]</td>
</tr>
<tr>
<td>4</td>
<td>260 Susan [right (.4) it is more than –]</td>
</tr>
<tr>
<td>4</td>
<td>261 Lisa [occasionally if he needs to go to the toilet you know (.4) taking the morphine and that seem to be working fine]</td>
</tr>
</tbody>
</table>
| 4    | 262 Susan [right oh well that’s not so bad then [ ] |}

Figure 10.5: Comparative display of circular questioning sequences

As the data in Figure 10.5 demonstrates, a circular question contains a relational element. It elicits a response which displays a relational concern by drawing another family member into the focus of ‘inquiry’. This may even include a family pet, as the example of Case 2 shows. The excerpts also
bring to light variations in the reflexive responses that were triggered. In Case 1, this type of exploratory conversation occurred noticeably. By comparison, in Case 2, the circular question did not lead to an extended response. Developmentally, Lilo was perhaps not ready to respond reflexively and therefore her mother continued the sequence. Responses to the few occasions of circular questioning were always arrested in some form. In Case 3, the conversation took on a meandering nature, where the couple were given time to explore. Reflexive in nature, the exploratory pacing of questions was marked by long pauses in Case 4. Except in Case 2, circular questioning appeared to promote a thoughtfulness among family members about the situation of concern. This type of questioning may be of some scope to the community nurse and family members for seeking understanding and promoting dialogue, to gain insight into the family experience. However, these circular question-answer sequences appeared randomly in the conversational flow of home visits. In none of the cases did the community nurse use this question type in a sequential manner to obtain a systemic view about the family and their concerns as is suggested by Wright and Leahey (2000) and Bell (2000).

Commendations and empathic responses were collated too. Data excerpts relating to both were presented in previous chapters. Table 10.2 summarises these instances for comparison.

<table>
<thead>
<tr>
<th>Relational Stance</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commendations</td>
<td>47</td>
<td>3</td>
<td>70</td>
<td>9</td>
<td>129</td>
</tr>
<tr>
<td>Empathic responses</td>
<td>46</td>
<td>30</td>
<td>105</td>
<td>83</td>
<td>264</td>
</tr>
</tbody>
</table>

Table 10.2: Prevalence of ‘relational stance’ across all cases

Across all four cases the displayed information allows the drawing of inferences to be made on the community nurse’s relational orientation towards the family. These comments were assumed to reveal a caring concern. It is the magnitude of these two dimensions associated with relational stance which highlights some interesting similarities and differences. In Case 1, both types of utterances were raised with near-equal magnitude. Betty in Case 2 responded empathically, yet offered only a few commendations. Although rich in commendations and empathic responses, Margaret in Case 3 was more orientated towards the latter. Susan in Case 4 responded empathically, but with fewer commendations. Both communicative behaviours seem to carry therapeutic meaning. Empathic responses represent the symbolic interactionist premise of ‘taking the role of the other’, which can be interpreted as compassionate and caring (Charon, 2007).
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Commendations also have a compassionate and relational orientation towards ‘the other’. These therapeutic features of talk can be traced to the work of Carl Rodgers (2003[1951]) which he promoted for psychotherapeutic practice. ‘Offering commendations’ is an integral concept in Wright & Leahey’s (1994; 2000) family systems nursing framework of assessment and intervention, thanks to their knowledge of family therapy practice (Wright et al., 1996). Such therapeutic prominence in assessment visits supports findings in Bryans’ work (2003). In this study, the linear question-answer sequences gave interactions a diagnostic-communicative flavour. This type of interaction was then transformed into a therapeutic-inquiry intervention through commendations and empathic responses, an impact that was notable from the families’ accounts in all of the cases.

With data of the observed non verbal interaction, correspondence to relational stance was sought to see whether it would lend confirmatory support to assertions about the therapeutic nature of interactions. As explained in Chapter 6, the focus of observation had been selective, using pre-defined concepts described in the literature as being of therapeutic intent. The occurrences of these representations were tallied and entered into the meta-matrix interaction perspective. Although findings must be treated with caution due to the method’s limited dependability, they suggest that in all cases the non-verbal behaviour of the community nurse seemed to convey an empathic presence. Listening appeared to signal acceptance and trust. Family perceptions about the community nurse’s communicative behaviours and their perception of important aspects of home visits corroborate this claim.

Interaction themes extrapolated from the talk-in-interaction in each case were presented in Chapter 6, Section 6.5.3.3; Chapter 7, Section 7.5.3.3; Chapter 8, Section 8.5.3.3; and Chapter 9, Section 9.5.3.3. Thematic conversational sequences were coded as categories and defined as interaction themes which were then aggregated across the home visits of each case. A summary of these findings was also presented in their respective chapters. Five distinct thematic conversational sequences were identified. While meaningful in their sequence of utterances, as interaction themes they also carried conceptual meaning according to health care and conversational relevancies. These meaningful sequences applied to diverse social settings. Three of these thematic sequences reflected health concerns relevant to the nurse and family members, and displayed both their perspectives. The interaction process could be appreciated from their
sequence, while linear and circular questioning moved the process forward. A summary of the five thematic conversational sequences is given in Table 10.3.

<table>
<thead>
<tr>
<th>Conversational Sequences</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Orientated Health Issues (FOHI)</td>
<td>54</td>
<td>49</td>
<td>107</td>
<td>70</td>
<td>280</td>
</tr>
<tr>
<td>Professional Concerns (PC)</td>
<td>44</td>
<td>64</td>
<td>103</td>
<td>36</td>
<td>247</td>
</tr>
<tr>
<td>Family Talk (FT)</td>
<td>66</td>
<td>20</td>
<td>77</td>
<td>48</td>
<td>211</td>
</tr>
<tr>
<td>Patient Health Concerns (PHC)</td>
<td>29</td>
<td>33</td>
<td>28</td>
<td>67</td>
<td>157</td>
</tr>
<tr>
<td>Building Relations (BR)</td>
<td>26</td>
<td>39</td>
<td>57</td>
<td>19</td>
<td>141</td>
</tr>
</tbody>
</table>

Table 10.3: Prevalence of the main thematic conversational sequences across all cases

When aggregated across cases, family orientated health issues (FOHI) emerged as the prevailing thematic conversational sequence. This is not surprising given the purposive sampling strategy and case selection criteria. Each case, however, had been selected in order to provide rich and varied information about the community nurses’ experience of family health assessment in different fields of practice and different family situations, therefore variation between cases was equally likely. This is evident from the information in Table 10.3. Irrespective of the specific role-bound professional focus and client group, family orientated health issues (FOHI) led the conversations, followed by professional concerns (PC), when compared across the four cases. It was the magnitude of family talk (FT) which is perhaps the most striking and unexpected finding. Family talk (FT) featured more strongly compared with patient health concerns (PHC). Family talk was grounded in family members’ shared experience, to which the community nurse remained an ‘outsider’. It is perhaps unsurprising then to see conversational sequences of building relations (BR), as these appeared to become instrumental for the relational work necessary to bind interactions and actions towards a common purpose.

Following the collation of findings from the different data sources, another worksheet was developed for each case. As suggested by Stake (2006) this detailed the assertions that had been drawn from the pooled material. In a further column, I commented on any evidence which corroborated these assertions with data or linked them with other findings in other cases. Triangulation became a form of cross-referencing of each assertion to the other data reports, a preparatory step towards the synthesis. While fully immersed in these analytic procedures which involved close and lengthy engagement with the case materials and required much thought, however, the repeated reading brought to light an unexpected issue.
10.5A LATE EMERGING ISSUE AND ITS PROCEDURAL ADVANCE

Interrogation of the case materials required frequent analytic shifts or ‘analytic bracketing’ to probe for differences, similarities, and underlying patterns (Gubrium & Holstein, 2000; Stake, 2006; Holstein & Gubrium, 2007[2004]). Categorical aggregation of interaction themes and direct interpretation of instances of question-answer sequences, commendations and empathic responses had contributed to an understanding of the content of the home visits and a description of the process. How this process might be explained across the four cases in order to deepen understanding remained of concern. Somehow I needed to assemble and discover patterns for which I could not draw on any rule, previous knowledge or any other suitable type. As I revisited the data from home visits, the cases now receded into the background as the ‘case quintain’, ‘community nurse-family interaction in family health assessment’, started to take shape.

Each interaction text file was copied into a new Word document and the transcribed text deleted. Line numbers and themes which appeared as headings throughout the text remained. Each theme with its associated conversational moves could still be traced to the turn-taking sequences in the original text source. These thematically sequenced representations of conversational moves of each home visit were then pasted again into a new Word document. Line numbers were removed and each theme colour-coded by hand. For example, in Case 4, the 12-page interaction text of the first home visit was now reduced to fewer than two pages only showing its colour-coded themes. The procedure was checked to ensure representations of colour-coded themes aligned with line numbered themes and originally coded texts. By now, a distinct colour pattern represented the sequence of conversational moves and content of interaction.

As a further step in this process of distillation, a new document was set up, in which only the coloured-coded segments were shown. All reference to printed text was now removed; yet each colour represented a thematic conversational sequence or single utterance that were meaningful and context rich (Sperber & Wilson, 1986). The outcome of this was a column of coloured sequenced patterns (see Appendix N & O as examples; Appendix P explains key symbols used). This display of thematically coded sequences of conversational moves allowed clearer comparison of the interaction process across different home visits and across different cases. Some patterns stood out more than others. All patterns fitted in their varied sequences in all four cases and across all home visit data sources. I could see consistently alternating patterns which showed a
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striking regularity. These alternating sequences are evident in the examples given in Chapter 6, Figure 6.17; Chapter 7, Figure 7.11, Chapter 7, Figure 8.11 and Chapter 9, Figure 9.11. There were also instances where the consistency in pattern formation did not hold (see Appendix O, HoV 1, Stage 4). Occasionally the recursive patterns were interspersed by a longer sequence of a non-alternating pattern (see Appendix N, HoV 1 and Appendix O, HoV 1). Across all home visits, in each of the four cases the five interaction themes configured into a total of 13 recursive-alternating patterns and four non-recursive patterns. I regarded these as negative instances. They were particularly puzzling as they appeared among the recursive-alternating patterns as though at random. Their prevalence also varied distinctly across the cases. To make sense of them, I returned to the texts to find that some non-recursive patterns related to sequences which did not match interactions that fitted assessment purposes. These non-recursive patterns I interpreted as evidence to support the predominant recursive-alternating nature of community nurse-family interaction patterns, creating the process of family health assessment. The negative instances provided disconfirming evidence that strengthened the distinct interactional regularities of conversational sequences. The nine main recursive-alternating patterns were identified and selected for proceeding with the analytic work (see Section 10.6 below, Table 10.4). Using all variations would have become too unwieldy. This decision impacted on the final stage of the cross-case analysis and its outcome.

Each pattern was grounded in the data. From a communication theoretical perspective based on Sperber & Wilson (1986), the recursive patterns represented both communication by encoding and decoding “(code model)”, and by producing and interpreting “(inferential model)” (Sperber & Wilson, 1986: 2 (italics in original)). Each thematic sequence was conceptually defined and associated with a distinct recursive-alternating pattern. This allowed me to approach these utterances from the ‘pragmatics’ premise “to reveal the speaker’s attitude to, or relation to, the thought expressed” (Sperber & Wilson, 1986: 10 & 11). The context of utterances was maintained, which I regarded as important given the different cases and care situations. The four main recursive-alternating patterns could now be interpreted within “a largely inferential process” that “squares well with ordinary experience” (Sperber & Wilson, 1986: 13). Each thematic interaction pattern was identified with a specific legend and symbol to enable tallying and recognition of sequences of each type (see Appendix P). The analytic procedure was systematically applied to all home visit interaction texts. Guided by this patterned structure, and by comparison with the content of conversational moves, an attempt was made to identify stages
the interaction process which were indicated by inserting a dashed line (see Appendix N & O). Although four stages could be identified, however, a conclusive interpretation remained tentative. More fruitful was the comparison of the prevalence of recursive-alternating patterns and non-alternating patterns across home visits in each case and across cases. These patterns were suggestive of the leading relevancies of interaction in family health assessment co-constructed among the community nurse and family members. Findings of the interaction analysis were collated, and interpretive accounts compiled for each case. This analytic work set me on the path of an inferential process which is now further explained.

In each case the typical features of conversational sequences appeared clearly and convincingly as patterned regularities in the talk-in-interaction texts. In addition, greater insight emerged as I drew deductive and inductive inferences during the within-case analysis from the nurse and family accounts. One was deductive, relating to theoretical concepts brought into the analysis. The other was inductive, where inferences were empirically grounded. For example, concepts such as ‘non-expert stance’, ‘listening’, ‘reflecting’ and ‘family as a system’ gave some orientation to the analytic process. Some of these concepts, such as ‘listening’, carried a general meaning which featured in each particular case. The drawing of deductive inferences across different contexts and situations was indicative of their transferability. On the other hand, being inclusive had emerged as a category in the account of the community nurse in each particular case. The category including family members had also emerged in the family account in each of the cases. Both categories transmitted co-constructed meanings grounded in the nurse and family perspective in each case. They carried some probability and, as inductive inferences, required confirmation by participants. Figure 10.6 depicts this interactive reasoning process of analysis towards the ‘case quintain’.
The dynamic nature of this process is illustrated with arrows. It proceeded from the data of nurse and family accounts, where two forms of reasoning informed this interpretive process. This stage is represented in the first two circles of the diagram. The theme *being inclusive* was extrapolated from both deductive, rule-governed and inductively gained probable inferences. The theme gave orientation towards pattern recognition of conversational sequences, displayed here as coloured shapes. In the first instance they appeared as if at random. Following further inspection they were categorised according to their patterned regularity. The five interaction themes were extrapolated by inductive inference. Examining their fit across all talk-in-interaction text data sets was then required to see whether this deeper understanding would require some explanatory interpretation. If patterns showed regularities not only across home visits in the individual cases, but also across the four cases, any commonality in pattern would warrant the making of assertions about community nurse-family interaction in family health assessment at a ‘case quintain’ level. In my attempt to move towards a synthesis informed by my previous analytic work, these regularities allowed me to draw abductive inferences that were neither grounded in a specific mode of reasoning, nor in an exact method (Reichertz, 2004). The concept of abductive reasoning was first introduced by the pragmatist Charles Sanders Peirce for knowledge development based on the formation of explanatory hypotheses (Josephson et al., 1996: 1). Paavola (2006: 71 "italics in New Knowledge: community nurse-family interaction in family health assessment"
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original) refers to “abduction as a mode of inference” and emphasises “to have means for finding and producing fertile, tentative hypotheses”. The conversational sequences as they stood out in their coloured patterns were just such means. Reichertz’s explanation of abductive reasoning struck me as profound at the time, as it captured my analytic experience of discovery:

Abductive efforts seek some (new) order, but they do not aim at the construction of any order, but at the discovery of an order that fits the surprising facts: or more precisely, one that solves the practical problems that arise from these (Reichertz, 2004: 163 (emphasis added)).

This matched my own viewpoint that cognitive realisation through contemplation and interpretation could enable abductive inferences to be made. The intellectual leap referred to by Reichertz can be described as the ‘art’ of pattern recognition, one that leads to a re-ordering into patterned regularities. Furthermore, according to Krippendorf (2004) abductive inferences transverse logically distinct domains; for example, different thematic conversational moves with their interplay of content and process fitted the four distinct cases of the study. While carrying only a certain probability, abductive inferences “may be strengthened if one is able to take other variables (contributing conditions) into account” (Krippendorf, 2004: 36). In this multi-case study, nurse and family accounts of perceptions, conceptualisations, relations, experiences and intentions, combined with data from documentation and observation, provided a degree of evidential substance in support of the plausibility of assertions. Some of these assertions are grounded in abductive inferences that are neither preferred nor valid. Instead, they lead to new knowledge that is plausible based on the Peirces’ premise: “The surprising fact, C, is observed; But if A were true, C would be a matter of course, Hence, there is reason to suspect that A is true” (Wirth, 1998: 1). Abductive inferences, therefore, are assertions about the community nurse-family interaction in family health assessment in four cases and are vital as representative of this interaction. These re-constructions nevertheless require some confirmation of their authenticity; new evidence may well challenge their plausibility. At this point the importance of triangulation and member check became apparent. Assertions were exposed to procedures to gauge their plausibility and fit in terms of their transferability, confirmability and authenticity. This process is represented by arrows moving from right to left in Figure 10.6. Verification of these grounded assertions was received from the community nurse in Case 3 and Case 4 (see Appendix K as an example of received member comments).
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These assertions would then offer an explanatory understanding with which to answer ‘how’ community nurse-family interaction proceeds as a ‘generalisation’ across the four cases, as the main contribution of this multi-case study. Thus, explanatory interpretations were robust in terms of their transferability. This type of understanding would go beyond description in a multi-case study, as assertions grounded in abductive inferences offered an experiential and deep understanding. Assertions would remain grounded in, and contingent upon, the conduct of participants. Possible explanations would be built out of interaction with participants and my reflexive engagement with the data. Judgments on their plausibility and utility would continue to “rely on actor and reader experience” and would, thus, remain as a “naturalistic generalisation” (Stake, 1995: 42). As co-constructor of these assertions, however, I perceived myself as passing judgment on their plausibility and utility, as I had initiated the search for a deeper understanding of the research phenomenon. Abductive reasoning is therefore consistent with a constructionist methodology.

10.6 THE ‘CASE QUINTAIN’ AS FOREGROUND

The visual representation of the conversational sequencing of themes prompted much reflection. By now the ‘case quintain’ had fully advanced into the analytic focus. This is shown in Figure 10.7.
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The Gestalt of the quintain is symbolically represented as a circle. A circle means roundness or wholeness; the encircling, incorporating and envisaging of a phenomenon, it symbolises integration. To achieve a holistic understanding of the ‘quintain’ requires an acceptance of the dialectic nature of referencing single cases selectively which may not result in all the aspects being accommodated – in fact, some phenomena may even remain hidden. It follows that no matter how integrative and rounded a perspective; even a holistic view may remain partial. And, as each single case is a construction of multiple perspectives, so does the case quintain embody multiple realities. These too required accommodation in order to build a robust foundation for the synthesis of findings. This was achieved in three stages. Firstly, the recursive-alternating patterns of conversational sequences were counted and summarised as shown in Table 10.4.
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<table>
<thead>
<tr>
<th>Recursive-Alternating Patterns</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOHI – FT</td>
<td>44</td>
<td>62</td>
<td>27</td>
<td>-</td>
<td>133</td>
</tr>
<tr>
<td>FT – PC</td>
<td>38</td>
<td>40</td>
<td>20</td>
<td>-</td>
<td>98</td>
</tr>
<tr>
<td>FOHI – PC</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>FOHI – PHC</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>FT – PHC</td>
<td>22</td>
<td>-</td>
<td>65</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>FOHI – BR</td>
<td>-</td>
<td>20</td>
<td>-</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>PC – BR</td>
<td>25</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25</td>
</tr>
<tr>
<td>FT – BR</td>
<td>23</td>
<td>-</td>
<td>-</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>PHC – PC</td>
<td>17</td>
<td>-</td>
<td>-</td>
<td>17</td>
<td>17</td>
</tr>
</tbody>
</table>

FOHI - family orientated health issues   FT - family talk   PC - professional concerns   BR - building relations
PHC - patient health concerns

**Table 10.4:** Prevalence of recursive-alternating patterns across cases

Secondly, the information displayed in Table 10.4 was re-configured to show the four main recursive-alternating patterns in each case according to its leading element, as illustrated in Figure 10.8. The circular flow of conversational sequences inherent in these pattern configurations justified this decision.

![Figure 10.8: Comparison of the four main recursive-alternating patterns](image)

Thirdly, for each case a diagram was drawn to help visualise the recursive-alternating patterns of conversational sequences based on the information displayed in Figure 10.8. The diagram built on my initial conceptualisation of the circular flow of phenomena shown in Chapter 10, Figure 10.1. The diagrams model this circular flow, to portray the recursive nature of the conversational sequences which kept up the momentum of interaction. See Figures 10.9 to 10.12.
Figure 10.9: Case 1 community nurse-family interaction in family health assessment

Figure 10.10: Case 2 community nurse-family interaction in family health assessment

Figure 10.11: Case 3 community nurse-family interaction in family health assessment

Figure 10.12: Case 4 community nurse-family interaction in family health assessment
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These representations helped with the considerations of the meaning of these conversational thematic patterns. Although each diagram displays the main recursive-alternating pattern in rank order of prevalence, random sequences also featured in their colour-coded column representations (see Appendix N & O). These are not represented within these diagrams, however. Instead, their typifying pattern in each case and their recursive, circular flow of conversational sequences within a comparative context, are revealed. The recursive and circular flow is illustrated with arrows. These patterns interrelated within a specific interactional situation. They comprised an interactional and a systemic meaning that represented the case quintain ‘community-nurse-family interaction in family health assessment’. These displays and configurations assisted greatly in the pooling of findings. The inferential process and extrapolation of commonalities and differences shaped the synthesis, which now follows.

10.7 THE SYNTHESIS OF FINDINGS

From conceptualisation of this multi-case study to this final stage, the ‘case quintain’ was approached in terms of the interacting individuals who co-created this social phenomenon. Its constitutive elements required to be built into an organising structure by me, as a co-participant in this process, who was dependent on participants’ interactions, perceptions and experiences. Therefore, this synthesis is an act of re-construction and integration based on principles of exchange, interdependence and interaction. Such co-effort and shared purpose I interpret as “solidarity” in Durkheim’s sense (1984: 85); a division of labour in nursing work, family work and research work. In each case, the community nurse and family in their interactions and actions showed purpose with “collective direction” (Durkeim, 1972: 144). In conducting this study, I too shared in the ‘collective direction’ of promoting solidarity in family health, to address the central research question:

“How is interaction in family health assessment in different fields of practice conducted, perceived and experienced by the community nurse and the family?”

Family health assessment in this multi-case study was conducted through a patterned process of a ‘relational inquiry’ between the community nurse and the family. Their interaction created distinct thematic conversational sequences of circular regularities and meanings. These meanings representing their mutual endeavours, relational investment and perspectives, were demonstrative of the differing professional roles, family members, health concerns and practices
which were inherent in each case. In all cases these interactional regularities contributed to the participants’ expanding of horizons and the promoting of solidarity for family health.

10.7.1 Circular Interaction Patterns: A Symbolic Interactionist Perspective

The emergence of the recursive, alternating interaction pattern family orientated health issues – family talk, depended on two social groups bound by a shared purpose. One social group comprised the community nurse and the family discussing family health issues. The other social group was the family, with family members talking to each other. In both conversational sequences, family orientated health issues and family talk, the family took centre-stage. Both social groups were interrelated and interdependent, however, creating a dynamic and circular relationship in their encounter. Figure 10.13 illustrates this point.

![Circular interaction pattern of family orientated health issues - family talk](original in Colours)

This type of community nurse-family interaction can be interpreted from a symbolic interactionist perspective, as discussed in Chapter 3, Section 3.2.2. The dynamic is illustrated with two circular arrows in a recursive-alternating association. Each interaction theme embodies further dimensions, however. The social group in each case explored family orientated health issues a conversational sequence of an inclusive nature. Family members with a range of concerns at different levels were “in the equation” (C1_HV_Pre_HoV_Int) which involved actual – and occasionally – virtual family members. Inclusion also constituted other symbolic representations such as the documentation and framework that was used in practice. By being inclusive the community nurse took account of the family’s point of view. Family orientated health issues involved the exploration of three assessment dimensions: structural, developmental and functional, in each of the four cases. Thus, inclusion also came to mean the integration of a family-derived assessment framework, although this was not always explicit in interaction or nursing case notes.
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While thematic conversational patterns were situated in context and time, they also changed in sequence according to relevancies. For example, it was the circular formation of family orientated health issues – family talk which contributed not only to the process, but also to its structure through the creation of recursive, alternating patterns. Within family talk, family members interacted with each other based on their mutual experience. These conversational sequences did not always display co-operative action from family members. Sometimes they were left as an incomplete speech act. On the surface, family talk appeared to be indicative of a disjunction in cooperation between the nurse and the family in each of the cases. While listening to and observing family talk, the community nurse had an opportunity to gain a deeper understanding of family dynamics and their intrinsic meanings. Family talk meant giving time and taking time for those in interaction, with the community nurse taking on the role of silent witness of family life.

The community nurse and each family member had to transcend the immediate situation and themselves as individuals through expanding horizons to create shared meanings. These shared meanings required the community nurse and family members to be present, however. Expanding horizons also appeared to depend on a readiness and timeliness to reflect, and a willingness to engage in building relations – to get involved in family “chit-chat”. Shared meanings then became a feature for each and became transformed into ‘the generalised other’ by promoting solidarity – that is, a common shared interest that emerges through interaction and association. This interactive process is depicted in Figure 10.14.

![Circular interaction of horizon and solidarity](image)

**Figure 10.14**: Circular interaction of horizon and solidarity
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Both horizon and solidarity were grounded in the purpose of identifying and dealing with health and illness concerns. Solidarity had symbolic meaning due to the community nurse and family’s co-efforts towards finding a possible solution. This also involved building relations. Conversational sequences of building relations featured as a common interaction pattern during home visits, which corresponded to experiences perceived by the community nurse and the family. Sequences of building relations also required giving time and taking time. The community nurse responded in idiosyncratic ways in order to “enter into relation with families” (Hartrick Doane & Varcoe, 2005: 229). This building relations and ‘entering into relations’ was of wider relevance. To protect family privacy, there were occasions when the community nurse would transcend assessment frameworks and system demands so “that they’re not lying open raw on a piece of paper” (C2_CCN_Pre_HoV_Int). Thus horizon and solidarity became symbolic for meaning-making and co-operative, circular interaction in family health assessment.

10.7.2 Circular Interaction Patterns: A Family Systems Perspective

The circular pattern of family orientated health issues - family talk can also be interpreted from a family systems perspective, as discussed in Chapter 3, Section 3.3.3. While exploring family orientated health issues, the community nurse and the family interrelated with each other in all four cases by re-configuring into a new social system at each home visit. The nurse and each family member can be defined as an individual system - each stood in relation to each other within a hierarchical structure. Within this context and time-bound system, the wider family issues were explored in all cases. Commendations were offered by the community nurse that may have helped to equalise the systems hierarchy; family accounts appeared to confirm this. As an act of integration, circular questioning promoted an exploration and reflection of health issues that went beyond an individual system. Systems integration was further boosted when a family systems nursing assessment framework guided practice and structured its documentation. The two circular arrows in Figure 10.13 and Figure 10.15 below illustrate the reciprocal relationship between the nurse-family system and the family system. The family system is here defined by their family talk which did not include the nurse. It would appear that within the circular pattern of family orientated health issues – family talk two systems exist side by side. Since systems are also defined by boundaries, the degree of their permeability remains uncertain, which may be problematic for both. Each community nurse spoke of having to negotiate entry and build rapport, without which a working relationship appeared to be more difficult to sustain over time. From the family’s point of view, uncertainty was alleviated by the continuity of home visits from
their known community nurse. It made building of trust possible which in turn increased the permeability of boundaries for each system. Openness of boundaries was necessary for the nurse-family system to interrelate. For the community nurse, a lack of openness in family boundaries resulted in interaction becoming “hard” work. This seems to indicate that resistance had to be overcome, a perceived difficulty further complicated by the shift in focus that was required when interacting took place with different subsystems at different levels. This could be an issue of either “you know that you are not going to get anywhere” (C1_HV_Pre_HoV_Int) or “we’re trying to actually get somewhere together” (C2_CCN_Pre_HoV_Int).

Alternatively, the problematic nature of interaction between the nurse-family system and the family system can be interpreted by reference to Luhmann (1995: 406), since interaction “cannot attain self-sufficiency in the sense of complete closure in the circuit of communication”. Applied to the nurse-family system, in which family orientated health issues were explored in interaction, and to the family system in which interaction of family talk continued, this proposition suggests that neither system may experience closure in communication. Instead, each may experience a sense of frustration due to the lack of complete closure in communication. As quoted in Chapter 3, Section 3.3.2., Luhmann notes the episodic nature of interaction as either having occurred earlier or to be concluded later. The circular appearance of conversational sequences of recursive-alternating patterns appears to support this. Figure 10.15 illustrates the systems’ relationship and their necessary integration in family health assessment.

![Figure 10.15: Circular interaction of systems in family health assessment](image)
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Figure 10.15 is an attempt to represent the integration of the nurse-family system and the family system, but the question arises: how can this circular communication pattern be brought to a close? Indeed, in each case the community nurse talked about how difficult it was to bring a home visit to an end. This re-surfacing of issues was also evident from the interaction texts. Sometimes health issues or questions were raised and responded to at the next visit. In the majority of situations, however, each home visit appeared self-contained within its conversational sequences, which were occasionally marked by a distinct entry and a disengagement phase.

10.7.3 Circular Interaction Patterns: A Fusion of Perspectives

A quite different family-centeredness in interaction was evident from the second main recursive-alternating pattern shown in Figure 10.16

![Circular interaction pattern of family talk - professional concerns](PC_FT)

**Figure 10.16: Circular interaction pattern of family talk - professional concerns**

In the previous sequence family talk created some disjunction in conversational flow, yet family orientated health issues represented conversational concerns of a shared nature. Together the community nurse and family members maintained a co-operative effort. Both subsystems were still in “in the equation” (C1_HV_Pre_HOV_Int). The pattern family talk – professional concerns highlights an imbalance from a systems hierarchy perspective. Family talk emerged in the family system and comprised family members airing concern about meanings grounded in their shared experience. While family talk was not necessarily concerned with health issues, the community nurse was concerned about moving her professional agenda forward, which was interrupted due to family talk. It is interesting to note that non recursive-alternating patterns associated with nursing interventions corresponded only with professional concerns. In these sequences, conversational opportunity for family talk was neither given nor taken. Whether the professional agenda focus contributed to the perceived experience of family health assessment processes being onerous is open to question. However, a comment such as “it is hard though because you
have to let go” (C1_HV_Pre_HoV_Int) lends support to such a speculation. Furthermore, from a symbolic interactionist perspective, co-operation and association in terms of individuals’ intentions may not align as easily with a circular pattern such as family talk – professional concerns. It may make the response ‘to acts of the other’ more difficult due to a lack of mutual interaction.

Conceptually, the recursive-alternating patterns of family orientated health issues – family talk and family talk – professional concern showed distinct differences in their communicative-co-operative purposes. They featured in all cases, however, with the exception of Case 2. A more complementary constellation is shown in the following two pattern formations as displayed in Figure 10.17.

![Figure 10.17: Circular interaction pattern of two recursive-alternating patterns](image)

From a systems hierarchy perspective these conversational sequences were prevalent in both the conversational sequence of family orientated health issues and the family position. Unlike the circular pattern in Figure 10.16, the community nurse was integral to the nurse-family system in the conversational sequence of family orientated health issues, which featured in the two recursive-alternating patterns illustrated in Figure 10.17. There was interrelatedness and interdependence among three systems. A specific health concern helped to bind the family, the community nurse and the individual family member. From a symbolic interactionist perspective, co-operation and association of intentions were more easily realised, as conversational sequences
emerged interactively in meaning units which encouraged the focus on a common objective. These two circular patterns were of a focused interaction, and action with an inclusive purpose. This inclusion represented collective, individual and professional concerns. Conversational sequences of this nature expanded horizons and promoted solidarity among those who participated in them.

The perspectives of symbolic interactionism and family systems theory provided a useful lens with which to interpret the selected four main recursive-alternating patterns that typified community nurse-family interaction in four cases. The comparative use of these perspectives did not serve triangulation purposes. Instead, it demonstrated some of their similarities and interrelationship, or rather their fusion - a most surprising finding that deserves further exploration. The data supported the concept of ‘circularity of interaction’, which was interpreted from two theoretical perspectives. Although the definition of the concept of circularity from either a symbolic interactionist or general systems theory perspective remains of interest, its significance is grounded in the community nurse-family interaction in family health assessment. Seeking further conceptual clarity and a more extensive transferability to different cases is justified, given the limited number of cases.

10.7.4 Unresolved Controversies
The documentation of family information added a different dimension to the ‘case quintain’. This dimension is portrayed in four themes - direction, disclosure, discretion and discrepancy. For the community nurse, documenting both nursing work and family work required navigational skills. Documentation was a containment of the nurse-family co-effort within bureaucratic and technological boundaries set by professional, legal and health care system demands. While much was disclosed in pursuit of evidencing assessment practice, much was left undisclosed to protect family privacy and promote their health - the common aspiration of four practitioners.

**Direction**
In each of the cases the community nurse used a theoretically informed assessment framework which gave direction to the assessment process. It assisted with structure thinking, visit planning and helped move forward in interwoven cycles of assessment and intervention. A framework’s
application was not always immediately recognisable in the interaction or the documentation. Each community nurse, however, was able to give an account of the framework that guided her practice. Some assessment frameworks exhibited their structural traces more easily than others, such as the Calgary Family Assessment Model (Wright & Leahey, 2000) and the Activities of Living Model (Roper et al., 2000). The use of a formalised information tool such as the Genogram was particularly illuminating in Case 2 and Case 3. It was apparent that documenting family information and care giving was defined by both the community nurse and the health care system. Professional and organisational intent regarding the documenting of family information did not necessarily overlap. In all four cases the fulfilment of professional aspirations and system demands required thoughtful navigation by the community nurse. Depending on guidance drawn from theoretical assessment frameworks, the documentation of assessment practice of the four community nurses was more or less family orientated. Depending on the direction given or taken, the disclosure of family information carried different meanings.

**Disclosure**

Seeking family information was integral to every home visit. The elaborate accounts given by the community nurse in each case, however, brought out some problematic issues associated with gaining and documenting this information. A theoretical assessment framework which accommodated a collective and an individual assessment focus eased this difficulty, while not overcoming it fully. It mattered from whom and for what purpose information was sought, not only from an individual but also from a collective perspective.

Family information contributed to the “institutional display” (Goffman, 1961a) of the family’s health needs and self-care abilities. While seeking family information was a means of “making the family informative” (Featherstone et al., 2006: 42) to the system, the information gathered represented the family’s inter-subjective life world. Its documentation created their social identity, now re-constructed and contained within a professional and legal framework. Both processes, although different in purpose, were similar in outcome and exposed the family to the professional gaze. Therefore the gathering of family information resulted in disclosure of information, with personal and collective meaning. It was purposefully used to evaluate family competence for self-care. As such, the nursing documentation with its recorded information gave a formal representation of the family in the sense of an “institutional display” (Goffman, 1961a).
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The regular home visits created a pattern of continuity not just in the interaction and documentation. Nurse-family interaction also contributed to shared knowledge which remained transient and thus interrupted continuity in documentation. Some of this transient, undisclosed ‘family-nursing’ knowledge may become significant for information-sharing purposes within a professional context. The community nurse was therefore at the intersection of practical-moral and professional-legal concerns. Navigation through these intersections called for discretion.

Discretion

Disclosure of family information required discretion at different levels. The community nurse considered which type of information needed to be made available and to what extent it was perceived to be relevant for institutional display. It would then be processed in a certain way. To achieve this, the community nurse was dependent on her judgment regarding whether the information could be captured within the nursing case notes. Each home visit gave an opportunity for information content to be gradually assimilated into a body of knowledge about the family situation. The documented content in the nursing notes was a limited reflection of the family knowledge that the community nurse actually held. Family information was recorded on a ‘need to know’ basis; however, who needed to know what, and why, was not always clear.

Each community nurse talked about using her discretion to navigate through the legal, ethical, public and private concerns which arose when family information was disclosed. She showed an awareness of having to use her judgment in order to avoid issues which might compromise either the family or her practice. Despite her circumspection, discrepancies became apparent in each case. The available structural means, such as assessment frameworks with their associated documentation, revealed incongruities in the recording of family information and the outcome of the dynamic and complex community nurse-family interactions in family health assessment.

Discrepancy

In each of the four cases the assessment and documentation was theoretically informed, but each assessment framework differed in scope and use. The same applied to the documentation, as each assessment practice varied according to the field of practice. There was a variable degree of discrepancy, dependent on the fit between the available structure and the accommodating focus.
for a family-orientated assessment. Although professional obligations were fulfilled and needs met, a comprehensive picture that allowed evaluation of every family member’s progress and interrelated health needs based on the available “institutionalised traces” (Wolff, 2004: 284 (italics in original)) was incomplete, except in Case 3. More importantly, though assessment, with its time-consuming and skilled interactional investment and therapeutic impact, was not mirrored in the nursing case notes. The community nurses’ professional evidence of therapeutic practice was lost.

In interaction, family health was explored from a structural, developmental and functional domain in all four cases. These domains are central to the Calgary Family Assessment Model (C-FAM) (Wright & Leahey, 2000; 2005). In Case 2 and Case 3 this family-derived framework guided assessment practice. Here, the data showed congruence between theory and practice. In Case 1 and Case 2 it was the discrepancy between the content in community nurse-family interaction, and the assessment framework used in practice, which came as a surprise. The elements of the C-FAM’s structural, developmental and functional domains were embedded in the assessment practice in Case 1 and 4. These family-derived domains, however, did not feature in either the assessment framework or the documentation in these two cases. This discrepancy demonstrates the usefulness of Wright and Leahey’s Calgary Family Assessment Model in different fields of community nursing practice. It also lends support to the credibility of a family-derived framework designed to explore the concerns of families with diverse health needs.

10.7.5 Final Commonalities
There was a striking alignment in the meaning given to ‘family’ by both the community nurses and family members. Family health assessment was seen as an inclusive, multi-layered experience of being in the equation. This experience was echoed in the interaction pattern of family orientated health issues, which positioned families centre-stage alongside the community nurses’ professional concerns. Four practitioners in different fields of practice promoted solidarity by adopting a family orientated approach which involved balancing the intrusion into family life with the families’ need for privacy. The families experienced the home visits as a therapeutic encounter with a trusted nurse; they did not view the visits as assessments but rather as ongoing conversations that were highly valued for the continuity of care provided by the community nurses. These conversations gave space for family talk and for patient health concerns to be
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revealed. Interactions between the community nurses and family members indicated that a sophisticated ‘relational inquiry’ had taken place, creating circular interaction patterns of a recursive-alternating nature from which explanatory models of family health assessment were constructed for each case.

Since the community nurses’ recorded case notes did not mirror the depth and breadth of the shared assessment information, there was no evidence of the relationship thread that was embedded in nurse-family interactions and which contributed to their therapeutic nature. Thus the documentation of family health assessment showed both harmony and dissonance. While a family-derived theoretical assessment framework helped with the mutual exploration of health needs and concerns, it also suggested a need for pluralism to be recognised in family health assessment practice.

SUMMARY

This comparative multi-case study took a novel approach to cross-case analysis. The conceptual and procedural journey towards answering the central research question was mapped out in support of the cross-case analytic audit trail. This included a discussion of the development of an inferential scheme of induction, deduction and abduction, demonstrating its fit with the constructionist methodology. This integration achieved a progression from a descriptive towards an explanatory understanding of community nurse-family interaction in family health assessment. The four main circular interaction patterns in this process were interpreted, compared and contrasted from both a symbolic interactionist and a family systems theory perspective. This comparative focus added depth and insight and also revealed an unexpected interrelation between symbolic interactionist and family systems theory premises, which can be referred to as a fusion of perspectives. While some unresolved issues surrounding the documentation of family information were uncovered, the credibility of a family-derived theoretical assessment framework was determined. A synopsis of commonalities across the four case studies signposts the key findings of this comparative multi-case study.

The focus in the next chapter is on a discussion of these key findings and their implications.
11 FINAL DISCUSSION, RECOMMENDATIONS AND CONCLUSION

INTRODUCTION
The final discussion is set within the boundaries of the study’s limitations, which are considered against the merits of the thesis and the contribution it makes to knowledge. The key methodological and theoretical issues, the case study design and the lessons learned are addressed. A discussion of the key findings arising from the study objectives follows. Recommendations for policy, practice, education and research which flow from these key findings are then presented, leading to concluding comments.

11.1 MERITS AND LIMITATIONS OF THE STUDY
A recognised limitation is that the study is confined to four cases; however, the small size is balanced by an in-depth approach. Ideally, additional cases would have been constructed, but limited resources, compounded by recruitment challenges, prevented their completion. The ethically sensitive focus of the research problem made recruitment difficult. Ongoing negotiations with community nurses were required to gain access to observation of their assessment practice in family home settings. Some participants withdrew from the study. Rigour was promoted through data triangulation (Stake, 1995; 2006). At a late stage of analysis, it became apparent that there were variable interpretations of the meaning of family health and, in retrospect, it would have been helpful to explore this concept with participants.

Despite these limitations, the study aims and objectives were satisfied. Due regard was given to the context-specific issues, when typical and substantive features in each of the four cases were examined. While exploratory and descriptive, and staying within the confines of the methodological rules of a constructivist enquiry, the multi-case study added explanatory value. Explanation was accomplished by the extension of an exploratory multi-case study design through comparison of its cases. Cross-case analysis made it possible to move from case-context specific understandings to case-bound naturalistic generalisations (Stake, 1995; Sandelowski, 1996). A
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The merit of the study is its innovative analytical framework, developed to guide analysis within and across cases and promote rigour. The theoretically grounded analytical framework provided conceptual strength and made it possible to arrive at a fusion of a symbolic interactionist and a family systems theory orientation. The analytic approach included an inferential scheme of induction, deduction and abduction to reach plausible inferences. These inferences are assertions which carry explanations of some aspects of the research phenomenon, while remaining open for revision in response to new evidence. The mode of abductive inferential reasoning is rarely discussed in constructionist methodology, case study design or nursing research, and is believed to be a strength of this thesis.

11.2 METHODOLOGY, THEORETICAL ORIENTATIONS AND STUDY DESIGN: CHALLENGES, INSIGHTS AND LESSONS LEARNED

11.2.1 A Constructionist View Point

The nature of the research problem and my values as a professional nurse exerted a decisive influence on the chosen methodology. Methodological rules were used to unite interpretations and the application of experiences and meaning from multiple perspectives. At the same time, knowledge was constructed out of perceptions and observations to reveal “human realities” (Charmaz, 2000: 523) from a divergent range of phenomena. Although not real in an absolute sense, reality was socially constructed, and therefore culturally embedded in each case study’s constitutive elements. Addressing these formidable challenges yielded new insights. For example, a flexible structure combined with an explanatory framework built from a broad inferential scheme is compatible with a constructionist methodology.

An ‘emergent design’ is a common premise of constructionist methodology. Research, however, is a purposeful, goal-directed activity for which resources are limited. Without a plan to work from, a researcher may be influenced towards a direction which may compromise the set objectives. Given the comparative multi-case study design, a certain degree of structure was needed to satisfy the study objectives. This approach resembles that of a pragmatist and can be justified given my declared assumptions (see Chapter 3, Section 3.1.). To speak of an ‘emergent design’ creates conceptual tension. A ‘construction’ reflects purposeful thinking, such as pursuing a theoretically orientated design as was followed in this study. Constructionist thought is enhanced by intuitive,
creative thought identified as a prerequisite for abductive reasoning (see Chapter 10, Section 10.4). A constructionist viewpoint accommodates openness and encourages mindfulness while promoting a relational yet critical stance. It was well suited for this thesis. The chosen methodology resulted in the synergy of a value-resonant framework, comparative multi-case study design and principles of research governance. This synergy fostered a sense of shared interest among the community nurses, the families and myself.

As this study demonstrates, a constructionist methodology is indispensable when the focus is on understanding co-constructed meanings; individual perspectives can be accommodated and strategies employed to guard against favouring one voice above others. The range and diversity captured in this work encompassed discipline, assessment practice, families and families’ needs. Similarly, it allowed connections with the rich theoretical perspectives embedded within community nursing practice, which are essential for the building of a co-constructed understanding. While this enquiry contributes new knowledge, it also adds to an evolving tradition of constructionist nursing research.

11.2.2 Theoretical Orientations
This thesis is evidence of the challenges that can be encountered in family research which aims to inform nursing practice. Symbolic interactionism and family systems theory offered conceptual scope for this enquiry. Both orientations reflected a deliberate choice from alternatives and allowed theory, family research methodology and community nursing practice to develop. The main challenge was to link meaningfully two theoretical perspectives in an overarching conceptual framework.

The purposeful interplay of these theoretical orientations with the data led to the building of plausible explanations of community-nurse family interaction. The explanatory framework demonstrated their utility. Such distinct theoretical conceptualisations are difficult to discard once immersion in the data begins, however. They preclude approaching the data with complete openness which an exploratory enquiry reputedly requires. From an interactionist perspective,
symbols may only display meaning superficially. More seriously, they may be devoid of meaning, if not given meaning or the meaning is not shared. Social relations and interactions may become vacuous or constrained by the situation. Interpretations may become displaced or biased, which compromises their trustworthiness.

A family systems theory focus is directed towards hierarchical structures, functional units and classifications indicative of a lack of experiential meaning in ‘human realities’. Indeed, some of the data supports this assertion. Interaction and reciprocity are regarded as creating interdependence between systems such as families, family functioning, health and illness, and health care environments in family systems nursing (Bell, 2009). However, ‘human systems’ depend on people to interpret situations and act in response to them (Blumer, 1972; Charon, 2007). While family systems theory offered useful structural conceptualisations, nurses and family members in this study responded of their own volition. They were actors, and gave meaning to and showed an awareness of their situation and its constraints.

Theoretical underpinnings are useful in order to apply conceptual order. The data and its analysis, however, highlighted that community nursing assessment practice and family life does not easily fit into an imposed order. Nonetheless, symbolic interactionism provided a useful pointer towards approaching the research problem and the data. The family systems theory perspective exerted a somewhat stronger normative influence and was less helpful for understanding the meaning given to phenomena. Conceptualisations from a symbolic interactionist and a family systems theory orientation made it possible to achieve a novel integration of these underpinnings, resulting in a plausible explanatory model as an ‘outcome’ of this thesis. This novel integration raises new questions in light of their comparative interplay, however. Some contend that these perspectives are difficult to reconcile (Blumer, 1972; Luhmann, 1995[1984]; Hall, 1998; Segaric & Hall, 2005; Charon, 2007). Examination of further differentiation and assimilation is merited when adopting these theoretical viewpoints to inform family health care practice.
11.2.3 The Multi-Case Study Design

In-depth understanding of the complex phenomenon of family health assessment was to be gained through multi-case study design. The aim was also for theoretical understanding to be advanced. Each case was linked with the research phenomenon. The features and elements of each case were to be explored, while accommodating their multiple dimensions and various actors. The case studies’ unique contexts and processes in terms of similarities and differences were to be captured. This required both procedural flexibility and a sound “conceptual structure” (Stake, 2006: 3 (italics in original)). This multi-case study design fulfilled these requirements and thereby added to the coherence sought in this thesis. It accommodated the ontological, epistemological and methodological assumptions that were brought to the research enterprise. Multi-case study design was well matched to both the research problem and the intention behind the approach.

A major influence on this design was Stake (1995; 2005; 2006), who argues that case study offers a holistic approach with which to unify multiple perspectives and methods. He also alludes to systems theory terminology, but without further explanatory reference to this social science paradigm. Instead, he favours a constructionist methodology. He emphasises the ideographic, descriptive intent, yet also implies a nomothetic, explanatory mode in methods. Inconsistencies in terminology cloud some of Stake’s language and his methodological premises. The guiding theoretical orientations selected for this case study assisted greatly in illuminating Stake’s approach. Hammersley (1989) recognises Diesing’s (1972) analysis of case study as a systemic design and its analytic scope in searching for patterns. Diesing’s work confirms systems theory’s utility for structuring multi-case study design. Systems theory provided a conceptual structure for approaching both the design and the data. Likewise, symbolic interactionism added an alternative perspective to the data and assisted in the construction of the various elements of the design. Meaning had to be given to the features and elements. Thus, the study became a deeply interactive and creative experience. While it required the acceptance of conceptual ambiguity and uncertainty, it also generated new insights, and compelling and robust evidence.
This multi-case study design allowed me to illustrate how theoretical concerns are manifest in each case study. It fostered my appreciation of shifts across different perceptual planes in relation to each case, and of the case study as a whole. These conceptual shifts were mirrored in the community nurses’ accounts of having to shift their focus from the individual to the family as a whole. While looking for associations in the data and between cases, the particular and the general could be recognised in their circular flow. This pattern recognition was facilitated through both the multi-levelled design features and data analyses.

This multi-case study was marked by a recursive flow from the binding concept (Stake, 2005) to binding cases and methods. Correspondingly, analytic progression moved from assimilation to integration and explanation, culminating in synthesis. This circular pattern demonstrates the integration of the research process and the content of enquiry within the specific context of different cases studies. Likewise, induction, deduction and abduction represented the building of an integrative, inferential scheme. The integration of this inferential scheme is a contribution to knowledge as it extends Stake’s understanding of the analytic process in multi-case study. Such knowledge construction fits well with an interactionist-constructionist enquiry - perhaps not such a surprise since it is traceable to one of the early pragmatists, Charles Sanders Pierce (Paavola, 2006). This type of integration was conceptually challenging and yet, seemed so straightforward once achieved. In that sense, this multi-case study generates holism in the investigation of the particular research phenomenon under consideration.

11.3 DISCUSSION OF KEY FINDING: STUDY OBJECTIVE ONE

To compare and contrast the meaning of ‘family’ from the community nurses’ and the families’ perspectives

11.3.1 Family as Relational Experience

There was a striking alignment in the meaning given to ‘family’ by both the community nurses and family members.

In each case the meaning of ‘family’ was perceived as a relational experience of a group of people characterised by their affectional bonds. While the community nurses further perceived an
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interactional and developmental life-span perspective, families regarded love, commitment, expectation, identity and stability as defining characteristics. Both community nurses and families considered ‘family’ as ‘self defined’, as cited by Wright & Leahey (1994; 2000; 2005). This finding supports the proposition of family put forward by Claveirole et al. (2001; see also Chapter 2, Section 2.5). ‘Family as relational experience’ also echoes the contextual model of family as proposed by Hartrick (1995) and further elaborated by Hartrick Doane & Varcoe (2005; 2006).

According to the reviewed literature, the dominant theoretical model of ‘family’ is grounded in a systems perspective. Some accommodation is made for variations in family configuration by looking at the family’s care needs, the health care environment and the nurse’s role (see Chapter 2, Section 2.3.3). The considerable overlap in theoretical descriptions of ‘family’ is noted by Segaric and Hall (2005). The above finding supports Segaric and Hall’s reservation about the dominant classification of ‘family’ into three practice models i.e. “family as context/family centred care; family as unit/family nursing; and family system theory/family systems nursing” (2005: 213). This classification may constrain practice knowledge. The data from this multi-case study was not sufficiently convincing enough to conclude that any of these models comprehensively and adequately represented community nurses’ practice knowledge of ‘family’. While each community nurse expressed the importance of taking a holistic view of the family and described structural and developmental elements, their perceptions were grounded in experiential insights and relational understandings they had gained over time. Their belief in ‘family’ as a necessary focus in their assessment practice seemed to confirm their experience. Their exposure to working with families had raised their awareness of family diversity and family features that were dynamic, could not be seen in isolation and were dependent on contexts and relations. Above all, their assessment practice had to be responsive to the variations in meanings co-created with family members in situations which changed with each home visit. Therefore, a relational-interactionist model of family proposed by Hartrick and Varcoe (2005; 2006) appears to be closer to community nursing practice and family members’ view of the meaning of family. For both, community nurses and families, ‘family’ comprised an experience of caring action, described by the district nurse in terms of “people that cared about you the most” and by the family member as “being like that”. A systemic family model may constrain nursing practice despite offering certain structural
conceptualisations. It appears to provide insufficient guidance in giving due regard to the reality of family life and the myriad of meanings that can be attributed to it.

The co-constructed meaning of ‘family’ presented in this study corresponds with the implicit phenomenon of ‘family care’. The family’s capability, and the extent to which family members required support, had to be explored and understood by the community nurse during home visits. Families valued support and advice, which helped them to care for family members. Nolan et al. (1995; 1996) conceptualise family care as involving internal and external family relationships, and mutual support based on complex affective responses. Crist (2005: 489) sees family care as integral to family relationships, but also recognises a family’s shared history. Shared values, relational experiences and developmental changes are constitutive elements of Hall’s (1998) family trajectory model. As the evidence presented in this thesis demonstrates, not one single theoretical perspective appears to be sufficient to fully conceptualise ‘family care’. Conceptual pluralism is recommended by Hanson (2001b) and Hartrick Doanne & Varcoe (2005). An amalgamation of concepts such as ‘family-centred health care nursing’ is suggested by Parfitt et al. (2006). Kean (2007) demonstrates the emergence of negotiated ‘family care’ in an intensive care environment at the interface between family and nursing systems. These nurses and families functioned within an imposed organisational structure, one which reflected a systems hierarchy. Community nurses and families in this study did not appear to experience the same degree of system control. While the negotiation of a working relationship still featured in all cases, the shared meaning of ‘family’ may have contributed towards an inclusive experience in family health assessment – the very focus of this thesis. While ‘family’ has to be understood as a relational experience, however, there remains a lack of consensus in the meaning attached to ‘family health’, ‘family care’, ‘family-centred care’, ‘family-centred health care’ and ‘family health care nursing’.
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11.4 Discussion of Key Findings: Study Objective Two

- To explore and describe community nurses’ and families’ understanding of family health assessment as experienced during home visits.

11.4.1 Being in the Equation

Family health assessment was seen as an inclusive, multi-layered experience of being in the equation.

The accounts of a health visitor, community children’s nurse, family health nurse and district nurse revealed that ‘family health assessment’ did not depend on role definition, role development or health care system requirements. For these community nurses, ‘family health assessment’ was an experience that was grounded in their belief in the integrity of families. Arguably, their response reflected “a value-based vision” of a community service delivery, as advocated in the recent Report by the Prime Minister’s Commission on the Future of Nursing and Midwifery in England (2010: 2). This required taking the family into account as a group of people while simultaneously integrating the specific needs of individual family members. The nurses’ accounts suggest that ‘family health assessment’ meets policy recommendations which promote service users’ inclusion in care, and the development of their self-care (SEHD, 2005a; 2006b). This contribution may not always be apparent as it is difficult to gain access to this type of practice. The community nurse carried out holistic assessments “recognising family members and carers as a vital part of effective delivery of care” (SEHD, 2006c: 23). Such an in-depth family assessment is a time-consuming and difficult process, as recognised by Macduff & West (2003). In this study, the community nurses’ discipline-specific focus combined with their family orientated approach and expertise was valued by families. Inclusion encompassed the community nurses’ recognition of the interdependence of the bio-psycho-social and spiritual nature of individual family members and the family group as proposed by Hanson (2001b). Such integrative and interactive working with families defined the community nurses’ understanding of ‘family health assessment’. Their accounts illustrate that ‘family health assessment’ cannot solely be understood on the basis of its instrumental components. Irrespective of the different assessment frameworks used, each community nurse took a broad approach to ensure that family members and their various situations were in the equation. The need to widen horizons in family care is discussed by Nolan et al. (1996: 34). In this study community nurses experienced ‘family health assessment’ as the expansion of horizons at multiple levels. Insight into community nurses’ approaches towards assessment performance in
the field of district nursing is noted in a study by Bryans (2000a). Bryans (2000a: 201) refers to “interpenetration” between theoretical and practical aspects of community nurses’ knowledge. Kennedy McAuley (2000) found an interrelationship between district nurses’ experiential structuring of assessment processes and their theoretical assessment frameworks. In this study, the subtle integration of professional beliefs, attitudes, ethical conduct, assessment frameworks, knowledge, skills and experience contributed to the inclusive and interactive components of family health assessment. A sentiment of solidarity could be traced through all these components.

11.4.2 Promoting Solidarity

The community nurses promoted solidarity by taking a family orientated approach, which involved balancing the intrusion into family life with the families’ need for privacy.

The approach taken by four community nurses in different fields of practice can be described as family orientated. Nursing concerns were directed mainly towards the collectively interrelated health issues, rather than those pertaining to the individual alone. Family members shared this collective orientation. This mutual endeavour promoted solidarity at different levels and on different occasions, and required the community nurses to shift focus continually between individual family members, the family group and their environmental context. Such shifts appeared to help these nurses keep the many complex phenomena in the equation. An ability to achieve such necessary focal shifts may not just be a matter of knowledge and skills. Maturity and reflective practice “toward higher levels of consciousness” (Newman, 2008: 5) and “professional artistry” (McIntosh, 1996: 321) appear to be further attributes.

The commitment towards the family as an interrelated group of people appears to have been the aim of the community nurses in this study. This commitment indicated the nurses’ core values, as identified in recent health care guidance (SEHD, 2006c). The significance of this finding supports Benzein et al.’s (2004) argument that a nurse’s belief reflects the meaning and value given to family health care. Professional values may generate a strong impetus towards practicing with clinical autonomy, even against the background of a perceived lack of control over nursing practice at an operational level (Weston, 2008). In three cases, the community nurses’ aspirations towards providing a family orientated health assessment resulted in feelings of tension. Family
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information had been gained that extended beyond an individual focus. The structure of case notes, however, did not allow for a coherent integration of this information.

Through their experience, community nurses realised the need to protect family privacy, set against the perceived intrusion necessary for information seeking activities inherent within health care provision. Clinical autonomy was exercised, based on their professional judgment within the context of inter- and multi-professional working practices that governed the sharing of this information. These community nurses fulfilled their obligations associated with their public health roles and practised according to policy principles (SEHD, 2006c: 25). Ethical implications of family health assessments are rarely discussed in the literature, although Whyte (1997b: 205) is unequivocal about the individual’s right to privacy and family values in “ethical family nursing practice” - an ethical premise reflected in the Human Rights Act 1998 (UK) and the Data Protection Act 1998 (UK). Although aware of legislative and professional requirements, the community nurse in each case study developed her own strategy to protect family privacy. Nonetheless, family information contributed to the “grey areas of practice” (Allison & Ewens, 1998: 447). Actions based on disclosed family information and a perception of ‘in the family’s best interest’ will create tensions. Information-sharing involves family members who may not be in agreement about the disclosure of confidential and sensitive issues. Potentially sensitive information may come to the surface when drawing a Genogram, compromising individual family members. This may involve matters of guardianship for a child, or other kinship issues. Permission would be required to keep this information in the nursing case notes. The disclosure of such potentially sensitive information may cause difficulties for the family as a whole. Further complexities may result within families from culturally and ethnically diverse backgrounds (Hannssen, 2004; Coyne, 2007). One solution offered by Allison & Ewens (1998) is to set ground rules. Specially developed additional case notes, as suggested by the FHN in this study, can be seen as a possible alternative solution. Nonetheless, vigilance should be exercised by the community nurse when it comes to fulfilling legal requirements, to avoid compromising a relationship of trust (SEHD, 2006c).
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11.4.3 A Therapeutic Encounter
The families experienced the home visits as a therapeutic encounter with a trusted nurse; they did not view the home visits as an assessment but rather as ongoing conversations that were highly valued for the continuity of care provided by the community nurses.

For the families in the four case studies, assessment of their health needs and concerns appeared to be associated with the nurses’ relational bonding qualities. Decisions on action were founded on these qualities, which made home visits meaningful for all family members. This finding resonates with the literature. Relationship-centred care is a profound and relevant concept for the promotion of family health care which requires going beyond person-centred care (Robinson, 1996; Hartrick, 1997; 1998; Nolan et al., 2003; Hartrick Doanne & Varcoe, 2005). The preference for co-creating such meaningful and long term relations between community nurses and families for care delivery, however, is difficult to reconcile with corporate case load management initiatives (Wilson, 2007; Holden, 2007). The community nurses’ unique professional contribution, expertise and personal qualities were highly valued by the families. These promoted confidence in self care which families were keen to adopt. Therefore, family health assessment practice conducted by a community nurse with a discipline-specific remit is worthy of retention, as advocated by Pollock (2009). Professional judgments are likely to be more differentiated and responsive through expertise built on experience (Bryans & McIntosh, 2000). Such judgments, in relation to disclosure of family information, become even more important in light of the families’ experiences. The perceived therapeutic nature of the visits was associated with the relational dimension that developed over time and through continuity. From both the families’ and the community nurses’ perspectives, time and continuity made it possible for trust to develop and for an ongoing conversation to flourish. Such co-constructed family orientated interactions are described by Benzein et al. (2008: 109) as “health-promoting conversations”. In this study such conversations were finely tuned to the specific needs of each family.

Moreover, akin to Carney et al.’s (1996) finding about ‘need’ being differently defined by patient or professional, ‘family health assessment’ is a socially constructed phenomenon as the four case studies confirmed. The professionally shared meaning of ‘family health assessment’ indicated the building of a layered conceptual scheme guided by a specific framework, perceptions and interactional experience. The community nurses gave an account of a multi-layered exploration of
family concerns that took place during home visits. The families perceived these as therapeutic encounters; they appreciated being approached with openness, respect and a genuine interest.

These sophisticated processes, with sometimes competing aims, have professional implications which the community nurses appeared to sense as they navigated through the documentation necessary for meeting health care system requirements. Of equal importance were the economic-political implications for families. Decisions based on a family health assessment may lack transparency for families, especially within a multi-agency environment hampered by resource constraints. Faced with the decision-making power and recently introduced primacy of corporate requirements, the importance of relational nursing care requires the community nurse to adopt a family advocacy role. In this study, the community nurses acted as gatekeepers to resources, a role commonly associated with General Practitioners (GPs) in NHS primary care in the UK. The community nurses intervened to provide some of the families with significant resources - families that would have been deprived of substantial health interventions without the community nurse’s support. As the data confirmed, responding to the health care needs of a group of people becomes more resource intensive. Alternatively, a corporate climate which encourages the promotion of partnership working and information-sharing across agencies could include giving family members space to speak on their own behalf, in order to keep both a perceived overbearing collective-professional gaze and a potentially overbearing corporate-professional force at bay. The process of the allocation of scarce health care resources may become more transparent when families are given the opportunity to take a role in service re-design (SEHD, 2005a). Together, families who require these resources and health and social care professionals who distribute them could discharge self-care and collective care with a sense of responsible citizenship and genuine partnership. As the review of the policy literature has indicated, the translation of their frameworks into operational processes creates challenges for each profession and for multi-disciplinary, inter-agency and partnership working. For families to assume a meaningful role in such modes of working, their stake in the decision-making process regarding family health care should be enhanced.
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11.5 DISCUSSION OF KEY FINDINGS: STUDY OBJECTIVE THREE

- To analyse and explain the process of interaction between the community nurse and family members and/or carers during home visits in order to inform family health assessment practice.

11.5.1 Family Health Assessment: A Relational Inquiry

Interactions between the community nurses and family members indicated that a sophisticated ‘relational inquiry’ had taken place.

Community nurses are charged to “become ‘enablers’ of individuals’ self care” (SEHD, 2006b: 17). In this sense there is an over-emphasis on the individual and the distinction between ‘individual’ and ‘carer’ or other family members. A perception of discreet roles blurs the necessary collective focus - and the relational bond - between two individuals involved in the reciprocal activity of caring for and about each other. This thesis adopts a collective focus and the data defines ‘family’ as a group of at least two people related by affectional bonds. The community nurses in this study also applied this collective focus to their assessment practice. They described following the families’ lead to gain insight into their health practices and health concerns, without which ‘self-care’, or rather ‘family care’, could not be mobilised. Assessment and intervention required the community nurses to lead the dialogue, which enabled them to pursue their agenda strategically in “supporting anticipatory care” (SEHD, 2006b: 18). While Hartrick Doanne & Varcoe (2005: 228) refer to “[f]ollowing the Lead of Families” as an interactive response to relational nursing practice, their framework does not consider the purposeful leading of such interaction. Home visit interactions, however, displayed alternating sequences where either the nurse or family members took the lead. These alternating sequences did not appear detrimental to their collaborative efforts. Indeed nurse-led responses, such as commending the family and responding empathically, were of therapeutic impact as were receiving support and advice.

The therapeutic impact of reflexive-interactive conversations with family members identified in these four case studies reflects the findings in a study by Bryans (2003) on health visitors’ interactions with mothers during home visits. In this study, conversations were nurse-led to promote different types of question-answer sequences. These were largely diagnostic-inquiry and therapeutic-inquiry interventions. Just as important was the ‘listening’ component of this
interaction process. As in Whyte’s study (1994), ‘listening’ was essential for the nurse in order to understand the family story. Analysis of the interaction and interview data in the four cases confirms the concept’s fit as an element proposed in Whyte’s (1997a) Family Systems Nursing Assessment Model. While ‘listening’ signalled acknowledgment of the family’s view point, it also meant each family member was being heard. ‘Being listened to’ became a therapeutic experience for the family at multiple levels. As a subtle component of polyphony in interaction, ‘listening’ and ‘being listened to’ gave further meaning to the “relational inquiry” (Hartrick Doane & Varcoe, 2005: 214). Silverstein et al., (2006) propose a relational framework based on family therapy. Their analysis of cases highlights the fluidity of relational orientations within a given social context. They regard these as “internal ways of experiencing oneself in relation to others” (Silverstein et al., 2006: 393). While participants’ accounts in this study shed some insight into their experience, their relational orientation became evident during their interaction. Moments of reflective silence were created which Benzein et al. (2008: 109) note offer “a way of giving room for internal dialogue for both families and nurses”. The sophisticated exploration of health needs fits Tolson & West’s (2001) description of nursing services. Practice in this study was nurse-led, responsive, and holistic. Holistic, however, meant both - family-person centred and person-family centred as displayed in conversation sequences. The data also confirmed assessment practice as an alternation of nurse-led and family-led reflexive interaction.

Reflexive-interactive conversation is time-consuming, as the length of the home visits demonstrated. Home visits require negotiation regarding timing so that all family members can be heard. Moreover, a relational inquiry invokes a meandering conversation that is not easily led, an experience revealed by the community nurse in each case study. The meandering flow saw ‘circularity’ emerge as an important phenomenon in the interaction process. ‘Circularity’ was identified by Whyte (1997a) as a phenomenon of family members’ experience and its impact over time. Whyte interpreted ‘circularity’ from a systems theory perspective. In this study, the concept of circularity was interpreted from an interactionist as well as a systems theory, orientation. This led to novel explanations (see Chapter 10, Section 10.7).
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11.5.2 An Interaction Model of Family Health Assessment

In the assessment practice of the health visitor, the community children’s nurse, the family health nurse and the district nurse, conversational sequences showed four distinct circular interaction patterns from which an explanatory model of family health assessment was constructed.

Nurse-family interaction in family health assessment was a recursive flow of conversational sequences that showed consistent thematic patterns across all four case studies. Each interaction theme also featured as a constitutive element of conversational sequences. Their transformation into recursive-alternating patterns reflected conversational content. These distinct configurations carried conceptual meaning which was grounded in the co-constructed realities of the four community nurses and four families. As defined concepts, the conversational sequences are connected by hypothesised relationships (see Chapter 10, Section 10). Therefore, this explanatory framework can justifiably be referred to as a Family Health Assessment Interaction Model (FHAIM). It represents a model of health care assessment grounded in a “positive and equitable engagement with patients, families and carers as the central focus of care” (SEHD, 2006c: 55).

The defining configuration was family orientated health issues – family talk. This pattern featured strongly in three of the cases, demonstrating the centrality of families in the assessment process and its impact on the community nurses’ assessment practice. In unison with further conversational sequences, polyphony and circularity in interaction was created, with some patterns more harmonious than others. Polyphony in interaction related not only to different voices in the nurse-family encounter, but also to the interplay of its components. Together, they added to the nature of family health assessment as a sophisticated relational process in which the family was central to the community nurses’ concerns. In the interaction pattern family orientated health issues – family talk, the ‘healthy family’ was positioned ‘centre-stage’. The community nurses demonstrated their professional competence in meeting WHO’s recommendations (WHO Regional Office for Europe, 1998; 1999; 2000a). The central position of families in health policy matters appears to have become eroded, however. In Macduff’s analysis of the latest community nursing review (SEHD, 2006b), the family no longer appears to be of “a focal concern” (Macduff, 2007: 252). That said, a “family health assessment” is regarded as “a critical difference in the perspective of the FHN, as opposed to social workers” (WHO Regional Office for Europe, 2006: 4
(italics in original). In this study each community nurse conducted a family health assessment. Their breadth of experience and skill helped them to identify health care needs that affected the whole family. Professional role diversity was particularly well matched to the health care needs of a diverse population such as families. This finding challenges the need for a new type of ‘family health nurse’ and a new generic role of ‘community health nurse’. The four community nurses exercised their ‘value-based vision’, which appeared grounded in their discipline-specific expertise. This finding calls into question whether policy rhetoric (SEHD, 2006c) alone can be the measure for nursing practice (Macduff, 2007: 241) and whether a whole system change is required to promote “family-centred health care” (Parfitt et al., 2006: 33).

The data indicates that community nurses adopt a longer term and more professionally grounded approach in their nursing work with families compared with government initiatives. The family’s positioning, however, is a co-constructed concern - the family took on their role, at times enthusiastically. This mutual concern meant ‘being in relation’ in order to get to know those present and their points of view. It confirms that family health assessment means “entering into relation with families” (Hartrick Doanne & Varcoe, 2005: 228). Meaning was co-created from this “relational activity” as suggested by Seikkula & Trimble (2005: 266). In this study, meaning was configured into the thematic conversational sequences of family orientated health issues (FOHI), professional concerns (PC), family talk (FT), patient health concerns (PHC) and building relations (BR) as the situation required. These interaction patterns represent the FHAIM shown in diagrammatic form in Figure 11.1.

![Diagram of Family Health Assessment Interaction Model](image-url)

**Figure 11.1: Family Health Assessment Interaction Model**
In these recurring patterns the community nurse and family members recognised patterns of family health or ill-health. This mutual process continued until understanding developed incrementally. It created patterns of interaction and promoted pattern recognition. In turn, it expanded horizons for both the nurse and the family in their pursuit of health. These sophisticated processes fit Newman’s (2008: 5 (bold in original)) proposition that “[h]ealth is the expansion of consciousness”, where meaning is created holistically. Newman defines ‘holistic’ as a mode of consciousness that is “nonlinear, simultaneous, intuitive, and concerned with relationships rather than the elements that are related” (Newman, 2008: 38 (italics in original)).

The findings in this study display these multi-layered, interrelated experiences, relationships and circular interaction patterns. These show a resemblance to Appleton and Cowley’s (2008) seven principles of the health visitors’ assessment process. Based on their data which was gained from examining health visitors’ interactions using a multi-case study, Appleton and Cowley (2008: 237) present “[e]ssential principles”. These resonate with the circular and integrative nature of elements, experiences and interaction patterns also uncovered in this study. Three of Appleton and Cowley’s defining principles are also described as critical attributes of health visitors’ assessment: (1) the holistic; (2) the multifactorial and complex nature of the process; and (3) the potentially unmet needs of all clients. While Appleton and Cowley do not differentiate between ‘clients’ and family members as such, these three principles are embedded in the interaction theme family orientated health issues. Correspondingly, the conversational sequences of building relations align with Appleton and Cowley’s principle (4) of the ongoing nature of the process that depends on relationship building to sustain its purpose. Moreover, as Appleton and Cowley suggest, the assessment process is (5) difficult to articulate, (6) influenced by personal values and requires (7) prioritisation. These are described as further characteristics. Indeed, these attributes were borne out in the data of this multi-case study which drew on four different fields of practice. The thematic conversational sequences of professional concerns comprised community nurses intentions which were prioritised, context specific and yet constrained by the situation as was also indicated by Appleton and Cowley (2008). Therefore, if community nurses in different fields of practice intend to conduct a holistic assessment, they need to reflect on their personal values in order to bring about co-created meanings with family members. A ‘value-based vision’ calls thus for an awareness of these practice values. To promote such awareness would also require being
clear about the different conceptual meanings of 'family'; on how to differentiate between family members; and in recognising needs both individual and collective.

In this study 'health promoting conversations' raised such an awareness and understanding of need for those present. This confirms Latimer’s claim “that it is the nurse-patient [family] relationship which acts as the central medium through which all understandings of need must ‘pass’” (Latimer, 2000: 127 (italics added)). Dickinson et al. (2006: 319) interpreted the relationship between nurses and families as a “complex and intricately woven” web. Participating families in their study described this relationship to be made up of more "'simple stuff’" (Dickinson et al., 2006: 319). In this study building relations, as one of the constitutive elements of the circular interaction model, was defined by just such an easy-going atmosphere. Some community nurses experienced this interaction pattern as ‘chit-chat’ which lacked instrumental purpose. However, it contributed to the relational bonding necessary to reach deeper beneath the surface for the more ‘complex’ issues. Hartrick Doanne & Varcoe (2005: 229) offer a number of premises which they view as “central to relational family nursing practice”. One of these is “[l]ooking beyond the surface” (Hartrick Doanne & Varcoe, 2005: 228). For the community nurses in this study, achieving this meant allowing a relational bond to develop through a variety of different ways. For example, the occurrence of family talk required them to take the role of silent witness to family interaction - before continuing to move forward together. Therefore, it is unlikely that a family health assessment can be meaningful and sufficiently exploratory if it is conducted solely with standardised assessment plans, tools or measurement scales. A similar point is made by Nolan et al. (1996), supported by family perceptions about the selective and standardised introduction of family health plans (Sanders, 2002; Cowley & Houston, 2003; Shucksmith et al., 2003; Sanders, 2006); their unreflective use by nurses has also been questioned by Hartrick Doanne & Varcoe (2005). For example, a standardised family health assessment and zoning tool has been introduced into local policy by a community health care organisation in England (Goff, 2009). It focuses specifically on vulnerable families. Elkan et al. (2001) argue that targeted family services leave out large sections of the population who experience health problems. Families suffering role strain due to long-term care demands may then be deprived of the benefit of a family health assessment. An inappropriate, selective use of family health plans as family health assessment may increase dissonance in family health care.
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11.5.3 Harmony and Dissonance

The community nurses’ recorded case notes did not mirror the depth and breadth of the shared assessment information and the thread of relationship that was embedded in nurse-family interactions.

Family health assessment is an ethically grounded and purposeful conversation with a relational dimension and binding quality. As proposed in Newman’s model of nurse-patient interaction (2008: 35), family health assessment facilitates “recognition, insight and transformation” in a recurring process, where the community nurse and family members “come together and move apart again”. At its centre, arguably, lie elements of “caritas” as a notion of care (O’Sullivan Burchard, 2005: 367) and “solidarity” as a “collective direction” (Durkheim, 1972: 144), rather than theoretical constructs. Theoretical frameworks provide only the scaffolding for building knowledge and skills for nursing work with families, and may require revision and re-evaluation once this has been achieved. Experience gained in this process of construction provides stability, yet, also allows for flexibility in response to family diversity. This represents ‘Bereitschaft’, a German term which indicates a readiness, preparedness, alertness and willingness to act even without prior knowledge of what may be required. It may call for an acceptance of having to forego pre-determined plans or actions in response to an unpredictable situation. This ‘Bereitschaft’ was displayed in the community nurses’ accounts and interactions and was demonstrated during home visits in which patterned circular regularities in interaction reflected both “the boundlessness of human interrelatedness” (Arendt, 1969: 190) and “its inherent unpredictability” (Arendt, 1969: 191). It may defy a holistic, systemic grasp. Thus the interaction process cannot be taken for granted despite its apparent regularities; it continually emerges within and between people, only to subside again, and remains situated in time and context. Such circular interaction calls for ‘Bereitschaft’ in order to respond with openness - an openness displayed by the community nurses which the families valued.

These elements of interaction contributed to an understanding of the challenges experienced by the health visitor, the children’s community nurse, the family health nurse and the district nurse. One of these challenges entailed the charting of family information with its intertwined threads of relationship and therapeutic impact. These highlighted discrepancies in practice, even when assisted by a relevant framework and documentation. Cheevakasemsook et al., (2006) found the
problematic nature of documenting nursing care to be related to disruption, incompleteness and inappropriate charting in individual care giving situations. Findings from a recent Cochrane review confirm the inadequacy of articulating the purpose of record keeping in nursing (Urquhart et al., 2009). Charting the assessment information of a group of people, such as a family, can only add to the complexities of such a task, especially if the lack of professional consensus and conceptualisation of family health care continue to remain unaddressed. The work of the community nurses in this study demonstrated a sense of the ‘boundlessness’ and ‘unpredictability’ of home visits and their documentary challenges. Some of which echoed those in a recent evaluation of the West of Scotland family health record (McIntosh & Astbury, 2008). While discretion in recording family information required to be exercised, informed by organisational, legal and professional requirements, a defining dimension of nursing work, with families was lost - the thread of relationship as a constitutive element with which therapeutic nursing practice during assessment home visits became meaningful to both the community nurse and the family. This dimension remained in a transient realm. The lack of evidence of such a significant dimension of community nurses’ work in nursing case notes is not only a loss to inter-professional and multi-agency working practices, but more importantly it also results in a professional impoverishment regarding the perceptions of nursing care: “relationships are not central to care, they are care” (Robinson, 1996: 153 (italics in original)). Such impoverishment can only be to the detriment of families and of the nursing profession as a whole.

11.6 DISCUSSION OF KEY FINDING: STUDY OBJECTIVE FOUR

- To examine the usefulness of a family-derived theoretical assessment framework in community nursing

11.6.1 Recognising Pluralism

A family-derived theoretical assessment framework helped with the mutual exploration of health needs and concerns.

The families’ structural, developmental and functional health dimensions were embedded in the conversations that occurred during home visits. Although varied in extent, uncovering these dimensions in the assessment practice of community nurses from four disciplines lends credibility to Wright & Leahey’s family assessment model (2000; 2005). While providing a structure for the
classification of family information, these dimensions were also reference points without any indication of process. The community nurses’ intentions had been to promote family health. The families were keen to recover good health through self-care, i.e. family care as far as that was achievable. This collective concern was informed by a variety of assessment frameworks which the community nurse applied to the family situation. Inclusiveness created a multi-layered, interrelated experience, of which the assessment frameworks were a part. Each community nurse demonstrated an awareness of her unique professional contribution grounded in her aspirations and experiences of working with families. This was bound up with professional knowledge and the use of a particular assessment framework to influence the assessment processes. While the family health assessment process in four cases was theoretically informed, this theoretical steer would have benefited from a fuller integration into the nursing documentation, a professional challenge also suggested by Urquhart et al. (2009). The FHAIM developed in this study may provide some principles on which to build in support of such developments in nursing records.

Macduff (2005) speculates that family health nurses may experience tension as primary care services are designed to focus on individuals. However, in this study it was the family health nurse who appeared to be the least perturbed. Her practice showed the most coherent fit between her beliefs, assessment framework, practice and documentation. Furthermore, her family health assessment was the most integrated, thanks to the alignment of a family-derived assessment framework with its documentation. This documentation included a family health plan which, contrary to Shucksmith’s (2003) concern, was not perceived as stigmatising. The completion of a Genogram was part of the family health assessment and was informed by Wright & Leahey’s Calgary Family Assessment Model (2000). Assessment practice fitted into the Scottish perception of family health nursing (SEHD, 2003b). It has come to be associated with the FHN role, which was seen to be dependent on service development (Macduff, 2005).

The community children’s nurse also used an integrated family-derived assessment framework. As well as drawing theoretically on Gottlieb & Rowat (1987); Wright & Leahey (1994); Roper et al., (1996) and Whyte (1997a), it was developed in practice through action research (Whyte et al., 1998). Home visits by the health visitor were structured around the Child Development
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Programme devised by Barker (1987) and Orr (1992), which had a family-derived focus for assessment and intervention. The programme had been positively evaluated in the UK (Hogg & Worth, 2000). The district nurse took direction for developing an assessment framework from Roper et al. (2000) and Orem (2001). Although not family-derived, the district nurse’s assessment practice and documentation demonstrated a collective approach. Each community nurse provided family health care; each family gained confidence when it came to undertaking family care. A pluralistic approach towards realising their ambitions is evident from this study.

From the literature, the predicament surrounding the need for a common and consistent language in policy and practice for nursing work with families became apparent. In her recent work, Kean (2007: 304-305) traces the genealogy of ‘family nursing’ from its roots as a term coined by Wright & Leahey (1990) which was based on a pragmatic decision to promote family focused nursing practice. Kean cites Wright & Leahey as renouncing this term, stating: “[w]e now prefer the term families in nursing, as it captures an aspect of nursing at the generalist level” (Wright & Leahey, 1994: 12). As Kean recognises, ‘family nursing’ had become a political utility creating “the current conceptual ‘muddle’ as to what is actually meant by it amongst nurses” (Kean, 2007: 304). Kean speculates that this is a contributing factor to “the lack of family nursing theories” and subsequently questions “the usefulness of an exclusive family nursing theory” (Kean, 2007: 304). This study confirms that ‘family nursing theory’ is not an exclusive requirement, at least not as a theoretical assessment framework. A family-derived theoretical assessment framework helped with the mutual exploration of family health needs and concerns. More influential, however, was the community nurses’ belief in, and determination to adhere to, the importance of being inclusive of family members. Therefore, the provision of family health care goes beyond an instrumental activity. Nursing practice which aims to centre care on the family has to be understood philosophically, ontologically, interactionally and systemically. Early pragmatists such as William James (James, 1975) and George Herbert Mead (Mead, 1967[1934]) recognised the tension that exists between the individual and the collective. This dilemma is reflected in the quest for ‘holism’ – that is, the attempting to integrate parts into systems (von Bertalanffy, 1968). As Denham (2003) recognises, giving simultaneous attention to the whole and its parts is difficult. Such integration requires involvement in interaction and the ability to discern its symbolic meaning (Blumer, 1969). For nursing work with families, however, simply ‘being in relation’ is
insufficient to meet the demands of organisational systems in which community nurses must operate. Health care systems create boundaries which the community nurses have to cross. System boundaries also impede family care in intensive care, where overcoming such barriers requires negotiation (Kean, 2007). Kean interprets this as a negotiated order. The findings of this study accord with the pragmatic and pluralistic approach to family nursing as relational inquiry that is advocated by Hartrick Doane & Varcoe (2006).

Within the primary health care environment of this study, the FHAIM comprises the collective, interrelated family health care needs (family orientated health issues); the nurse’s instrumental care intentions (professional concerns); the shared family experience (family talk); the individual family member’s needs (patient health concerns), and the community nurse’s and family’s shared relational experience (building relations). These elements merge into polyphony and circularity, creating a whole out of parts during each home visit. This model is a symbolic representation of the family health assessment process. The interplay of theoretical conceptualisations and the data resulted in a construction that represents an empirically grounded, community nurse-family derived and family-centred assessment framework. The usefulness of a family-derived theoretical assessment framework became evident in this study. Although plausible and value-based, the utility of the FHAIM remains uncertain. However, this thesis demonstrates that a pragmatic and pluralistic approach offers scope for the assessment practice of community nurses. Such an approach would have to accommodate both a collective and an individual focus in order to meet a family’s health needs. It would require the capacity to continually make conceptual as well as perceptual changes. Such a change in focus was recognised as problematic throughout the Evaluation of the WHO Multinational FHN Study (WHO Regional Office for Europe, 2006: 9). Whether the approach is ‘family nursing’ or caring for ‘families in nursing’, such a family orientation is indispensable for ‘family health care’ in support of ‘family care’.

11.7 RECOMMENDATIONS
This study demonstrates that community nurses from four disciplines conducted a family health assessment using a family orientated approach. The community nurses described their assessment practice within their remit, which confirmed each discipline’s contribution to family
Chapter 11 Final Discussion, Recommendations and Conclusion

health care. The community nurses focused their assessment practice on families’ health care needs irrespective of policy rhetoric or organisational requirements. Nonetheless, they fulfilled their public health role as their focus was on the collective, interrelated health problems of families. Although varied in each case, the community nurse took an integrative service approach as recommended by Scottish Government (SEHD, 2006b). Key principles in the development of theoretically informed and empirically grounded documentation in support of family health care can also be identified, which echo suggestions made in a recent Cochrane review (Urquhart, et al, 2009). The findings are from a relatively small sample; nevertheless, a range of recommendations flow from these.

11.7.1 Recommendation for Policy

- Family representatives should be more actively involved in the decision-making processes at service level for the allocation of their required health/social care resources and evaluation of service provision and documentation.

11.7.2 Recommendations for Practice

- Community nursing documentation, informed by family-derived nursing theory and family research should be developed. It should accommodate the key principles of collective, interrelated family health care needs; nurses’ instrumental care intentions; shared family experiences; individual family members’ needs; and community nurses’ and families’ shared relational experience.

- Conditions for therapeutic conversation with families should be created, in ways that align with the conceptual framework used by the community nurse to provide family health care, along with the necessary recording documentation.

- Continuing professional development that focuses on communication/inquiry skills in support of relational-therapeutic family health care practice should be provided.

- Current nursing documentation should be evaluated for fitness of purpose in providing discipline-specific family health care, especially when considering incorporation into health care information systems.
11.7.3 Recommendations for Education

- Curricula for undergraduate nurses should include a systematic and progressive introduction to ‘family health care’ and communication skills for family/group settings supported by family-derived theoretical frameworks.
- Post-graduate nurse education should offer advanced exposure to, and critical engagement with, family health care perspectives and family-derived theoretical frameworks that will promote discipline-specific and multi-disciplinary dialogue in family health care practice.

11.7.4 Recommendations for Research

- Relational models for assessing family health should be further developed and tested through research.
- Opportunities for methodological advance using theoretical perspectives such as symbolic interactionism, systems theory and interpretivism should be grasped. Advantages should be taken of combining different methods of data collection.
- Intervention studies should be conducted into family health care that is provided by community nurses within a comparative, inter-professional context.
CONCLUSION

The WHO European Region Family Health Nurse Initiative was brought to a close at the fifth WHO workshop in 2006 (WHO Regional Office for Europe, 2006). Representatives of the six participating countries agreed on the concept and the value of the Family Health Nurse. While they accepted variations in terminology of this role across the European regions, delegates concluded that family health nurses’ main functions “are dealing with families, combining public health and care and working in homes” (WHO Regional Office for Europe, 2006: 13). Informed by the policy initiative and its evaluations, the panel members concluded that commonalities existed across fields of practice such as “family health nursing and community / home care nursing” (WHO Regional Office for Europe, 2006: 13). This multi-case study provides evidence in support of both conclusions.

The findings of this study are of interest to national policy makers and contribute to the international debate surrounding family health care. Both the co-constructed accounts of the four community nurses and families, and their interactions during home visits, confirmed their mutual concerns about family health. While the community nurses considered public health, health promotion and disease prevention issues in their assessment practice, they also contributed to family health via their discipline-specific knowledge base. In that sense, each community nurse demonstrated a highly integrative approach towards her family health assessment practice, one that was valued by each family. This type of family health care practice is perhaps not sufficiently recognised by policy makers. With evidence from family research in primary health care settings still limited, this thesis makes a contribution towards filling this knowledge gap.

Based on the findings, a family health assessment interaction model (FHAIM) was constructed to inform the assessment practice of community nurses working with families. This model explains the process of family health assessment in the four cases. While the utility of this model would benefit from wider testing across the primary health care sector, it provides an empirically-grounded conceptual framework generated from community nurse-family interaction in four different disciplines. This Family Health Assessment Interaction Model, family-derived and family-centred, contributes to the development of family health care practice.
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The methodological-theoretical approach taken in this study has confirmed the value of a constructionist viewpoint for family research. This approach facilitated analytic procedures within the structural confines of a comparative multi-case study design. An innovative conceptual framework combined with a broad inferential scheme of induction, deduction and abduction resulted in a fusion of two theoretical perspectives. It also extended understanding of multi-case study procedures thereby contributing to methodological debate. While the study’s findings confirm the credibility and relative value of a family-derived assessment framework, the usefulness of a pluralistic theoretical approach to family health assessment is also underscored.

The study raises new questions about some of the distinguishing premises of a symbolic interactionist and systems perspective on family health care that are suggested in the literature. This thesis, therefore, advances the debate about policy, practice, theory and research in nursing work with families.
APPENDIX A – CONSENT FORMS

CONSENT FORM FOR COMMUNITY NURSES

Title of Project: An Exploration of Family Nursing Assessment and Decision Making: a multiple case study

Name of Researcher: Dorothee O’Sullivan Burchard

1. I confirm that I have read and understand the information sheet dated ......... for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I give permission for the researcher to look at nursing documentation that arises from my home visits of the selected families.

4. I understand that a maximum of up to five of my visits to a selected family will either be audio-recorded and / or observed.

5. I agree to two visits being audio-recorded and observed by the researcher.

6. I agree to up to three further visits being audio-recorded.

7. I understand that a maximum of up to four interviews with the researcher either before or after my home visit will be audio-recorded.

I agree to take part in the above study.

Name of Community Nurse (in capitals) Date Signature

Name of Researcher Date Signature

1 copy for community nurse, 1 copy for researcher, 1 copy to be kept with community nursing notes
CONSENT FORM FOR FAMILY / HOUSEHOLD MEMBER AND /OR PERSON WITH LEGAL / PARENTAL RESPONSIBILITY

Title of Project: An Exploration of Family Nursing Assessment and Decision Making: a multiple case study

Name of Researcher: Dorothee O'Sullivan Burchard

Please initial box

1. I confirm that I have read and understand the information sheet dated ....... for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my nursing care or legal rights being affected.

3. I understand that sections of any of my health care notes may be looked at by the researcher where it is relevant to my taking part in the research. I give permission for the researcher to have access to my health records.

4. I understand that a maximum of up to five visits my community nurse makes will either be observed by Dorothee O'Sullivan Burchard and/or audio-recorded.

   I agree to two visits by my community nurse being audio-recorded and observed by the researcher.

   I agree to up to three further visits by the community nurse being audio-recorded.

5. I understand that a maximum of up to four interviews with the researcher either before or after the home visit by my community nurse will be audio-recorded.

6. I agree to take part in the above study.

Name of Family/Household Member (in capitals) Date Signature

Name of Researcher Date Signature

(If applicable)
As the person with legal/parental responsibility of

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

(please insert names of children under 12 years)

I give the researcher permission to access the health records of the above named.

Name of person with legal/parental responsibility  Date  Signature

1 copy for each family/household member, 1 copy for researcher, 1 copy to be kept with community nursing notes
ASSENT FORM FOR CHILDREN AND YOUNG PEOPLE
(to be signed by the child if 6 to 15 years and their parent/guardian)
(Assent means saying that you agree to do something)

Title of Project: An Exploration of Family Nursing Assessment and Decision Making: a multiple case study

Name of Researcher: Dorothee O’Sullivan Burchard

Please put a circle round your answer

1. Have you read about the project? Yes  No
2. Has someone else told you about the project? Yes  No
3. Do you understand what the project is about? Yes  No
4. Have you asked any questions you want? Yes  No
5. Have you had your questions answered? Yes  No
6. Are you happy for the person who explained the project to you to look at what’s written about your health? Yes  No
7. Are you happy to take part? Yes  No

If you don’t want to take part, don’t sign your name!

If you do want to take part, please write your name and today’s date.

Your Name..................................................................................Date..............................................

Your parent or guardian must write their name here too if they are happy for you to do the project.
Appendices

Print Name.........................................................................................................................................................

Sign................................................................................................................................................................
Date...........................................................................................................................................................

The person who explained the project to you needs to sign too.

Print Name.........................................................................................................................................................

Sign................................................................................................................................................................
Date...........................................................................................................................................................

1 copy for child/young person, 1 copy for parent/guardian, 1 copy for researcher, 1 copy to be kept with community
nursing notes/health record
APPENDIX B – INFORMATION SHEETS

AN EXPLORATION OF FAMILY NURSING ASSESSMENT AND DECISION MAKING

Information Sheet for Community Nurses

You are being invited to take part in a research study. Before you decide, it is important for you to consider why the research is being done and what it will involve. Please read the following information carefully. If there is anything that is not clear, or if you would like more information, please feel free to contact me.

Why am I doing this study?

The study aims to improve our understanding of the processes involved in family nursing assessment practice of community nurses. My aim is to work with community nurses in order to gain insight into their interactions with families when conducting a family assessment and to discover families’ perceptions of this process. A better understanding of the assessment process of individual family member’s health needs during home visits, and their influence on the family unit, will be of practical value for community nursing practice.

How am I planning to do the study?

The study will explore community nurses’ assessment practice using a collaborative, multiple case study approach. Research methods will include interviews with families and with community nurses about their perceptions and experiences of the family nursing assessment process. I would also like to examine interactions between the community nurse and family through observations and/or audio-recordings of visits and to analyse relevant extracts of the family’s community nursing case notes.

What use will this study be for practice?

It is expected that taking part in this study will be of positive value to community nurses by providing them with many opportunities to explore issues related to their own personal approach to working with families. It is anticipated that findings will inform the assessment practice of community nurses and support the current emphasis on partnership working with service users. Preliminary findings and the final report will be presented to all the participants.
Appendices

Who may be selected to participate in the study?

In order to meet the objectives of the study a number of selection criteria have to be fulfilled.

- Do you have experience of working in a community setting for at least 3 years?
- Do you hold a Specialist Practitioner Qualification in Community Nursing?
- Do you have some knowledge about family health nursing?
- Do you conduct holistic family assessments?

If your response to at least three of the above questions is yes, I would be delighted to hear from you.

Who is organising and supporting this research?

The research is a PhD study and supported by Glasgow Caledonian University. My Director of Studies is [name], [position], School of Nursing, Midwifery and Community Health.

Contact for further information

The researcher is Dorothee O’Sullivan Burchard and I am a Lecturer and Registered Children’s Nurse. I would be grateful if you could complete the enclosed letter indicating your response to this invitation and return it to me in the provided envelope.

Alternatively, please feel free to contact me for further information.
Tel: [number]  Email: [address]

Thank you for reading this.
Appendices

An Exploration of Family Nursing Assessment and Decision Making

Information Sheet for Family / Household Member and/or Person with Parental Responsibility

You are being invited to take part in a research study. Before you decide, it is important for you to understand, why the research is being done and what it will involve. Please read the following information carefully and discuss it in your family. Ask me, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. If you agree to take part, you will be given a copy of this information sheet and your signed consent form to keep.

What is the purpose of the study and why have I been chosen?

The purpose of the study is to explore community nursing practice. I hope to identify and describe how community nurses assess the health needs of individual family members during home visits and how these influence their families. I feel your side of the story, as the family, is very important in helping nurses to better understand and develop this part of community nursing practice. As well as asking you, when gathered as a family, about your views and opinions, I would also like to observe and record the home visits so that I can look closely at what happens between the community nurse and the family group during visits.

Your community nurse is taking part in the study. Because I would like to discover how a group of family members feels about a family nursing assessment, it is important that at least 2 family members or if possible all the family are present to meet the nurse. It is difficult to say at this stage how many visits may be necessary for this research, but I would hope not more than five visits.

Protecting you privacy

I fully respect your personal and family privacy and would particularly like to emphasise that any audio-recordings and notes made will be strictly private and confidential. Information gathered will be used only for the purpose of the research study. Each interview and each home visit will be given a code number and under no circumstances will your name, address or any identifying characteristics be included in the research report.

If you decide to take part in the study, I will ask for your permission to approach your GP for accessing sections of your health records relevant to this research. At the time I will also inform him of your consent.
Appendices

Participation in the study

I hope that you and your family will agree to take part in this study as I expect it will help community nurses to develop and improve the service families receive. Taking part would involve recording the meeting between you, your family members and the community nurse during the home visits on perhaps 5 occasions. On two of these visits I would be observing the family meeting you will have with the community nurse.

I would also like to interview you and your family either before and/or after the visit by the nurse. These recorded interviews would be arranged in advance at a time that suits you. While I hope that you and your family will take part in the study, this is entirely voluntary. It will make no difference to the future involvement of the community nursing service with you or your family. Even if you give your permission at first, you are free to change your mind at any time without having to explain why.

What are the possible disadvantages and risks of taking part?

Because it is important to understand how families feel about having their health needs assessed by the community nurse as a family group and not just as an individual, it would be helpful, if as many family members as possible can be present at the time of the home visit. The visits will therefore be planned to suit your needs. Perhaps coming together to meet with the nurse may result in sharing information in the presence of all family members for the first time. If, for some reason, you or any member of your family may feel uncomfortable about any aspect of the conversation during the family assessment meetings, you should let the nurse know as soon as possible.

What happens to the result of the study?

I expect to complete the study by Autumn 2007. Study findings will be used to help inform the assessment practice of community nurses and their work with families. You will be sent a copy of the preliminary findings. I will invite you to comment on these initial findings. A summary of the final report will be made available to you following completion of the research.

Who is organising and supporting this research?

The research is a PhD study and supported by Glasgow Caledonian University. My Director of Studies is Dr [name], [position], School of Nursing, Midwifery and Community Health.

Contact for further information

The researcher is Dorothee O’Sullivan Burchard, Lecturer and Registered Children’s Nurse. I would be grateful if you could complete the enclosed letter indicating your response to this invitation. Your community nurse will call again to collect your response. She will pass your letter on to me and I will contact you to arrange a time to discuss any further details of the research and to gain your consent. If you have any questions you want to ask about this study, please call me on [number].

Thank you for reading this.
Appendices

AN EXPLORATION OF FAMILY NURSING ASSESSMENT AND DECISION MAKING

Information Sheet for Young People

Hi, my name is Dorothee O’Sullivan Burchard. I am a Children’s Nurse and teach students who want to become children’s nurses. I am also a researcher and would like to find out how nurses help families.

You are being invited to take part in this research study. Before you decide, it is important for you to understand, why the research is being done and what it will involve. Please read the following information carefully and discuss it with your parent(s)/guardian. Ask me, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. If you agree to take part, you will be given a copy of this information sheet and your signed assent form to keep. It would also have to be signed by your parent/guardian.

What is the research for and why ask me?

I hope to identify and describe how community nurses assess the health needs of individual family members during a home visit and how these influence their families. I feel your side of the story is very important in helping nurses to better understand how to care for families. I think it is important to find out what it means to you when someone in your family is not well.

What will happen to me?

The nurse will come to visit your family at home. She will sit down with your family. Hopefully, you will be there as well, that is, if you decide to join in. The nurse will talk and listen to what your family has to say. She will also ask questions about everyone’s health. Yours as well, if that’s ok with you. She will write things down and will record everything that’s being said with an audio recorder. She will visit perhaps three to five times. On two of the visits, I will come along as well. I will just sit quietly and watch and listen to what happens. When watching, I will sometimes be writing things down. I wouldn’t want to disturb you in your conversation with the nurse, but I would like to find out what happens during the meeting.

Do I have to take part?

That is really up to you and your parent(s)/guardian. If you wish, you can talk to your parent(s) about it. You may prefer to think it over on your own. Take your time. Ask questions, if you are not sure about something. It is important that you and your parent/guardian are happy to take part, as you both have to agree to it. If you both decide to take part, but either of you changes their mind at any time that’s quite alright. Just let me know.
Will joining in help me?

Perhaps you will learn something from taking part. For example, you might think a lot more about what it means to you that someone is not well in your family. You might think about how it affects you or your family. You might think that talking things over makes you feel better. But there again, you might not like it at all.

What about my privacy?

I fully respect your personal and family privacy and would like you to know that any audio-recordings and notes made will be strictly private and confidential. Information gathered will be used only for the purpose of the research study. Each interview and each home visit will be given a number and under no circumstances will your name, address or anything that might identify you be included in the report. If, for some reason, you may feel uncomfortable about any aspect of the conversation during the visit by the nurse, you should let her know as soon as possible. She will listen to you and support you.

I will ask for your permission to approach your GP for looking at some sections of you health record relevant to this research. If you decide to take part and both you and your parent(s) have signed the assent form I will let your GP know about this.

What happens to the result of the study?

Study findings will be used to help other nurses in their work with other families. You will be sent a copy of the findings. I will invite you to tell me what you think of them, but you don’t have to, if you don’t wish to respond.

Did anyone else check the research?

The study has been checked by several people, to make sure it is alright.

How can I find out more about this study?

You could ask your parent(s) or you may prefer to speak to the nurse. I would also be happy to answer your questions just phone or email me.

This is my telephone number [number] and this is my email: [address]

Thanks for taking the trouble to read this.
Hi, my name is Dorothee O’Sullivan Burchard. I am a Children’s Nurse and teach students who want to become children’s nurses. I am also a researcher. A researcher is someone who likes to find things out. I would like to find out how nurses help families.

What is the research for?
I am working with nurses who visit families in their homes and hope to find out how these nurses talk to everyone in the family when perhaps one of them is not well. You are invited to take part.

Why you?
Well, you are part of your family. It is important to find out what it means to you when someone in your family is not well.

What will happen to you?
The nurse will come to visit your family at home. She will sit down with everyone who is around. If you decide to join in, I hope you will be there as well and others of your family.

The nurse will talk and listen to everyone to what they have to say. She will also ask questions about everyone’s health. She may ask you questions as well. She will write things down and will record everything that’s being said on a tape. She will bring along a tape recorder with a microphone in order to do that. She will visit perhaps three to five times. On two of the visits, I will come along as well. I will just sit quietly and watch and listen to what happens. When watching, I will sometimes be writing things down. I wouldn’t want to disturb you in your meeting with the nurse, but I would like to find out what happens nonetheless. Remember, I am a researcher – and researchers like to find things out.

Do you have to take part?
That is really up to you and your parent(s). Talk to your parent(s) about it and how you feel. Think it over. Take your time. Ask questions, if you are not sure about something. It is important that you are both happy to take part, as you both have to agree to it. If you both decide to take part, but either of you changes their mind at any time that’s quite alright. Just let me know.
Will joining in help you?
Perhaps you will learn something from taking part. For example, you might think a lot more about what it means to you that someone is not well in your family. You might think about how it affects you or your family. You might think that it helps you to feel better when talking things over. If you decide to take part, it would probably help other nurses in the future, perhaps even those I am teaching, when they look after other families.

Will anyone else know that you are doing this?
Once you have made up your mind and both you and your parent(s) are happy to take part I will have to talk to your family doctor and tell him about your decision.

What happens to what I find out?
As I said earlier, all the talking between the nurse and the family will be recorded on a tape. When I listen to the tape I will write down what you said, I will make sure no one will be able to find out who you, your family or the nurse were. For example, if the nurse asked you by your name, I will not let anyone know neither your name nor your family’s name as it is private and confidential. I will write a story about the meetings and will let your parent(s) see it.

Did anyone else check the project?
The project has been checked by several people, to make sure it is alright.

How can you find out more about this project?
Your Mum and Dad or the nurse may be able to answer your questions or you can phone or email me. Make sure you ask your Mum or Dad before you speak to me.

This is my telephone number [number] and this is my email: [address]

Thank you for reading this.
Appendices

An Exploration of Family Nursing Assessment and Decision Making

Information Sheet for GPs

I would like to advise you of my intention to undertake a study exploring the family nursing assessment practice of community nurses and I would like to include one of your patients.

Why am I doing this study?
This study aims to improve our understanding of the processes involved in family nursing assessment, to provide insight into the interactions between community nurses and families and to discover families’ perception of this process.

How am I planning to do the study?
The study will explore community nurses’ assessment practice using a collaborative, multiple case study approach. Research methods will include interviews with families and with community nurses about their perceptions and experiences of the family nursing assessment process. I would also like to examine interactions between the community nurse and family through observations and/or audio-recordings of visits and to analyse relevant statements of the family’s community nursing case notes.

What use will this study be for practice?
It is expected that taking part in this study will be of positive value to community nurses by providing them with many opportunities to explore issues related to their own personal approach to working with families. It is anticipated that findings will inform the assessment practice of community nurses and support the current emphasis on partnership working with service users. Preliminary findings and the final report will be presented to all the participants.

Permission to approach your patient for consent
This study will involve audio-recording and/or observing up to five visits by a community nurse to your patient [name]. The selection of this patient has been made following advice from the community nurse. I very much hope that you have no objection to me carrying out these visits. Could you please advise me if you would prefer me not to contact your patient, using the enclosed letter of response.

Who is the researcher and how may she be contacted?
The researcher is Dorothee O’Sullivan Burchard who is a Lecturer and Registered Children’s Nurse undertaking PhD studies supported by Glasgow Caledonian University. [voice mail and email]

Thank you for your assistance.
APPENDIX C – SEEKING R & D MANAGEMENT APPROVAL

Exemplar relating to first research host organisation [Original on headed note paper]

13 May 2004

[name]
Director of Nursing
[address]

Dear

Re: R & D Management Approval in Principle to Host the Research
‘An Exploration of Family Nursing Assessment and Decision Making: a multiple case study’

I am a lecturer and postgraduate student undertaking a PhD at Glasgow Caledonian University. The aim of my research is to gain insight into the interactions of community nurses with families when conducting a family assessment and to discover families’ perceptions of this process. Developing a better understanding of family assessment is timely given the current emphasis on partnership working and moves towards family health nursing.

The study aims to explore the family assessment practice of community nurses. I would like to conduct interviews with families and community nurses supplemented by observations of interactions. The project will involve audio recording and/or observing a possible of three to five home visits by the participating nurses. Interviews will also be conducted individually with the nurse and the family. Community nursing case notes and other nursing documents relating to the family assessment will be looked at.

The likely benefits of the study will be a better understanding of how community nurses assess and engage with patients, carers and families. It is anticipated that findings may contribute to theory development to inform the assessment practice of community nurses. Service user involvement and evidence in support of family assessment processes may also contribute to enhanced service delivery.

I am writing to seek your management approval whether in principle your organisation would be prepared to host the project, subject to further scrutiny by yourselves and approval from the Research Ethics Committee.

Following your response I would welcome the opportunity to discuss the project and recruitment of participants in more detail and to answer questions you may have. A letter of response and a stamped addressed envelope is enclosed for your convenience. Alternatively, you may wish to contact me either by phone [number] or email [address]

My Director of Studies is Dr [Name], [position] at the School of Nursing Midwifery and Community Health, Glasgow Caledonian University [voice mail].

Thank you for your assistance.

I look forward to hearing from you.

Yours sincerely

[signed]
Lecturer, Subject Leader Children’s Nursing, Division of Pre-Registration Nursing
Appendices

APPENDIX D – SEEKING GP APPROVAL TO APPROACH PATIENT

Exemplar relating to GP approval [Original on headed note paper]

November 2004

Dr [name]
[address]

Dear Dr [name] (GP)

Re: R & D Management Approval in Principle to Approach Identified Patients and their Families for Research ‘An Exploration of Family Nursing Assessment and Decision Making : A multiple case study

I am a lecturer and postgraduate student undertaking a PhD study at Glasgow Caledonian University. The aim of my research is to gain insight into the interactions of community nurses with families, when conducting a family assessment and to discover families’ perceptions of this process. Developing a better understanding of family assessment is timely, given the current emphasis on partnership working and moves towards family health nursing.

The study aims to explore the family assessment practice of community nurses. I would like to conduct interviews with families and community nurses supplemented by observations of interactions. The project will involve audio recording and/or observing a possible of three to five home visits by the participating nurse. Interviews will also be conducted individually with the nurse and the family. Community nursing case notes and other nursing documentation relating to the family assessment will be examined. I will be seeking the support of the participating community nurse for recruiting families from her caseload.

The study shall provide a better understanding of how community nurses assess and engage with patients, carers and families. It is anticipated that findings may contribute to theory development and to inform the assessment practice of community nurses. Service user involvement and evidence about family assessment processes may enhance service delivery.

I am writing to request your permission to approach patients and their families, previously identified with the help of the community nurse, for consent to take part in this research. In order to safeguard confidentiality in accordance with the Data Protection Act 1998, I will be asking your patients for their permission to approach you with the request for access to their health care records. As well as seeking your patients’ approval to look at their nursing case notes, I would also like to seek your permission to do so.

However, at this early stage it is difficult to predict which patients and families are likely to respond to the invitation. I will therefore contact you again to notify you of the selected patient(s) and to confirm their consent for me to look at their health records.

I very much hope that you have no objection to me recruiting potential participants and granting me access to the relevant health care records used by the community nurse as it relates to the individual patients.

The Research Ethics Committee [name] has granted ethical approval for this research. The project reference number is [number]. However, should you have any questions about the project, please do not hesitate to contact me [voice mail] or email [address]. A letter of response and a stamped addressed envelope is enclosed for your convenience.
Appendices

My Director of Studies is Dr [name], [position] at the School of Nursing Midwifery and Community Health, Glasgow Caledonian University [voice mail]. A copy of the Patient Information Sheet and Consent Form is enclosed for your reference.

Thank you for your assistance.

Yours sincerely

[signed]
Lecturer, Subject Leader Children’s Nursing, Division of Pre Registration Nursing
APPENDIX E – REFLEXIVE INTERVIEW FLOW CHART

Ethnographic Interviewing: Formal and Bounded
(Based on Hammersley & Atkinson, 1995)

A social interaction – a verbal stimuli

Beware
no transparent representation of reality
bias
reactivity
effects of audience

Build Rapport
Meet Research Agenda
Researcher Effects

Context
Environment

Elicit Perspectives
Reveal Discursive Practice

Speech

What is spoken?
Who speaks?
Why collected?
How assessed & examined?

Presentation of self
Response

Directiveness
Non-directive

Facilitative tone
Non-judgemental

Response

Feelings
Attitudes
Behaviours
Perceptions
Explicit, detailed, non-ambiguous responses
One-to-one
More formal

Who

Non-directive
Group

Elicit

Go to

Reflect

React

Respond

What is spoken?
Who speaks?
Why collected?
How assessed & examined?

Environment

Timing
Locale
Seating
Privacy
Equipment

Mode of Questioning

Presentation of self
Response

Directiveness
Non-directive

Facilitative tone
Non-judgemental

Response

Who

Non-directive
Group

Elicit

Go to

Reflect

React

Respond

What is spoken?
Who speaks?
Why collected?
How assessed & examined?

Presentation of self
Response

Directiveness
Non-directive

Facilitative tone
Non-judgemental

Response

Who

Non-directive
Group

Elicit

Go to

Reflect

React

Respond

What is spoken?
Who speaks?
Why collected?
How assessed & examined?

Presentation of self
Response

Directiveness
Non-directive

Facilitative tone
Non-judgemental

Response

Who

Non-directive
Group

Elicit

Go to

Reflect

React

Respond

What is spoken?
Who speaks?
Why collected?
How assessed & examined?

Presentation of self
Response

Directiveness
Non-directive

Facilitative tone
Non-judgemental

Response

Who

Non-directive
Group

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Presentation of self
Response

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Non-directive

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Response

Who

Non-directive
Group

Elicit

Go to

Reflect

React

Respond

What is spoken?
Who speaks?
Why collected?
How assessed & examined?
APPENDIX F – TRANSCRIPTION SYMBOLS

Transcription Symbols

The interviews and audio-recorded home visits were transcribed verbatim using some of Silverman’s (2006: 398-399) simplified transcriptions symbols. Only minimal use was made of the transcription symbols for the nurse interview texts because large data segments were used for coding and interpretation in line with the thematic analysis scheme. Interpretation of texts from the family interview and audio-recorded home visits required application of the transcriptions scheme in more detail. This allowed for representing and contextualising the dynamic nature of interaction within a group situation and assisted its subsequent interpretation. Close repeated listening of recordings was carried out during which symbols were entered into the verbatim transcribed home visit audio-recordings.

The transcription symbols are:

[ overlapping talk

= continuing speech

(.4) numbers indicate elapsed time in silence in tenth of a second

___ underscoring a word indicates speaker’s emphasis

WORD capital letters in the middle of a line or sentence indicates especially loud sound relative to the surrounding talk

( ) empty parentheses indicate inaudible talk

(word) parenthesised words signify possible hearings

(( )) double parentheses contains author’s description

Four syllable word = 1 second  con (.25) sti (.25) tu (.25) tion (.25) = 1 second
(.1) = 1 tenth of a second  (1.0) = 1 second

A pause will foreshadow some difficulty (Silverman: 2006: 206)

Hmm indicates active listening or (understanding???)
### APPENDIX G – INTERVIEW TOPICS

#### Nurse Interview Topics – Pre-Home Visits

<table>
<thead>
<tr>
<th>Topics</th>
<th>C1_HV</th>
<th>C2_CCN</th>
<th>C3_FHN</th>
<th>C4_DN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meaning of family assessment</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. Experience in family assessment</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>3. Relationship building</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. Use of theoretical framework</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. Describing holistic assessment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6. Developing the family relationship</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7. Inquiring into family health</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8. Use of genogram and/or ecomap</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>9. Disengaging from the home visit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>10. Anticipating the family perspective</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>11. Perception about family contribution</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>12. Perception about diversity of families</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>13. Role specific importance of family assessment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>14. Implications of multi-agency working</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>15. Meaning of family</td>
<td>Not asked</td>
<td>See post interview</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14</td>
<td>14</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

#### Nurse Interview Topics – Post-Home Visits

<table>
<thead>
<tr>
<th>Topics</th>
<th>C1_HV</th>
<th>C2_CCN</th>
<th>C3_FHN</th>
<th>C4_DN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perceptions about the home visits</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. The most important aspect</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. The developing relationship</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. Perceptions about family support offered</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. The case specific assessment framework</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6. Consideration of unanticipated family needs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7. Knowledge of family nursing dimensions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8. Relevance of documentation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>9. Expectations about assessment frameworks or tools</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>10. Perceived change since start of nurse’s visits/data collection</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>11. Perceived level of family co-operation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>12. Case specific issues</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>13. Perceived understanding about family nursing</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>14. Balancing the public-private dimension</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Appendices

| 15. Balancing the individual-collective dimension |  |  | (✓) | ✓ |
| 16. Resource implications of family assessment | (✓) | ✓ | ✓ |
| 17. Role perceptions | (✓) | ✓ | ✓ |
| 18. Implications of the uniform | (✓) | ✓ | ✓ |
| Meaning of family (only C2_CCN see above) | (✓) |  |  |
| Total | 12 | 13 (17) | 16 (18) | 18 |

(✓) = issue emerged in the particular case and was then carried forward into the next case

### Family Interview Topics – Post-Home Visits

<table>
<thead>
<tr>
<th>Topics</th>
<th>C1_HV</th>
<th>C2_CCN</th>
<th>C3_FHN</th>
<th>C4_DN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perceptions about family assessment visits</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. The most important aspect</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Meeting family needs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. Approach towards the family (Meaning of family assessment visits)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. The developing relationship</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6. The meaning of family</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7. Perceptions about the documentation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8. Negotiating a working relationship</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>9. Perceptions about nurse’s role</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>10. Perceived change since start of nurse’s visits</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>11. Family recommendation for practice</td>
<td>✓</td>
<td>Not asked</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Appendices

APPENDIX H – NURSE PRE-HOME VISIT: EPISODIC INTERVIEW

Name: C1_Pre_HoV_Nurse_Int_Quest_Type

Case HV

First, I would like to remind you that you have the right to withdraw from the study at any time without giving a reason. You also have the right to control the disclosure of any information or response to questions during this interview.

As you know the purpose of this study is gain an understanding of the interactions between the nurse and family and the process of a family health assessment. In this interview, I will therefore ask you repeatedly, to recount your experience of assessing family health needs.


2. When you look back, what is your experience of assessing families? Could you please tell me about that? Periodic invitation to present narrative of the situation.

3. What was your most significant experience of a family assessment? Could you please tell me about that event? Periodic invitation to present narrative of the situation.

4. How would you describe a holistic family health assessment? Concrete pointed question seeking subjective definition.

5. In what way, if any, is your assessment practice informed by a theoretical framework or model? Seeking abstractive relations.

6. What do you think is important when conducting a family assessment? Concrete pointed question seeking subjective definition.

7. When you look back how do you go about developing a relationship with families? Can you please tell me about that? Periodic invitation to present narrative of the situation.

8. How do you go about assessing family needs? Concrete pointed question seeking subjective definition.

9. What are you looking for when talking to the family? Concrete pointed question seeking subjective definition.

10. When you look back, can you recount how you collect information from a family, how do you proceed? Periodic invitation to present narrative of the situation.

11. Do you normally introduce a genogram and/or ecomap when visiting families? Concrete pointed question seeking subjective definition.

12. What may influence you to bring a visit to an end? Could you tell me how you go about this? Concrete pointed question seeking subjective definition.

13. How might you negotiate the next visit? In what way may it be different from a first visit? Seeking abstractive relations.
Appendices

14. How do you usually document the family assessment? **Concrete pointed question seeking subjective definition.**

15. When you look back can you recount, how you make sense of the family in terms of understanding their perspective? **Periodic invitation to present narrative of the situation**

16. What do you think have families to offer in terms of their contribution to meeting their health needs? **Seeking abstractive relations including hypothesizing.**

17. What contributes in your view to the diversity of families? **Concrete pointed question seeking subjective definition.**

18. Families are so diverse, how do you accommodate their diversity? **Concrete pointed question seeking subjective definition.**

19. Why is a family assessment important to you as a HV? **Concrete pointed question seeking subjective definition.**

20. Government policy suggests closer working relationships in health and social care. What do you think does this mean for assessing family health needs? **Narrative incentive question.**

10 concrete pointed questions seeking subjective definition of the topic

5 periodic invitations to present a narrative of the situation i.e. specific episodes

3 questions seeking abstractive relations one of which included hypothesizing

1 narrative generative question seeking experiential data

1 narrative incentive question seeking subjective definition of the topic

Thank you for sharing your views and contributing to this research.

Evaluation / small talk / critique / additional comments?
APPENDIX I – NURSE POST-HOME VISIT: SEMI-STRUCTURED INTERVIEW

Name: C1_Post_HoV_Nurse_Int_Quest_Type

First, I would like to remind you that you have the right to withdraw from the study at any time without giving a reason. Your response to any of the questions is also voluntary and your confidentiality will be maintained at all times. The opportunity to learn from your nursing work with a family has given me a better understanding of the assessment process. With this interview I would like to explore some remaining issues.

1. When you look back over the recent visits, what is your experience of having explored the participating family’s health issues? Can you please tell me about that? **Semi-structured**, concrete issue, response open ended.

2. What was most important for you about these visits? **Unstructured**

3. How would you describe the relationship that developed between you and the family? **Semi-structured**, concrete issue, response open ended.

4. Do you think it would have made a difference if [name of family member] partner had been around at the time of the visit? **Pointed semi-structured**

5. How would you evaluate the family’s response to the support you offered? **Semi-structured**, concrete issue, response open ended.

6. The CDP is an intervention programme with an integrated assessment. In what way does it differ to any other family assessment tools you are familiar with? **Structured**

7. When you look back over previous assessment visits, do you ever consider any unanticipated needs prior to visiting families? **Narrative**

8. Do you ever speculate about a family’s structural, functional or developmental domain? **Pointed structured**

9. How relevant is the documentation of family information to your practice? **Structured**

10. Would you have any specific expectations about a conceptual framework that may assist you in assessing family health needs? **Structured**

11. Has anything changed for you in your role as HV since you have explored the health needs with the participating family? **Structured**

12. During your visit you introduce new cartoons for the family. How to go about deciding what might be most appropriate? **Semi-structured, concrete issue open ended response**

13. What is your knowledge and understanding of family nursing? **Unstructured**

Thank you for contributing. Evaluation / small talk / critique / additional comments?
Appendices

APPENDIX J – FAMILY POST-HOME VISIT: SEMI-STRUCTURED INTERVIEW

Name: C1_Post_HoV_Fam_Int_Quest_Type

First, I would like to remind you that you have the right to withdraw from the study at any time without giving a reason. Your response to any questions during this interview is also voluntary and your and your family’s confidentiality will be maintained at all times. Thank you again for giving your time at this final stage of the research.

In this interview, I will ask you at a number of occasions about your experience of the last visits. [Name of nurse] has now been to visit for a few times in order to talk through your health concerns and to decide on further action. I would like to learn about your view of these events.

1. When you look back over the recent visits, what is your experience of having explored your family’s health issues with [name of nurse]? Can you please tell me about that? Semi-structured, concrete issue, response open ended.

2. What was most important for you about these visits? Unstructured.

3. Were things any different before the nurse came to see you? Semi-structured.

4. [Name of nurse] was not just concerned about [name of son] health. She was also concerned about everyone else in your family. What is your view on such an approach towards your family? Semi-structured.

5. When [name of nurse] came to see you, she asked you about your children and your partner, how did you feel about such questions? Semi-structured, concrete issue, response open ended.

6. How would you describe the relationship that developed between the nurse and your family? Structured.

7. Do you think it would have made a difference, if your partner had been around at the time of [name of nurse] visits? Structured.

8. At a previous visit, you mentioned how important it is for you ‘to work as a family’. In what way was [name of nurse] supportive to you and your family? Can you please tell me about that? Unstructured.


10. On previous visits, [name of nurse] brought along some development cards that show cartoons about different topics on how children grow and learn. What do you and [partner’s name] think of them? Specific documents used by nurse in this case. Unstructured.
Appendices

11. You looked at family concerns with the nurse. What do you think about the drawing she showed you and asked you to complete (genogram / ecomap)? Not appropriate for this case. Semi-structured.

12. When you look back on the previous visits, how were the subsequent visits agreed? Semi-structured.

13. When you looked for solutions to some of the concerns you raised with [name of nurse], what made you try new ways of doing things? Semi-structured.

14. What has changed for you as a family since [name of nurse] has come to see you at home? Semi-structured, concrete issue, response open ended.

15. What would you say is important for a nurse to consider when she comes to visit a family at home? Semi-structured, concrete issue, response open ended.

Thank you for sharing your views and contributing to this research.

Evaluation / small talk / critique / additional comments?
APPENDIX K – GENOGRAM SYMBOLS

Genogram Symbols

Indicates a death

Family unit with children

No colour indicates family member not participating in the study

Light shaded symbol indicates family member participating in the study

Indicates boundary around identified family unit

Dark shaded symbol indicates identified patient

Children appear from left to right in age descending order

Gender symbols and meanings of lines used

Connector line between individual family members

No contact between family members

Separation or divorce
APPENDIX L – PARTICIPANTS’ FEEDBACK CASE FOUR

C4_ Feedback Sheet for C4_DN_Case Report_Nurse Perspective
Feedback received by post 19.11.2008

This feedback sheet is designed for you to comment on the Case Report_Nurse Perspective. Your comments will be greatly appreciated. Once you have read the report please tick the relevant column and comment if you wish. A stamped addressed envelope is provided for return of this feedback sheet. Thank you for your co-operation!

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme</th>
<th>Participants Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. How does the nurse see her role in working with families?</strong></td>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td></td>
<td>Professional historical context</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Role perceptions</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Multi professional context</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Declining professional input</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Resource implications</td>
<td>✓</td>
</tr>
<tr>
<td><strong>2. What is the nurse’s definition of the situation?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meaning of family</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Family as development</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Defining family assessment</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Meaning of family nursing</td>
<td>✓</td>
</tr>
<tr>
<td><strong>3. What is the nurse’s orientation towards the family?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relational stance</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Being inclusive</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Type of focus</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Being culturally sensitive</td>
<td>✓</td>
</tr>
<tr>
<td><strong>4. What are the nurse’s espoused communicative actions?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Circular questioning</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Use of genogram</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>Use of ecomap</td>
<td>✓</td>
</tr>
</tbody>
</table>
5. What assessment framework is being used?

<table>
<thead>
<tr>
<th>Activity</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picking up cues</td>
<td>✓</td>
</tr>
<tr>
<td>Seeking understanding</td>
<td>✓</td>
</tr>
<tr>
<td>Promoting dialogue</td>
<td>✓</td>
</tr>
<tr>
<td>Verifying cues</td>
<td>✓</td>
</tr>
<tr>
<td>Pursuing strategic action</td>
<td>✓</td>
</tr>
<tr>
<td>Looking at all the aspects around</td>
<td>✓</td>
</tr>
<tr>
<td>Negotiating a working relationship</td>
<td>✓</td>
</tr>
</tbody>
</table>

5. What assessment framework is being used?

<table>
<thead>
<tr>
<th>Activity</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment framework used</td>
<td>✓</td>
</tr>
<tr>
<td>Very interesting. What you say is true. I am looking for patterns then trying to move forward.</td>
<td></td>
</tr>
</tbody>
</table>

6. What type of information is being sought?

<table>
<thead>
<tr>
<th>Activity</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of information sought</td>
<td>✓</td>
</tr>
<tr>
<td>You are really kind.</td>
<td></td>
</tr>
</tbody>
</table>

7. What use is being made of the information?

<table>
<thead>
<tr>
<th>Activity</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of information</td>
<td>✓</td>
</tr>
<tr>
<td>You are completely right – have never thought of this before and yes a lot of work is invisible to others but I hope not to those who matter (the family).</td>
<td></td>
</tr>
</tbody>
</table>

8. What has been of particular importance about the home visits?

<table>
<thead>
<tr>
<th>Activity</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspect of importance</td>
<td>✓</td>
</tr>
<tr>
<td>Very true.</td>
<td></td>
</tr>
</tbody>
</table>

9. What has been the impact of participation on the nurse?

<table>
<thead>
<tr>
<th>Activity</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of participation</td>
<td>✓</td>
</tr>
</tbody>
</table>

Any other comments you wish to make?

Comments received:

This has been a very enlightening experience for me. I truly believe I involve all family members into someone’s care and don’t consider only the person but everyone around them. I do try to work out exactly what’s going on in a family and how they will continue to cope. If I can do anything to help that, then that’s all to the good. However, to have all this highlighted to me has made me feel proud that you have recognised this in me. If I have helped you to promote this type of nursing then I am delighted. I am not a confident nor assertive person myself so I hope in participating in your study, I may have helped, even in a small way to promote the type of nursing
I would wish for myself. Kind regards and thank you for involving me in your study. Good luck for the rest of our study. What a lot of work you have put into this. I hope your study helps to push forward this worthwhile and satisfying work. Signed by participating DN.
**C4_Feedback Sheet for C4_DN_Case Report_Interaction Process**

**Nurse Perspective Feedback received by post 19.11.2008**
This feedback sheet is designed for you to comment on the C4_DN_Case Report_Interaction Process. Your comments will be greatly appreciated. Once you have read the document please tick the relevant column and comment if you wish. A stamped addressed envelope is provided for return of this feedback sheet.

<table>
<thead>
<tr>
<th>Tentative Findings</th>
<th>Question</th>
<th>Participant’s Response</th>
<th>Comment</th>
</tr>
</thead>
</table>
| 1. During conversations at three home visits you experienced an *expanding of horizons* when exploring and learning about the health needs of both family members. | Can you recognise your experience of events in this interpretation?         | √                      | It was enlightening to have had visits examined so thoroughly. I feel privileged that my practice has been studied and not come out wanting. |}
| 2. Out of the co-produced explorations of family health concerns emerged a collective understanding of family health care needs for you and the couple providing a foundation for *acting in solidarity* – to do something about these health needs together. | Can you recognise your experience of events in this interpretation?         | √                      | Has also made me realise how much of the work is invisible but so essential. |}
| 3. During each home visit you gained an understanding of the current health concerns by way of co-participation which brought a sense of closure to the immediate concerns raised at each visit. | Can you recognise your experience of events in this interpretation?         | √                      |                                                                           |}
| 4. Each home visit built on previous understandings of health concerns and the developing of relations between you, the patient and his carer. | Does this statement make sense to you?                                   | √                      |                                                                           |}


5. Each home visit raised further awareness for you with regard to health concerns impacting on the family as a whole. Does this statement make sense to you? √

6. Each of the three home visits was a family orientated assessment visit. Does this statement make sense to you? √

7. During each home visit health concerns of family members were closely interrelated. Does this statement make sense to you? √
### C4_Feedback Sheet for C4_DN_Case Report_Documentation

**Feedback received by post 19.11.2008**
This feedback sheet is designed for you to comment on the C4_DN_Case Report_Documentation. Your comments will be greatly appreciated. Once you have read the document please tick the relevant column and comment if you wish. A stamped addressed envelope is provided for return of this feedback sheet.

<table>
<thead>
<tr>
<th>Descriptions &amp; Interpretations</th>
<th>Question</th>
<th>Participant’s Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context of the documentation</td>
<td>Is there anything you wish to add or revise?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational context</td>
<td>Is there anything you wish to add or revise?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What type of documentation was used?</td>
<td>Is there anything you wish to add or revise?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What assessment framework was used?</td>
<td>Is there anything you wish to add or revise?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was the assessment framework used in the documentation</td>
<td>Is there anything you wish to add or revise?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was the information being used?</td>
<td>Is there anything you wish to add or revise?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the meaning of the assessment documentation for the nurse and family?</td>
<td>Is there anything you wish to add or revise?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your comments!
Comments received:
I feel the written documentation was not really relevant to the family as I felt we discussed all that was relevant – perhaps I am wrong in thinking that but no written information could cover all that we discussed. The written framework does not lend itself at all to the assessment process I use.
Appendices

C4_Feedback Sheet for C4_DN_Case Profile

Family Perspective

Feedback received 21.12.08
This feedback sheet is designed for you to comment on the C4_DN_Case Profile. Your comments will be greatly appreciated. Once you have read the document please tick the relevant column and comment if you wish. A stamped addressed envelope is provided for return of this feedback sheet.

<table>
<thead>
<tr>
<th>Case Descriptions</th>
<th>Question</th>
<th>Participant’s Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1. The Nurse</td>
<td>Are these descriptions accurate?</td>
<td>√</td>
</tr>
<tr>
<td>2. The Family</td>
<td>Are these descriptions accurate?</td>
<td>√</td>
</tr>
<tr>
<td>3. Prior Events</td>
<td>Are these descriptions accurate?</td>
<td>√</td>
</tr>
</tbody>
</table>

No other feedback received.
## APPENDIX M – META MATRIX EXAMPLE

<table>
<thead>
<tr>
<th>Meta Matrix Nurse Perspective</th>
<th>Unit of Analysis</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Nurse</strong></td>
<td>Health Visitor</td>
<td>Community Children’s Nurse</td>
<td>Family/Health Nurse</td>
<td>District Nurse</td>
<td>Description beyond question little need for triangulation</td>
<td></td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>Mother Daughter 4 yrs</td>
<td>Son 2 yrs</td>
<td>Mother Father, not living in same household Son 12 yrs Daughter 11 yrs Son 4 yrs</td>
<td>Husband, carer Wife, patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Referral/Reason</strong></td>
<td>Son’s behavioural problems</td>
<td>Mother history of post natal depression</td>
<td>Stroke, incontinence, chronic constipation</td>
<td>Terminal illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nurse Perspective</strong></td>
<td>Perceived role</td>
<td>Promoter of and resource for health</td>
<td>Assessor of risk Provider of family self care Provider of nursing requirements</td>
<td>Promoter of and account for family health across the life span</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meaning of family</strong></td>
<td>Relational experience defined by cultural diversity and affectional bonds.</td>
<td>Multigenerational Developmental life span perspective Interactional, interrelated, systemic</td>
<td>Relational experience defined by affectional bonds. A group of people living within a boundary mantenering intimacy and security. Developmental life span perspective</td>
<td>Relational experience and self defined by affectional bonds and shared living. Experts on their experience. A group of people as a functional unit. Developmental life span perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Defining family health</strong></td>
<td>Exploration of the situated presence of the individual and the collective. An interactional experience. Use of senses to develop an incremental understanding. Building a layered conceptual scheme guided by a specific assessment framework. Taking account of the other in a real sense and a virtual sense.</td>
<td>Exploration of the situated presence of the family as a whole whilst promoting their autonomy and integrity. An interactional experience. Recognition of a family’s capabilities with family privacy being protected. Building a layered conceptual scheme guided by a family assessment framework. A co-constructed process of raising awareness and building family knowledge. Taking account of the other in a real sense and a virtual sense.</td>
<td>Comprehensive and holistic exploration of the situated presence of the individual and the collective from an interactional perspective. Use of senses to develop an incremental understanding. Building a layered conceptual scheme guided by a family assessment framework. Taking account of the other in a real sense, not a virtual sense.</td>
<td>Exploration of the situated presence of the individual and the collective. An interactional experience. Use of senses to develop an empathic and incremental understanding. Taking account of the other in a real sense and a virtual sense.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meaning of family nursing</strong></td>
<td>Working together that takes account of systemic intersrelationships and interdependent dimensions at an individual and collective level. Community.</td>
<td>Working together that takes account of systemic intersrelationships and interdependent dimensions at an individual and collective level. Meeting nursing requirements Community</td>
<td>Working together taking purpose that takes account of systemic intersrelationships and interdependent dimensions at an individual and collective level. Not seen as providing functional care. Community.</td>
<td>Working together to account of systemic intersrelationships and interdependent dimensions at an individual and collective level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Being inclusive</strong></td>
<td>Recognition of actual and virtual presence of family members. Therapeutic conversation.</td>
<td>Dependence on actual presence of family members. Therapeutic conversation.</td>
<td>Recognition of actual presence of individuals as a group. Therapeutic conversation.</td>
<td>Recognition of actual and virtual presence of family members.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type of focus</strong></td>
<td>Interactional. Relational.</td>
<td>Interactional. Problem focused.</td>
<td>Interactional. Problem focused.</td>
<td>Interactional. Relational.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- The table outlines various perspectives and case scenarios for understanding family health and nursing practices.
- Each row represents a different category or aspect of family health, with columns detailing specific scenarios and outcomes.
- The comments column provides additional context or feedback on the described scenarios.

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APPENDIX N – COLOUR CODED CONVERSATION SEQUENCES CASE 2

Case 2 Coloured pattern displays of thematic conversational sequences
APPENDIX 0 – COLOUR CODED CONVERSATION SEQUENCES CASE 4

Case 4 Coloured pattern displays of thematic conversational sequences
APPENDIX P – KEY & SYMBOLS OF CONVERSATIONAL SEQUENCES

Interaction Themes
- Family Orientated Health Issue (FOHI)
- Family Talk (FT)
- Building Relations (BR)
- Patient Health Concern (PHC)
- Professional Concern (PC)

Recursive Circular Patterns
- FOHI
- FT
- PC
- PHC
- BR
- FOHI

Symbols
- Purple
- Pink
- Yellow
- Green
- Blue

Non Recursive Patterns
- FOHI
- PC
- PHC
- BR
Glossary

**GLOSSARY**

**Anaemic:** sign of deficiency of red blood cells.

**Aye:** Scots for ‘yes.’

**Doppler ultrasound:** assessment to detect velocity and location of blood flow in both arteries and veins; used to record a Resting Pressure Index or Ankle Brachial Pressure Index. Part of a holistic leg ulcer assessment to exclude arterial disease and impaired blood flow.

**Catheter care:** a clean procedure to maintain free drainage of body fluid from a long hollow rubber or silicone tube. It prevents retention and infection and allows for measurement of body fluid.

**Cerebral thrombosis:** a type of stroke where a blood clot or thrombus forms in an artery that supplies blood to the brain. The clot prevents blood flow and cells are starved of oxygen.

**Cerebrovascular accident:** a stroke caused by a disruption of blood flow to the brain resulting in sudden onset of weakness often on one side of the body.

**Congenital hydronephrosis:** a rare kidney disorder presenting at birth. It involves enlargement of the ureter to the kidney causing obstruction of the flow of urine out of the kidney. It can result in severe electrolyte imbalance and kidney failure.

**Couldnae:** Scots for ‘could not’.

**Diabetes mellitus:** a metabolic disease that results from defects in insulin secretions or insulin action. Blood glucose is abnormally high because insulin, released from the pancreas, is either absent or insufficient and can no longer control the amount of sugar in the blood.

**Dinnae ken:** Scots for ‘don’t know’.

**Dyslexia:** a learning difficulty which can range from mild to severe; an impairment in the brain’s ability to translate images received from the eyes or ears into understandable language which presents as a difficulty in learning to read, write or spell.

**Dyspraxia:** an impairment or immaturity of the organisation of movement which may also be associated with problems of language, perception and thought. The impairment may be caused by lack of oxygen supply during birth or defects during foetal development.

**Endoscopy:** a diagnostic procedure to relay an internal body image to an external television screen. The endoscope is a thin long flexible tube with a light source and video camera which is inserted through a natural opening or a small surgical incision made in the skin.

**Gastrostomy feeds:** an artificial feeding regime which allows tube feeding with a percutaneous endoscopic gastrostomy tube (PEG tube) inserted through the abdominal wall into the stomach. It ensures nutritional support for patients who are not able to eat orally.
**Glossary**

**Gotta:** Scots for ‘has to’.

**Hypertension:** is a blood pressure that is 140/90 mmHg or above each time it is taken. That is, it is 'sustained' at 140/90 mmHg or above; as a risk factor, it may contribute to developing heart disease or stroke.

**Inguinal hernia:** a condition in which intra-abdominal fat or part of the small intestine, also called the small bowel, bulges through a weak area in the lower abdominal muscles. It appears as a bulge in the groin and generally requires surgical repair.

**Insertion of urethral stent with ureterostomy catheter:** A ureteral stent is a thin, flexible tube threaded into the ureter to help urine drain from the kidney to the bladder or to an external collection system via an ureterostomy catheter; a tube inserted through the abdominal wall via a stoma for the collection of urine into a urine collection bag.

**Insertions of gastrostomies:** the surgical placement of a tube into the stomach through creating a stoma or opening in the abdominal wall. Once the gastrostomy tube becomes dislodged or blocked a tube needs to be re-inserted to safeguard the supply of nutrition via this enteral feeding method.

**Ken:** Scots for ‘know’.

**Laryngo malacia:** a congenital abnormality of the laryngeal cartilage resulting in noisy respirations and expiratory stridor making co-ordination of breathing and feeding difficult. Children often have poor weight gain.

**Microcephaly:** a smaller than normal circumference of the head because the brain has not developed properly or has stopped growing and is often caused by genetic abnormalities that interfere with the growth of the cerebral cortex during the early months of fetal development. It is associated with Down’s syndrome, chromosomal syndromes, and neurometabolic syndromes. Children with microcephaly may have mental retardation, delayed motor functions and speech, facial distortions, dwarfism or short stature, hyperactivity, seizures, difficulties with coordination and balance, and other brain or neurological abnormalities.

**Nephrectomy:** the surgical removal of a kidney in response to disease, injury or congenital conditions.

**Palliative care:** nursing or medical care that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

**Pancreatic carcinoma:** a tumour of the gastrointestinal tract i.e. the pancreas resulting in disturbance of endocrine functions, such as insulin production. It occurs predominantly in later life.
Glossary

**Refashioning of stoma:** involves a temporary or permanent diversion or outlet for the elimination of body fluids; a stoma formation is a surgical correction and may need refashioning to maintain its function.

**Stridor:** a high-pitched sound produced by an obstruction of the airway either in the larynx or the trachea.

**Stroke:** an interruption of blood supply to the brain; it is also called a cerebrovascular accident (CVA).

**Ureterostomy:** the creation of an opening or stoma to allow one or two ureters a diversion to the abdominal wall. The opening acts as outlet for elimination of body fluids and is usually a surgical correction of congenital hydronephrosis.

**Wee** – Scots for ‘little’ or ‘small’.

**DATA SOURCE REFERENCES**

<table>
<thead>
<tr>
<th>Case 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HV_FN</td>
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</tr>
<tr>
<td>HV_CIID</td>
<td>HV_Contextual Information Interview Documentation</td>
</tr>
<tr>
<td>HV_CIID_Fam_Int</td>
<td>HV_Contextual Information Interview Documentation_Family_Interview</td>
</tr>
<tr>
<td>C1_HV_Pre_HoV_Int</td>
<td>Case1_HV_Pre_Home Visit_Interview</td>
</tr>
<tr>
<td>C1_Fam_Int</td>
<td>C1_Family_Interview</td>
</tr>
<tr>
<td>C1_HV_HoV</td>
<td>C1_HV_Home Visit</td>
</tr>
</tbody>
</table>

| Case 2 |
|---|---|
| CCN_CIID | CCN_Contextual Information Interview Documentation |
| CCN_CIID_Fam_Int | CCN_Contextual Information Interview Documentation_Family_Interview |
| CCN-CSF | CCN_Contact Summary Form |
| CCN_DSF | CCN_Document Summary Form |
| C2_CCN_Pre_HoV_Int | C2_CCN_Pre_Home Visit_Interview |
| C2_CCN_Post_HoV_Int | C2_CCN_Post_Home Visit_Interview |
| C2_Fam_Int | C2_Family_Interview |
| C2_CCN_HoV | C2_CCN_Home Visit |

| Case 3 |
|---|---|
| FHN_CIID | FHN_Contextual Information Interview Documentation |
| FHN_CSR | FHN_Contact Summary Form |
| C3_FHN_Pre_HoV_Int | C3_FHN_Pre_Home Visit_Interview |
| C3_Fam_Int | C3_Family_Interview |
| C3_FHN_HoV | C3_FHN_Home Visit |

| Case 4 |
|---|---|
| DN_CIID | DN_Contextual Information Interview Documentation |
| DN_CSR | DN_Contact Summary Form |
| DN_DSF | DN_Document Summary Form |
| C4_DN_Pre_HoV_Int | C4_DN_Pre_Home Visit_Interview |
| C4_Fam_Int | C4_Family_Interview |
| C4_DN_HoV | C4_DN_Home Visit |
REFERENCES


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References


References


References


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References


References


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References


