PERSPECTIVES ON CHILD-REARING
IN AN URBAN COMMUNITY
AND THE ROLE OF THE HEALTH VISITOR

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ABSTRACT

Perspectives on Child-Rearing in an Urban Community and the Role of the Health visitor

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The study focused on the child-rearing practices of mothers from three different cultural groups in one urban community and on the role of health visitors as perceived by these mothers and the area health visitors.

Universal factors affecting child-rearing practices were identified in the cross cultural literature on child-rearing. Three major determinants of practice emerged; economic survival, family cohesion and cultural transmission. These variables were confirmed in this study.

Child rearing in the UK this century is revealed in the literature as the province of appointed ‘experts’. These have emerged from such disciplines as religion, medicine, psychology and education. The current model for professional practice in child health care is empowerment of parents. The concepts of ‘expert’ and empowerment are both examined.

Questionnaires established the professional and personal background of the area health visitors, their perceptions of how different client groups prioritised their child-rearing problems and sources of information seen as pertinent to their practice. In-depth interviews were carried out with ten of these health visitors. They focused on the role of health visitors and attitudes and beliefs in relation to client groups and their child-rearing problems.

Focused interviews were also carried out in the same city with thirty five mothers with young children who were from Italian, Bangladeshi or indigenous white families. The topics of the interview were taken from the current popular child-rearing literature as being the child-rearing subjects of most interest to mothers. There were differences across the groups of mothers on preparedness for motherhood. Some mothers were
seen as having unrealistic expectations of themselves and of their children, regarding some behaviour of their babies as problems. Others were more accepting of changes in their life brought by motherhood and saw their child’s behaviour as being consistent with babyhood.

Confidence and consistency in child-rearing practices appeared to be strongly related to family cohesion and the support given by the family. Child rearing practices were also seen to be influenced by the socio-economic status of the family, and in some instances, enduring cultural values.

The health visitors perceived their roles as therapeutic, educational, empowering and as themselves as experts in child-health. These perceptions differed from those of the mothers. The concept of empowerment appeared not fully understood by the health visitors nor was it exercised equally for all mothers.
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Perspectives on Child Rearing in an Urban Community and the Role of the Health Visitor

INTRODUCTION

This study is an investigation into a range of perspectives on child rearing attitudes and practices, located both within and across cultural groups, and into the relationship of these perspectives with those of health visitors who work in the same geographical area.

Most urban communities in the UK today are a mixture of ethnic and cultural groups. This study explores some of the features of child rearing within an urban setting, taking into account this variety of cultures and social practices. The focus is on a major contemporary source of child care, mothers. It is not intended to open up a discussion of gender and the role of women, racial issues, or to evaluate social change. Instead, the attitudes and related child care practices of 35 mothers living in the same city are examined with reference to the historical context and social structure of three groups having different cultural antecedents: indigenous white British, Italian and Bangladeshi people.

There is no intention to attempt overall group comparisons or attribute to them stereotypical cultural differences. Where different groups have lived side by side for a number of years, it is expected that there may be cross-cultural influences on many aspects of behaviour and attitudes. On the
other hand there may also be enduring cultural heritages in respect of child rearing. Focusing on mothers associated with three identifiable groups is a cross-cultural attempt to ensure this range.

The emphasis in the study is on bringing up children in their first two years of life and the empirical element is further delimited by giving attention mainly to matters of practical concern which - taken together - give overall profiles of child rearing practice. These specific issues were raised with the mothers in semi-structured interviews, and though it is recognised that there are many ramifications beyond them, they clearly are important concerns.

Health visitors have a direct and statutory role to play in child health care and support of the family. For this reason they are also included in the study as a fourth group and their 'expert' professional knowledge is seen alongside and interacting with the informal knowledge of the mothers. Initially the health visitors were asked to respond to a questionnaire designed to probe whether they perceived differences between mothers in the three groups in the way in which child rearing problems were prioritised. The questionnaire also asked for sources of information and literature which the health visitors found helpful to their practice. Ten of these health visitors, all of whom had direct contact as part of their work with some of the mothers from the three groups, were later interviewed on broad aspects of their professional practice and attitudes.
Professional groups in the UK who serve, administer, and advise infant and child care-givers, were, in the first half of this century, likely to have been influenced by the writings of a number of child development psychologists. Truby King (1913), the Robertsons (1953, 1967-73) and Bowlby (1951) in the UK, and Gesell (1928), Erikson (1950) and Spock (1946), from the USA, were all given serious acknowledgment by the health care professionals. The work of these and other theorists has over time become 'funded knowledge', and provided guidelines on child rearing for the professionals who have attempted to pass them on to parents. This model has been that parents lacked certain knowledge in child rearing and depended to some extent on 'culturally appointed "experts"' (Harkness and Super, 1996: 290). Harkness and Super have drawn together some of the recent research on parental beliefs and demonstrate a growing recognition that parental cognition is socially and culturally organised through parental 'ethnotheories', culturally organised understandings relating in systematic ways to action. These may include, for example, ways of talking to children, methods of discipline and negotiation with the 'experts', issues which are considered in this research. Such studies will necessarily be concerned both with the internal consistency of each cultural group and with the issue of cultural variability.

Youniss (1994) claims that it is only in the last decade that psychologists have acknowledged that practices are founded on parental beliefs and knowledge. His view is that it is best to balance this focus with a broader
perspective of the sociological and historical context from which parents child rearing practices arise. This position is taken throughout this study. The theoretical basis of the research has to include the sociological and historical context of participating mothers, an overview of past and current theories of child rearing from psychological, inter-cultural and intra-cultural perspectives. It will also be necessary to take into account a current philosophy in health visiting of empowering mothers in their child rearing practices. The concept of empowerment as it relates to the practice of health visiting was developed by Barker (1990) of the Child Development Unit at Bristol University. A critical appraisal of the application of this theory to practice by the health visitors participating in the study will be made.

There are four related research questions:

(i) are there differences in the attitudes and practices in child rearing among mothers across and within cultural groups?

(ii) how are these differences perceived, and is the social and cultural contexts from which they derive acknowledged by professionals who are supporting and advising the carers?

(iii) how do mothers perceive the role of the health visitor and does this reflect the health visitors’ view of their relationship with their clients?
Does the professional approach appear to meet the needs of the mothers and empower them in the fullest sense of the word?

The answers to these questions may be of value to health visitors, paediatric nurses and other health care professionals who care for children and their families, enabling them to give appropriate support. The health care professional might ideally be seen as part of a caring triad, where the professional, the parents and the child are partners in negotiation, where knowledge and control of health care problems are shared with the parents and the health care professional acts as a facilitator, providing information and support. Taking the client’s or patient’s point of view seriously in decisions about health care has been recognized as an important pre-condition of empowerment (Anderson and Bury 1988, Strauss 1984).

This suggests a broader focus for health care professionals with involvement at a political level, as pressure and action for the rights of client groups is implicated. A partnership model of care has been developed by Casey (1988) for paediatric nursing and is practised by many paediatric units in the UK. The study explores whether the concept of parental empowerment is fully understood and implemented by health visitors working with mothers in the community.
CHAPTER 1

PERSPECTIVES ON Child REARING ACROSS CULTURES
CHAPTER 1

PERSPECTIVES ON CHILD REARING ACROSS CULTURES

The parental role is experienced in a cultural setting, in a social and physical environment and in relation to the unique genetic inheritance of each child. In this chapter we consider the interaction between some of these complex variables and how they affect child rearing.

There are several precedents for a study of the theory and practice of parenting. One of the earliest in Britain is the work of the Newsons. In their influential and major longitudinal study which commenced in the 1960’s they set out to discover what sort of practices mothers engaged in, irrespective of what they were advised to do in relation to child rearing. In their study they looked at normal healthy children in ordinary family situations. They excluded children with special needs and those who were not in the care of their mothers. What may be seen in retrospect as limiting in the Newsons’ research was their decision not to include recent immigrants. This is an issue addressed in this study by including both recent and long standing immigrants, for as noted by Whiting and Whiting (1960),

If children are studied within the confines of a single culture many events are taken as natural and obvious.... it is only when it is...
discovered that other people do not follow these practices that have been attributed to human nature that they are adopted as legitimate variables (Whiting and Whiting, 1960: 933).

On an examination of the literature three themes can be identified as major influences on child-rearing, these may be summarised as:

- economic survival
- family cohesion
- transmission of cultural values.

Interacting with these variables are the urban-industrial and rural-agrarian environmental contexts of particular families, the universal innate characteristics of babies, and the instinctive nurturing behaviour of parents.

Harkness (1992) observes that cross-cultural research has often been concerned with delineating causal relationships between culturally regulated parental child-rearing practices and behaviour and developmental outcomes. This is a problematic distinction, as causal relationships are difficult to assign in a blanket fashion to a culture as a whole. It may be that there is considerable intra-cultural variance in child rearing practices and subsequent behaviour. For example, a question arising in relation to the research of Richman et al (1992), is whether differences which generally are perceived to be cultural are really the function of different educational levels.
Richman's research investigated the determinants of maternal behaviour in two contrasting pairs of mother and infant samples. One comparison was between rural African Gusii mothers and urban middle class American mothers. The other was a comparison within Mexican culture of well educated and less well educated mothers. The findings suggest that cross-cultural differences were largely paralleled by within culture differences. Richman concludes that school experience provides women with verbal skills and models of adult-child verbal interaction which they would not otherwise acquire. These skills and models of behaviour may be carried forward and become part of parenting skills. It is therefore important to keep in mind within-group differences when looking across groups.

Multiple practices exist in all cultures, as Briggs (1992) affirms, and even small cultural groups have more than one view of the world and one way of doing things. One contention of this study would be that the socio-economic context of the family and family cohesion are major determinants of parental goals for their children, and as such influence practice. Miller and Goodnow (1995) propose a dynamic conception of context. They suggest that context is not treated as a static 'given', but see the individual and context as interdependent and mutually active. In this approach individuals and society are mutually constituted with society producing persons of a particular kind and at the same time people producing society (Miller and Goodnow, 1995: 8).
There may also be universal tendencies indigenous to children and their patterns of biological and social growth. According to Bornstein, some characteristics of parenting are likely to be related to instinctual behaviour by the parent at a particular stage in the life cycle, in an attempt to optimize the development of offspring (Bornstein, 1991). A common environment may also influence parents to think and behave in similar ways. Obvious examples might be the need to instil discipline in relation to road safety in children living in a busy urban environment, or to breast feed if proprietary milk foods are not easily affordable or available.

Shaping Parenting Behaviour: the Child and the Environment

Bowlby (1971: 298) has described a biological propensity of babies to elicit certain behaviours from caregivers. He suggested that crying, rooting, smiling and sucking, which infants naively exhibit, all send signals to the caregiver and usually provoke universally observed patterns of care giving, a response to babyishness and helplessness.

The child’s role in shaping child-rearing practices has been given attention by Brazelton and Lester (1982: 53) who view infant behaviour in its cultural context, both as a shaper of, and as shaped by cultural expectations. The parent infant dyad is seen as a microcosm of the culture at large. The range and form of adaptation achieved by the infant sets the limits and puts a focus on the dyadic interaction, thus shaping the practices and expectations of the culture. At the same time, Brazelton and Lester accept that the infant is shaped by postnatal environmental forces. These include
methods of care and handling, the familial constellation, the ecological
milieu, physical setting and expectations within the culture. In their view,
cross cultural studies of human infancy enable us to describe the
variability of infant behaviour and provide a broader understanding of
child rearing patterns. For example, in societies where the environment is
hostile and infant mortality is a problem, child-rearing patterns may have
developed to facilitate the survival of the family by adopting such
behaviour patterns as co-sleeping and prolonged parental contact.
Brazelton and Lester conclude that child-rearing practices may best be
understood by accounting for the environmental demands of the culture,
the effects of the physical environmental on the mother and foetus, and
the characteristics of the individual infant.

Babies within any cultural group vary widely in their behavioural
dispositions. Thomas and Chess (1982) have examined this issue in a
number of papers on infant temperament (1977, 1982, 1989), and have
shown that levels of regularity and adaptability vary greatly between
infants in any culture, but that their significance depends on the niche that
the baby is born into and the degree of flexibility it allows. Super and
Harkness (1982) found striking differences in the responses to infant night
waking, in a comparative study of infant temperament and maternal child-
care practices in an upper middle-class Boston community, and a farming
and herding community in Kenya. From their findings they suggest that
night time waking may not be as stressful for the mother and child in
Kenya as in Boston. Parents’ expectations of the behaviour of babies may be a factor here.

In a longitudinal study of New York mothers, Thomas and Chess found a correlation in the rating of children considered to have a difficult temperament and a symptom check list of the behaviours of these children. The check list was derived from interviews with the childrens’ mothers. This was not so in the Puerto Rican working-class sample. A likely explanation for this was that the New York parents made more demands than the other group for the early establishment of regular sleep and feeding schedules. The New York parents also pressed for the achievement of early self feeding, self dressing and for quick adaptation to new situations and new people, a likely necessity for those mothers working outside of the home in the interests of the family’s economic survival. New and Richman (in Harkness and Super, 1996: 385-404) also draw attention to relative independence as a goal in USA child rearing. These demands may be especially stressful for children with a difficult temperament. (‘Difficult’ is interpreted here as being less easily adaptable to new situations.)

In discussing a baby’s adaptations to sleep patterns in different cultures, Super and Harkness (1982) say that of critical importance are the ways in which a cultural ‘niche’ can and cannot adapt to the individual characteristics of the baby. Areas of rigidity and flexibility will determine the kinds of behaviour that will create upset or difficulty. Early
socialization and the related development of emotional life includes learning the sensitivities of one's 'niche'. For the North American mother, scheduling her baby's activity by the clock may be of considerable importance, not only because of her value system, but also in relation to her personal and economic needs.

At a later date Harkness (1992) comments that insight into larger patterns of cultural organization shows traditional ways of life becoming modified by increased inter-ethnic contacts and associated changes in infant behaviour expectations. Social pressures of both peers and family and in some instances health care professionals may disturb the security of the earlier carer-infant relationship. Jaeger and Selznick (1964) have pointed out that not everything prized by a social group has equal functional status. Some traditional group values can become inappropriate in a changing social setting and may have to be reviewed. Moving from rural India to a Western urban industrial setting may obviate some of the cultural roles assigned to family members. Initially this may create dissonance within the family and adaptation may be necessary to reestablish harmonious functioning.

**Parental Transmission of Cultural Values**

Parents and families, observes Jordan (1980), occupy the most powerful position of cultural influence. In child-rearing, parents pass on attitudes, values and skills which permit children to develop from a state of complete dependency to more or less independent adult status. Margaret Beale
Spencer (1983) carried out three studies in the Midwest, South and North USA to examine young black children's white-biased cultural values. These studies suggest a pattern of changing models for behaviour as these children matured. Pre-school children showed consistent Eurocentric (white-based) choice behaviour while the trend changes to an Afrocentric orientation during middle childhood. Parental interviews with a sub-sample of Southern parents offer an interpretation of these choice patterns. Where values were transmitted by teaching children about civil rights and racial discrimination, there was an association with Afrocentric racial attitudes and preferences.

The more Afrocentric response pattern for older primary school children suggests that alternative value structures are a result of the child's own increasing maturation and social experiences in combination with parentally transmitted values (Beale Spencer 1983: 369).

Parentally transmitted values were explored by Stopes-Roe and Cochrane (1989) in a comparative study of Asian and indigenous white British families in the West Midlands. A parent and either a son or a daughter were interviewed - twenty of each - from four groups. In all there were forty Asian Muslims, forty Asian Sikhs, forty Asian Hindus and forty indigenous white British. These young people were between 18 and 20 years old and had lived in Britain for at least 10 years. The parents were required to have been born in their country of origin. Stopes-Roe and
Cochrane explored several hypotheses related to ‘family traditionalism’ amongst the Asian population in the West Midlands and the indigenous white population.

Hypotheses were constructed around questions related to traditional opinions on styles of family living, based on obedience to and respect for authority, and the importance of the family’s interest and obligations to family members. It was expected that Asian respondents would express more traditional opinions than the indigenous white British group (IWB), and that the younger generation would be less traditional in their outlook than their parents.

Individuals were questioned on attitudes related to obedience to parents, respect, consideration for family members, decision making and helping siblings. Parents and children were also questioned on whether parents and children should continue to live together.

The IWB group were found to be the least ‘traditional’ in attitude and the Sikhs the most traditional. Asian parents were equally traditional in attitude, but British mothers were more traditional than the British fathers. Asians of both generations were more traditional than the IWB. There was however a greater difference between Asian young people and their parents than between the IWB young people and their parents. The Asian families displayed differences in attitudes across generations which the IWB families did not.
One Hindu father is reported to have said:

I couldn’t bring the children up the way I wanted - I didn’t give them
the love and time that I should have, consequently they are more
independent.

Independence was obviously not seen in this setting as a desirable
characteristic in young people.

There was a significant difference between sons and daughters in all
ethnic groups. Daughters were less traditional in their attitudes than the
sons. Daughters in all of the cultures felt themselves to be disadvantaged
as a group. For Stopes-Roe and Cochrane, this is because of the range of
opportunities now seen to be opening up for women, although Asian
young women and the IWB young women are starting from different levels
of independence.

The only point on which Asian and IWB parents made comparable
comment was on the desirability of a stricter routine of obedience and
respect within the family. While the IWB families were happy to support
each other when necessary they did not feel that parents and older
children living together was a good thing, the young people did not
however discount the benefits of family support. Neither did the young
Asians want to be entirely contained within the family.
In a continuation of this study at a later date Stopes-Roe and Cochrane (1990) asked the two generations of Asians and IWB to rate the three most desirable of Kohn's (1969) 13 values in child-rearing. These values are categorised into two groups, conformity and self direction. It was found that Asians valued conformity more and self direction less than the IWB, and that the difference was considerably more pronounced in the older rather than the younger generation. The conformist qualities included obedience and sex appropriate behaviour. Compared with the IWB families, for first generation Asians in Britain, traditionalism rather than socio-economic status seemed to be the critical influence on attitudes towards conformist qualities. Stopes-Roe and Cochrane concluded that second generation immigrants are more likely to become assimilated into the host society than their parents. However they will still be subjected to influences by the culture of origin and values of their parents and the community in which they are reared as every child is (Stopes-Roe and Cochrane 1990: 150).

Schooler's (1972) earlier work in this area also shows that a greater tolerance of constraint in later life can be related to a more restricted and traditional childhood and that values of family and culture of origin were not lost over the space of one or more lifetimes, emphasising the power of previously established cultural models. A recent study by Nakagawa et al (1992) of stress, social support and attachment behaviour among Japanese mothers and children in the United States, demonstrates how 'symbolic meaningful systems' may be held onto even when immersed in
another culture. Nakagawa proposed that because the stay in the United States of these families was temporary, their primary cultural identification, value systems and child-rearing practices would remain largely Japanese. This emphasises the power of previously established patterns of family interactions, and cultural models of child care, in the absence of other cultural supports.

However two studies reported by Youniss (1994), which were carried out on Croatian families who had emigrated to the USA (Zivkovik 1990), and Turkish families living in Germany (Nauck, 1987, 1988, and 1989) reached different conclusions. Nauck and Zivkovik both agreed that although adults differ in their assimilation to the host culture, they display similar child rearing practices that tend towards the host cultural norms. This suggests, says Youniss, that parents are sensitive to cultural differences, and seek for their children behaviour that will suit adaptation to the host society. It seems that although immigrant parents value and wish to preserve their ethnic traditions and identity, the goals for their children are directed towards economic practicalities.

**Differing Parental Interactions**

Some of the differences observed by Caudill and Frost (1973) between Japanese and American mothers were consonant with the kinds of social intercourse and patterns of interaction at a later age. For example Japanese mothers spent large amounts of time soothing and lulling their infants rather than stimulating them with active chatting as the American
mothers did. They saw quiet contented babies as the desired norm, whereas the American mothers encouraged open, expressive, assertive and self directed behaviour. These differences are further explored by Wolf et al (1996). The USA mothers may have been more exposed to ‘expert’ advice from psychologists in the middle of this century, when the attention of parents was drawn to the possibility of lasting psychological damage that could result from excessive inhibition of natural feelings, such as jealousy, especially in relation to sibling rivalry (Wagner and Stevenson, 1982). Spock (1968) felt that this belief about the nature of personality development influenced parental reaction to some kinds of emotional disturbance in young children. Parents thought it important to allow emotional conflict to be expressed and played out so that it could be discussed (Spock, 1968: 12). Spock advised that there were three requirements of the parent in an emotional outburst - such as jealousy: to protect the other child or baby, to show the child that they will not be allowed to carry on with their harmful action, and to reassure the child of the mother’s love.

Discussing childhood aggression more recently, Ekblad (1988) declared that in all societies, parents must socialize their children to exert control over their aggressive and hostile motivation. She maintains that the literature on ethnographic evidence shows that some form of aggression occurs in nearly every society. However, the child rearing methods that parents use may differ from one society to another and indeed within societies. One important determinant, Ekblad believes, about how a child
is reared is the parents’ belief about the basic nature of children and their theory of how one moulds a child into their ideal.

In this Ekblad is restating a position held by Super and Harkness (1982) who saw cultural differences in child-rearing resulting from adult beliefs about the nature of children, and the world in general. An historical concept of childhood is introduced as an element affecting child rearing practices, a position fully discussed by Aries (1973). It can be a limiting view if one reflects on the different lifestyles of children from affluent and impoverished families throughout the last century in many societies. The way in which children are and were reared has often been a consequence of the level of economic pressure on the family.

Family Cohesion and Economic Survival

As we have seen above the family is a social unit but with definitions and parameters varying considerably between and within cultures, according to the context in which it is being discussed. Where agriculture and business are family based and wage labour is not the basic economic form, the traditional joint family provides a secure labour force and an independent unit of production (Stopes-Roe and Cochrane 1989). To ensure smooth running of a unit including several adults a hierarchical and authoritarian structure often evolves, and this in turn sets up certain goals which influence child-rearing. Decisions are made by and in the interests of the group rather than the individual. Obedience and respect for elders and those in authority and the family reputation are superordinate
requirements (Stopes-Roe and Cochrane, 1989). Stopes-Roe and Cochrane accept that this ‘traditional’ type of family is characteristic of the Indian sub-continent, especially in rural areas. Members of such families, they say, are expected to be obedient and respectful to those above them in the hierarchy, and to give support when needed to siblings and parents. In contrast, Lau (1984) found that in the indigenous white population in Britain, the individual constitutes the most important unit and self sufficiency, personal autonomy and independence were highly valued.

Super and Harkness (1982) observe that many aspects of a young child’s environment are influenced by the way families are organized for other purposes, and cite the use of child caretakers as an important example. In many societies around the world, the moment to moment care of a baby is given to an older sibling or other relative. Whilst attitudes within a group concerning the desirability of multiple caretakers are probably consistent with the dominant pattern of that group, it would appear that aspects of socialization, such as means of economic production, family size and mother’s work load are more directly linked to the use of caretakers than to cultural values themselves. Certainly in America and other Western countries over the past decades, it can be argued that maternal employment outside of the home has led to increased group care for young children. Parental attitudes however may lag behind, and a sense of guilt still worries young mothers who feel either the economic or personal need to go out to work, leaving their children with caretakers. This is
probably more so where an extended family is not available to assist in this role (Oakley, 1992: 202).

Defining the Requirements of Child-Care

The question of how parents of a given culture define the requirements of child care during the first year of life is discussed by LeVine (1988). He has in the past he says defined the dual roles of a phylogenetic perspective - an innate sensitivity on the part of mothers to respond to infant signals for nurturance - and a cultural perspective, which assumed that parents were guided by culture-specific models of interpersonal relations. He gives as examples the independence model for middle class Americans and the interdependence model for middle class Japanese parents. He now extends this, saying:

parental activity whilst constrained by the human genome, and directed by cultural values, must also be seen as adjusted consciously or unconsciously to those aspects of the environment that threaten or facilitate the attainment of parental goals (LeVine 1988: 4).

LeVine now sees this adaptive behaviour in parental care as being influenced by historical changes in demographic, socio-economic and cultural environments. He claims that each major type of human socio-economic adaptation, whether it be agrarian or urban-industrial, is assumed to have an optimal parent investment strategy. This strategy
reflects the specific incentives and hazards which affect reproduction and conditions the assumptions with which adults approach parenthood.

Agrarian parental strategies are quantitative, says LeVine, with high fertility the primary goal. This reflects the high value placed on relatively unskilled child labour for the purpose of food and craft production. There is also a high value placed on children for parental support in later years. The high mortality rate of infants and children in societies such as this - an example would be sub-Saharan Africa (Page and Lesthaege 1981) - makes the main goal for parents the survival of the maximum number of children. Long periods of exclusive maternal attention, including co-sleeping and breast feeding are strategies for achieving this. (It must be noted however that parental goals may not always be consonant with the ideology of the country, as may be seen currently in China and in the past in Singapore. In these cases parents have had to subjugate their values to those of the government.)

Conversely, parental strategies in the urban-industrial model suggest that the primary goal for their children is the acquisition of more academic skills. A low infant mortality rate and an expensive preparation for adult roles by education necessitate smaller families. Contraception and delayed marriages are methods of keeping the supply of children in balance. Infant care is construed less as nurturance for the child and more as mental and social stimulation for a child with a future. Thus the distribution of maternal attention should be opposite to that in agrarian
societies. Indeed urban-industrial parenting requires a large commitment of parental attention, with the provision of such resources as space, food, clothing, playthings and educational provision usually outside the home. It can also involve a variety of caretaking arrangements, and sometimes multiple caretakers, not always from within the family.

In a study of child-rearing goals by Richman (1979), nineteen out of twenty mothers in Boston mentioned the importance of independence, and stated that it was the parents’ responsibility to help their children achieve this (cited in Richman et al 1988). They were also concerned about children being happy. Seventeen of these mothers felt that children should be generous, honest and respectful of the rights of others. Richman et al offer the theory that parents in the United States stress general cultural values because they feel that they have little control over the specific economic path their children will follow. This attitude they see as being related to the unpredictability of the future and the acknowledgement of their children’s right to make independent choices.

Many of the mothers in the Boston study felt that their child care practices concerning meals, bedtimes, play and social interaction were purposeful and of long term consequence. As the patterns of child care became established and predictable there was feedback from the children’s behaviour which led the mothers to feel they were doing a ‘good job’. Some of the most common short term goals voiced by mothers in the
Boston study, and in this study, were protection against hazards and the management of eating and sleeping.

The avoidance of hazard can be of equal concern in both rural agrarian cultures, and modern urban-industrial societies. In the United States for example, 66% of deaths for boys and 30% for girls in the first year of life are due to accidents (Richman, 1988). This reduces slightly in the second year of life to 56% for boys and increases to 38% for girls, most being related to household hazards. The mothers in the two different societies respond quite differently. The American mothers try to remove potentially hazardous situations by child-proofing the environment, and by the use of high chairs, car seats, stair gates and playpens. There is also an attempt to educate the child to being aware of the hazards. The Gusii, an agrarian people of Kenya, restrain their children primarily by holding and binding them to the mother’s back.

Another observation by Richman is that children in most Western societies have to learn the demarcation between social time with other family members and time alone, i.e. bedtime, and sleeping alone. Pressure put on children to be separate and develop autonomy may produce emotional side effects such as separation fears and nightmares. However, Richman says that these child care practices are consistent with the culture-specific long term goals of training for independence, happiness and good relationships with others.
Rebecca New’s (1984) study of Italian mothers’ attitudes towards the management of their infants’ eating and sleeping patterns shows almost the reverse of the American pattern. The Italian pattern allows social interaction for the infant but limits scope for developing initiative, whereas the American child care pattern limits social interaction to specified times but encourages the development of initiative. (New’s study is discussed more fully later in the context of the Italian families).

The Expert

A strong influence on child rearing in the Western world during the last century has been that of the ‘expert’. These are notably the developmental psychologists, the medical profession and the health care professionals who advise and support mothers. Sweden, it is claimed by Welles-Nystrom (1988), is a country where parents more than in most other countries look to medical science and a progressive government for guidance in matters of reproduction and child care, with mothers measuring their performance against the optimum standards set by ‘the experts’. Welles-Nystrom suggests that parental attitudes and behaviour are heavily influenced by legislation. With a low birth rate of 1.6 per woman and an infant mortality rate of 4.5 per 1000 live births, (1993, Swedish Embassy) which is one of the lowest, if not the lowest in the world, parents are serious about giving their babies the best care possible. This can create some dilemmas, says Welles-Nystrom, for example if breast feeding is defined as optimal by the experts, first time mothers may worry about whether they are capable of doing it effectively.
Of the 49 couples in Welles-Nystrom’s research, 10% equally shared parental leave and acted as the primary caretaker for equal amounts of time. Feeding the baby by bottle and spoon was seen as a paternal task to allow the father to share the emotional satisfaction of parenting. Younger parents tended to share all the tasks such as bathing the baby, while older parents divided child-rearing tasks. For example, a mother would feed the baby and the father put the child to bed. Fathers in Sweden have had the right to take parental leave since 1973.

Sweden is a prime example of a Western society where mothers rely very much on ‘the experts’ for guidance in their child-rearing practices, especially where young mothers are isolated from a supportive family network. However, continually striving to meet this current popular ideology may deprive mothers of the security which folk models of child-rearing afford to mothers in more traditional societies. At its best, expert advice may help to develop insights and offer strong support. At worst it may generate confusion and guilt.

To return to the three major influences on child-rearing identified at the beginning of this chapter; economic survival, family cohesion and the transmission of cultural values, we might ask how these relate to Sweden, or any other modern technologically advanced Western society. Economic survival has for parents in these industrialised societies assumed a major role, perhaps equal in importance to these parents as to those parents in a rural agrarian society. The needs may be different, in accordance with the
expectations of the individuals, but nevertheless there is a striving towards parental goals both material and ideological. Family cohesion may be weakened by the social mobility within such an economy. Friends, carers for the children and other social networks fulfil some of the roles of the family. The transmission of cultural values in relation to child-rearing becomes more the province of the ‘expert’.

It now becomes necessary to identify those who have established themselves as the ‘experts’ on child-rearing in the UK. The evolution of their views will be traced, and the impact these views have had and are having on young mothers today.
CHAPTER 2

CHILD REARING PRACTICES IN THE UK IN THE 20TH. CENTURY
The Experts

Child rearing practices vary over time and in different races and religious groups. Intervention carries a substantial risk of ‘saving’ children from families who merely have different life styles from dominant conceptions of appropriate child rearing, but there is no ‘proper’ way to raise children (Morris et al., 1980: 127).

This statement reflects the counter-cultural currents of the 1960s, contend Dingwall and Eekelaar (1986) who ask: ‘Can there be no proper way to raise children?’ They argue that there can be limits and illustrate this by saying that children fed on certain diets could starve to death or suffer serious malfunctions. They also suggest that children reared in certain ways experience avoidable prejudice to their life chances and that here the psychologist may have a part to play in evaluating these processes.

This argument is qualified by saying that:

in a complex modern society it is probably wrong to think of a single ‘proper’ way to raise children. A degree of diversity may well be part of that society’s evolutionary dynamic. On the other hand, it is probably equally incorrect not to recognise a proper range of variation outside which children are unacceptably disadvantaged. The question is how is this range judged and its limits drawn (Dingwall et al., 1986: 69).
They go on to ask if this is a task where psychologists have taken over from Shelley's poets as the 'unacknowledged legislators of mankind'.

He, the poet, must write as the interpreter and the legislator of mankind and consider himself as presiding over the thoughts and manners of future generations, as a being superior to time and place (Samuel Johnson, Sermons 1788, Ch. 11, No.23).

Dingwall et al think not and have identified disunity amongst the regulators. Quoting Hughes (1971: 287) they say:

when psychologists move into a prescriptive role they begin to concentrate power which is mystified by the rhetoric of science. The professional adds to the licence to investigate and advise, the claim to a mandate to define not merely proper conduct, but even modes of thinking and belief for everyone individually and for the body social and politic with respect to some broad area of life which they believe to be in their occupational domain.

Dingwall summarises the argument by saying that as soon as psychologists begin to specify a form of child care practice they imply a mode of social organisation (Dingwall et al., 1983).
Since children have been recognised as individuals with needs, perceptions and ways of understanding that are different from those of adults, theories with regard to their upbringing have abounded. Psychologists, educationalists, health workers and theologians have declared their views on how children should be reared. Parents are usually the child’s primary source of instruction and influence throughout the early years and virtually all parents attempt to socialise their children into the values and culture most familiar to them. There may be differences between households in the way in which parents interact with their children but received ‘wisdom’ from the culture has a powerful influence on those who prescribe, legislate and advise on child rearing and this ultimately affects the parents themselves. Health care professionals regard themselves as having a role in this; ‘Nurses have long recognised their responsibility to assist individuals in their acquisition of knowledge to become effective parents’ (Gorzka et al., 1991, p. 16).

Children are also seen to have a part to play. Miller et al (1995) propose that cultural practices provide the route by which children come to participate in a culture, allowing the culture to be ‘reproduced’ or ‘transformed’. They see children re-creating culture as they learn to participate in the practice. This cannot be better illustrated than by listening to the creative way in which children use language. Miller et al believe that this view offers a most significant challenge to traditional beliefs of the relationship between children and culture. It is an
interactionist stance which has been accepted for some time in other areas of child development.

Earlier this century, and previously with the Victorians, 'will breaking' was the recommended approach to bringing up children. Alice Miller (1987) gives spine chilling accounts of advocated beatings and humiliating treatment of children prescribed as attempts to curb their will and as a way of eliciting obedience and behaviour desired by their parents and teachers. She quotes from Rutschky's (1977) historical research, Schwarze Pädagogik. This black pedagogy is a review of the German and Austrian literature of the 18th and 19th centuries which gives advice for parents and teachers. The following examples are typical of the advice given:

the infant must perceive order and discipline before he becomes conscious of them, so that he will proceed to the stage of awakening consciousness with good habits. The adult must instil obedience by the exercise of power, this is done with a severe glance, a firm word, possibly by means of physical force (Miller, 1987: 41).

Wilfulness must be broken at an early age by making the child feel the adult's unquestionable superiority. Shaming the child had a more lasting effect especially on vigorous natures (Miller: 47).

Alice Miller claims that the adult's friendly regretful manner following severe punishment is all that remains in the child's memory, accompanied
by a predictable submissiveness. Miller sees this tyrannical approach to child care as the backcloth responsible for Freud's disturbed patients in Viennese society.

Humphries et al. (1988) note the shift from formality, authoritarianism and distance to informality and libertarianism and closeness between parents and children in the course of this century.

The approaches of 'spare the rod and spoil the child' in the poorer classes and for children to be 'seen and not heard' in the more affluent classes was congruent with the moralist beliefs of the Puritans and the Evangelist movements of the 19th Century. These religions encompassed the concept of original sin. Children were perceived as being born sinners and requiring a stern moral upbringing in order to break their wills. As Charles Wesley said: 'Break his will now and his soul will live'. According to Humphries et al this was by no means a universal phenomenon. They describe Jewish and Italian communities where evangelicalism had little influence and a unique libertarian view of child rearing flourished. Corporal punishment was practically unheard of and parents controlled children by reasoning with them (p.49). In the UK however, a controlling approach was advocated in most areas of child-rearing, borne out in the advice given to parents on mothercraft.
Mothercraft

Around the 1920’s, following the first world war, the idea of Mothercraft developed due mainly to the influence of Frederick Truby King, a Scottish doctor. Clear cut rules about the way in which babies were to be reared were prescribed in an attempt to ensure healthy children. The state also became involved in providing better health care to combat the very high levels of infant mortality. As early as 1905 Huddersfield had pioneered compulsory notification of births to the Medical Officer of Health in order to enable a comprehensive health visiting programme to get off the ground.

Initially there were many voluntary schemes which set out to inculcate middle class values of thrift, cleanliness and godliness. Such a venture was that of the MacMillan sisters (1930) who opened an open air nursery for the slum child. Here, they said, the child could live in the open air, having shelter from rain, cold and heat, but free to look upon the sky, to see the moving trees and feel the warm and healing light of the sun on his limbs. Their intention was to encourage new habits and to educate mothers into keeping their children clean, healthy and well nourished.

Eventually the government gave financial support to local authorities to establish ‘Infant Welfare Centres’. Attendance was not compulsory but working class mothers flocked to them. There was advice on feeding and clothing. Babies were weighed and had regular health checks. Mothers
also had the opportunity to take part in sewing classes and cookery
demonstrations.

This focus on keeping healthy together with improvements in the standard
of living and better housing resulted in a drop in the infant mortality rate
from 154 per 1,000 live births at the beginning of the century to 66 per
1,000 live births by the early 1930’s. In 1963 this was 21.8 (Office of
Population census, Eurostat Demographic Statistics 1993). In a recent
survey by the Labour Party, (Guardian Feb.8th,1996), the average rate for
the UK is 6.1, with a range of 3.2 (Surrey) to 11.4 (Sheffield).

With the advent of health clinics also came professional and ‘expert’
advice. Most notable amongst these early professional advisers was Sir
Frederick Truby King. He proposed a relentless physical and
psychological programme of infant care which largely ignored individual
differences between babies. His ‘Mothercraft’ theories typified the age
and together with those of the behaviourist Watson (1928) they presented
a totally mechanised view of child rearing.

Having studied medicine at Edinburgh, Truby King became Superintendent
of a psychiatric hospital in New Zealand and he became interested in the
scientific rearing of animals because of the high death rate of calves from
a disease called ‘scouring’. He devised a scientific system of feeding
which brought an end to these deaths. The disease was similar to gastro-
enteritis in babies and he was convinced that if mothers adopted the same
systematic approach to feeding human babies, lives could be saved.

In New Zealand the Plunkett Society was formed to put his ideas into
practice and within five years the infant mortality rate had dropped by
1,000 deaths a year. He had demonstrated that skilled attention to infant
care and feeding could save lives. The Mothercraft movement developed
rapidly and infant mortality was halved. Breast feeding was encouraged
with rigid clock bound schedules to avoid overfeeding.

Truby King came to England in 1913 to spread the word, 'Breast fed is
best fed'. Cows' milk was for baby cows not humans. Babies had to be
fed by the clock three or four-hourly five times a day and should have
eight hours unbroken sleep at night. Crying should not deter the mother
from sticking to the routine.

Mothers have too much to do in any case; why should they throw
away time and leisure by frequent useless nursings (Truby King
1913).

In his Mothercraft book he claimed:

A real Truby King baby is completely breast fed until the 9th month,
and then slowly weaned onto humanised milk with the gradual
introduction to solid foods. Truby King babies are fed 4 hourly from
A Truby King baby had as much fresh air and sunshine as possible and the right amount of sleep. He is not treated as a plaything, made to laugh and crow and 'show off' to every visitor to please his parents' vanity (Truby King, 1913).

Newson (1974) comments that it took a great deal of courage for educated mothers to ignore a system which combined quasi religious beliefs such as 'duty' and righteousness. By the time the Newsons undertook their large study of child rearing practices in Nottingham (1963) they found that working mothers ignored these directives and followed their natural instincts by feeding on demand and cuddling their babies for comfort.

Hardyment (1983) comments that the Truby king movement undeniably revived breast feeding at a time when artificial feeding had become a world wonder. It also established hygienic standards of Mothercraft and no doubt saved many babies' lives. However, some cynics felt that it led to a generation or two of hungry babies convinced of their unimportance during the long night time sessions of crying it out.

Watson's (1925) views on toilet training were equally rigid. He advocated 'holding the baby out' regularly after breakfast and at the age of eight months strapping them to a special toilet seat and leaving them alone in the bathroom with the door shut and no toys. Within twenty minutes he suggested that a bowel movement should have occurred.
Marie Stopes (1939), who was also advising mothers on child rearing, was much more liberal than King or Watson but could not go as far as the permissive Freudians in matters of potty training. She stressed that babies who were loved properly and well bred do not like to be soiled.

‘Furthermore they do not take the perverted pleasure in ordure which the aberrant mind of Freud had smeared on the social consciousness’.

With the behavioural approaches of Watson, the strong high minded principles of Truby King and the clearly laid out developmental process schedules of Arnold Gesell (1940) mothers found themselves confined within very strict boundaries of how they should rear their children. This contributed to feelings of guilt and inadequacy if children didn't adapt or fit into these norms.

I was caught up in the Truby King Mothercraft doctrine. The Health Visitor prated and bullied. One’s baby screamed and tears splashed down one’s cheeks while milk gushed through one’s jersey but one must never pick up the baby. It was practically incestuous to enjoy one’s baby (Quoted in Humphries et al. 1988).

Spock and Bowlby: The New Approach to Child Care

Spock (1946) and Bowlby (1951) arrived on the scene in America and England respectively at about the same time. The arrival of Spock’s Common Sense Book of Baby and Child Care must have been a welcome relief to many mothers. It sold in millions, only surpassed in sales by the
Bible. The rigid approach to child rearing which was in vogue was totally rejected. The 1957 edition opened with a chapter headed Trust Yourself, you know more than you think you do'. The chapter goes on:

don't take too seriously all that the neighbours say. Don't be overwhelmed by what the experts say. Don't be afraid to trust your own common sense. Bringing up your child won't be a complicated job if you take it easy, trust your own instincts and follow the directions that your doctor gives you. It may surprise you to hear that the more people have studied different methods of bringing up children the more they have come to the conclusion that what good mothers and fathers feel like doing for their babies is usually best after all (Spock, 1957: 3).

Spock who described his own mother as ‘an idealistic disciplinarian, and killjoy ‘(The Guardian, 20/3/93), said he had set out to make child rearing more comfortable for parents and children.

The student radicals in the 1960's who protested in America against the bomb and the Vietnam war, were the first generation of children whose parents had enjoyed Spock talking ‘sense' about child rearing. Spock also made clear his opposition to the Kennedy government policies on nuclear testing and the Vietnam war. He became the President of the peace movement in 1963 and spoke openly on these issues to students on
many campuses. He was eventually arrested on conspiracy charges for supporting draft resisters.

Spock was blamed by conservatives in America for the lack of patriotism and discipline in the American college students. They accused him of encouraging permissiveness because of his influence on the child rearing of these young people. This was twenty two years after the publication of his book. This still upsets him a great deal and may be seen as another example of a socio-political situation entering into and affecting the child rearing debate. Spock maintains that the people who accused him had not read his book as he had never advocated permissiveness, just a more relaxed attitude to being a parent in order to enjoy one's children.

The women's movement also attacked Spock for being sexist, which led him to revise his book in 1976, changing the male pronouns throughout and withdrawing some stereotyped comments about girls. Now at the age of 91 years he feels that he has become more moralistic and no longer thinks that setting children a good example is enough. He believes that children should be much more involved in parental discussions about the world, ideals and morals.

They should have dinner together. They should discuss the neighbourhood’s unwanted pregnancy, how the couple were not thinking about the baby, how they should be more careful. Parents should express opinions. (Guardian, 20/3/93 ).
Controversy apart, Spock says he is still stopped by parents and thanked for helping them to rear their children.

Hardyment (1983) comments that the new model baby of this era was warmly affectionate, dependent, impulsive and (preferably) scintillatingly intelligent. She identifies intelligence and emotional depth as the modern touchstones for child rearing theories at this time. In her view, the work of Freud and Piaget, which had infiltrated thinking in areas of child development over the past 30 years, epitomized these concerns. Hardyment also comments that a reaction set in after the second World War to give children greater freedom. Babies were fun to be enjoyed and child rearing became child centred. Child rearing literature spoke with a unanimous voice on the enjoyment and fun of parenthood (Jolly (1975), Leach (1977). Writing in 1957, Spock has Enjoy Him as a chapter heading (p. 42). Katharine Whitehorn writing in the Observer said that Dr. Spock and his ‘baby knows best’ theory was arguably the most dispiriting of all the theorists.

His advice was sensible enough but he kept insisting it was all such fun; so that if things were going wrong you felt guilty and miserable. (Observer, 10/11/91).

Educational trends in the latter half of this present century have also become very child centred. Curriculum, particularly in primary education, has been influenced by the work of Froebel (1826) who stressed that
children should be allowed to develop in the way and pace appropriate to them. His work had a great influence on John Dewey, the American philosopher whose thinking in turn was to be so influential on education. In Italy, Montessori had emphasised the innate potential of children and their ability to develop in environmental conditions of freedom and love (Lillard, 1972).

Susan Isaacs (1930 and 1933), an educationalist of the psychoanalytical school, based her approach to children's learning on the work of Maria Montessori, but also pioneered ideas which were considered 'progressive' in education. The assumption she held was that even quite young children were capable of making decisions about their own lives. She encouraged children to take the initiative, she stimulated active inquiry and believed in helping children to formulate their own concepts. These ideas are reflected in the work of Piaget and more recently Bruner, both of whom have influenced curricula based on the child coming to grips with basic principles through active discovery learning.

Perhaps the strongest influence on parenting in England during the last half of this century was brought about by John Bowlby. He was appointed consultant in mental health to The World Health Organisation in 1950 and the paper he wrote for them in 1951 entitled Maternal Care and Mental Health was later expanded into his influential book, Child Care and the Growth of Love (1953).
In this book Bowlby claimed that it was essential for the mental health of children that they should experience warm intimate and continuous relationships with a mother or person who steadily mothered them during their early years. These relationships, which could be varied in many ways with other family members, were necessary for the development of character and mental health. It was Bowlby’s view that if this state of affairs did not exist for children they would experience and suffer from maternal deprivation. Furthermore even if children were living at home they could experience this deprivation if the mother figure was unable to give loving care.

Bowlby also expressed the exclusivity of the maternal bond by maintaining that children still suffered partial deprivation if they were cared for by someone who they knew and trusted such as a foster mother. Complete deprivation he associated with situations such as residential nurseries and hospitalization of children. Time spent in these institutions could have far reaching effects on the character of children and cripple their capacity to make meaningful relationships with other people. He also made the following particularly strong statements.

The difficulty of deprived children to become successful parents is perhaps the most damaging of all the effects of deprivation (Bowlby, 1953, p. 34).
The absolute need of infants and toddlers for continuous care by their mothers will be borne in on all who read this book (Bowlby, 1953: 18).

He concludes;

There is a very strong case indeed for believing that prolonged separation of a child from his mother or mother substitute during the first five years of life stands foremost among the causes of delinquent character development (1953: 41).

Bowlby’s evidence for these theories was based on observational studies of the mental health and development of young children in hospitals and institutions. Numbered amongst these were the Robertsons’ studies (1953, 1968, and 1970). He also used retrospective studies of adolescent boys with psychiatric and delinquency problems whom he saw in the course of his work.

These affectionless characters almost always had a history of separation (Bowlby, 1953: 41).

There were positive outcomes from his theories, the most immediate being a reaction against rigid attitudes towards child rearing prevalent at the time. Attention was also drawn to the plight of young children in hospital where visiting by parents was usually very restricted and, in some
instances of infectious diseases, forbidden. There were also major implications for children undergoing long-term treatments. As evidence from the numerous studies grew, pressure mounted for a change in attitudes towards children in hospital. Consequently in 1956 the Platt Committee was set up to make a special study of the arrangements for the welfare of sick children in hospital. Their report was published in 1959 and recommended many changes. In particular the report advocated home care wherever possible. Parents’ authority was to be recognised and their methods of handling their children respected. One of the major issues was the admission of the mother with the child and if this was not immediately possible then it was recommended as vital that the child be visited frequently.

One of the most negative consequences of Bowlby’s book was the guilt it engendered in working mothers. There were also socio-economic repercussions. The need for women to work during the 1939-44 war had resulted in an expansion of nursery places for young children. These places had decreased in the 1960’s to less than a third of those available during the war. New towns like Harlow in Essex were built in the late 1950’s with no nursery provision whatsoever (Hughes et al., 1980).

**Theories of Attachment and Bonding**

Hot on the heels of Bowlby’s theories of attachment came the concept of ‘bonding’ introduced in the 1970’s by Klaus and Kennell (1976) who suggested that mothers needed to become bonded to their infants and
the critical period for this to take place was immediately after birth. This early contact is meant to release innate behaviours of touching, smiling and caressing which lock mother and child together. A disruption of this process by separation could alienate mothers from their infants.

To investigate this, Klaus and Kennell carried out an initial study on 28 unmarried low-income black mothers, 14 of whom received one hour of skin to skin contact with their infants within the first three hours of birth and for five hours on each of the next three days. The control group of 14 mothers received brief contact after six to eight hours and then 20 - 30 minutes during feeds. When observed at the one-month check up, the contact group were described as exhibiting more attentive, soothing and fondling behaviours.

Studies of this type multiplied and Vesterdal (1976) claimed that lack of this initial contact could result in difficulties with future relationships for the child. Hales et al., (1977) reported that skin to skin contact significantly increased affectionate behaviours from the mother.

As with Bowlby’s theories, there were positive and negative influences. In hospital it meant that mothers were admitted to special care baby units if their babies needed to be admitted at birth and they were encouraged to participate in the care of their child. Maternity hospitals allowed mothers to have their babies at the bedside, rather than being taken away after feeds and put into the nursery. Epidurals became more popular for
caesarian births so that the mother would be awake to receive the baby when it was delivered.

However, the practice was in danger of becoming doctrinaire with mothers being forced into ‘bonding situations’. Many mothers experienced guilt if they did not feel immediate love for their baby. It also created a very pessimistic outlook for adopted and fostered children. It seemed that mothers had no alternative but to devote themselves body and soul to their children (Hardyment, 1983).

The balance was redressed eventually by Rutter (1977) and Richards (1979). Sluckin, Sluckin and Herbert (1983) also carried out a thorough review of the research on the bonding hypothesis and found evidence to be inconclusive that early skin to skin contact had any lasting effect on maternal behaviours. They said that there was no evidence from human studies that supported the notion of a sensitive period for the formation of mother-infant bonding attachment.

**Popular Current Theories on Child Rearing**

Leach (1977, 1989) perhaps represents the popular public view at present. She claims that her book is written from the baby’s or child’s point of view and says that however child rearing may shift and fashions change, their viewpoint is the most important and the most neglected. She believes that rearing a child by any book or set of rules or pre-determined ideas can work well only if the rules happen to fit the baby, but even a minor
misfit can cause misery between the two. Leach concludes her introduction by saying:

I am not laying down rules. I am not telling you what to do. I am passing on a complex and, to me entrancing folk lore of child care, which once upon a time you might have received through your extended family (Leach, 1989).

This statement of Leach’s does not ring entirely true in the light of her recent activities as founder member of EPOCH (End Physical Punishment of Children). Their recent publication is entitled Positively no Smacking (1991) and is aimed at parents. The thrust of the campaign is for a change in the law concerning parents’ rights to smack their children. The Health Visitor Association has joined with EPOCH in this campaign and their view is that many parents wish they did not smack and a legal ban on this would resolve the dilemma.

The author took up this issue in a discussion with a group of 22 paediatric nursing students. They were asked what form of discipline they had found most hurtful and disturbing as a child. None of the 22 students mentioned physical punishment. They hated being sent from the room, a feeling of withdrawal of parental warmth, being alienated from a parent and to some extent having privileges withdrawn. Many had been smacked from time to time but it had not concerned them unduly. They commented that it was over and done with and they knew they had done wrong.
They were asked their opinions of the EPOCH campaign. All but one said they did not agree with making smacking illegal. The discussion concluded that whilst it was probably better to try other alternatives where possible, at times it was more appropriate to 'tap' a child or smack. They felt that it could be less psychologically damaging. There was also a general consensus within the group that smacking as a spontaneous corrective or due to a parent's alarmed response to a child putting themselves in danger should not be aligned with systematic child abuse. Certainly there are sections of this publication which seem to encourage this opinion.

We might reflect on Hardyment's following statement.

> Telling mothers and fathers how to bring up their children in books is arguably as silly as sending false teeth through the post (1983).

**Child Rearing and the Health Visitor**

The research question central to this study refers to the professionals who support and advise parents. These professionals are specifically identified as the community health visitors, as they are seen as having the most opportunities for advising and offering support to parents in their child rearing practices.
Orr (1990) and Luker and Orr (1985) describe the key strengths of contemporary health visitors as their freedom of access to people in their own homes and their access to community networks.

They may be seen as the specialist practitioner who is involved at a community level enabling and facilitating communities to address their own health needs. This fits in with the WHO's thinking on Primary Health Care (Orr, 1990).

However, they also go on to identify some of the perceived problems of the current approach to health visiting as follows;

The notion of intervening in family life to assess need is complex and has within it tensions based on the relationship between the state and the family.

Pregnancy and childbirth result in the private family becoming the public property of professionals.

The parents have to measure up to the professionals’ expectations and current child rearing theories and the emphasis is mainly on reinforcing conformist types of family patterns (Luker and Orr, 1985: 68).
Foster and Mayall (1990) identified four models of health education in a paper which explored the concept of health visitors as educators. The first model is a top down method where the educator tells the learner what is good behaviour and urges them to adopt it. The second, whilst still aiming at changing behaviour within the context of the learner’s circumstances, assumes that change will only take place if learners take an active part in defining what their health problems are. The health educator can then engage in a dialogue where solutions may be identified. This process is frequently termed ‘empowerment’, a concept to be discussed later.

The third and fourth models discussed are ones in which the educator aims to help people change their circumstances and help them to consider improvements in their health care behaviour in the better circumstances. Again, in one of these models the health educator may set the agenda and in the other, as with the empowerment model, there will be a dialogue with the clients concerned to identify the problems and work on them together.

Barker and Anderson (1988) took empowerment as the basis for their large child development programme which has been in operation for seven years, directed jointly by the Early Childhood Development Unit at the University of Bristol and participating health authorities. At present 100 health visitors are taking part in this programme which is seen as a profound change in the approach of health visitors to the families they
visit. The traditional role has been for the health visitor to enter homes with a clear set of aims and objectives. The visit is usually unannounced and although the approach may be friendly and informal there is usually clear advice from the health visitor on how to tackle problems (Barker, 1990).

The health visitors involved in the programme adopt a very different stance from the usual one. Appointments are made with the parents and the health visitor's task is to discover the parents' aims and objectives and to try to help them achieve them. She endeavours to develop the parents' own skills and provide support where necessary. The results of this programme will be considered later in the study.

**Foster and Mayall’s Study**

In a sample of 28 health visitors working in the same inner London district health authority and a further sample of 20 working in a county area, Foster and Mayall (1990) found that they saw their role as that of urging mothers to improve their child care practices. They generally favoured the top-down style of health education and believed that there was one correct way to rear children and that they knew what it was.

The health visitors participating in the study advised on a wide range of areas which included the physical aspects of health and emotional aspects of child care. They are said to have believed that they held superior knowledge to mothers on such issues as disciplining children, establishing
routines and the social aspects of eating. They tended to view their brief as that of changing the behaviour of mothers to the ways that they had identified as correct. Many also gave very prescriptive answers to questions about good nutritional practices for particular age groups of children (Foster and Mayall: 287).

Thirty three mothers in the same inner London health district were also interviewed about the professional stance of the health visitors. Only four approved of the top-down approach. The majority disliked being patronised, being given text book advice and any undermining of their own knowledge, and considered these to be offensive attitudes.

The mothers in this study favoured the partnership model where they were not made to feel stupid or that they were doing the wrong thing. Their comments showed appreciation of the non-judgemental behaviour of some health visitors and of being treated as if they themselves knew a lot about their own child.

The partnership model between educator and learner has long been advocated as an approach to adult education. Knowles (1984) says that adult learners should feel respected and supported and the psychological climate in learning situations should be one where there can be freedom of expression without fear of ridicule. Self-diagnosis of needs is advocated in order to help the students express competencies they desire.
to achieve, and the planning for these achievements involves a sharing of responsibility between teacher and learner.

Mutual trust, freedom of expression and acceptance of individual differences are all part of the transactional process of learning accepted as the model for adult education (Rogers, 1980; Knowles, 1984). In paediatric nursing professionals are acknowledging parents as partners. Many are using Casey’s Partnership Model (Casey 1995) on which to base their practice. The nursing of children is shared between family, child and nurse, the aim being to assist the child and family to have control of the child’s illness and thus regain the greater independence they enjoy when well.

If we are to accept the findings of Foster and Mayall (1990) it would seem that this philosophy of adult education and family centred care has not yet permeated the community network of carers. There are exceptions of course. One health visitor reported in this present study said she would not recommend any books to parents but rather encourage independence of thought and confidence in their own ideas and abilities.

Contemporary health care providers and educators are faced with a challenge to find health values, beliefs and practices relevant to different cultural groups in order to ensure their needs are met. This requires sensitive, informed and skilled providers and involves developing a concept of culture and an understanding of the ways in which different
people manage life events, including health and illness. The object is to reduce ethnocentricism.

In Bradford, for instance, indigenous white middle class health visitors may find themselves working in a totally Asian community. During this study the researcher accompanied health visitors in Bradford for a day of observation of client visits. All of the clients were Asian, and strenuous efforts were seen to be made by the Health Authority and the individual health visitors to understand and meet the needs of these families. According to these health visitors there are still very few Asian health care professionals working in the community, and a dearth of literature on the health beliefs of peoples from South Asia. These are issues which will need to be addressed if parents are to be empowered to take control of their own health care needs.

Empowerment has emerged in the literature as the recommended approach to health care management in the community. It is therefore necessary to explore further the idea of empowerment as it relates to health care issues and practice.
CHAPTER 3

EMPOWERMENT AS A HEALTH CARE CONCEPT
EMPOWERMENT AS A HEALTH CARE CONCEPT

The Concept of Empowerment

Rappaport (1984) drew upon the concept of empowerment as one which, combined with the study of naturally occurring helping systems, might energize and guide mental health policies. Key among his assumptions is the belief that the most important and interesting aspects of community life are by their nature paradoxical in that there is always more than one solution to a problem. He suggests that providing for the perceived needs of people may sometimes infringe their rights, and assuring rights does not necessarily satisfy needs. His solution to investigating social problems, which by their nature are complex, is a dialectic approach.

In this context empowerment is viewed as a process, knowable only in the form it takes. The forms, strategies and contents achieved will be variable from setting to setting. It is also seen as the mechanism by which people, organisations and communities gain mastery over their lives. For some people this mechanism may lead to a sense of control and for others actual control.

Gibson (1991) in her analysis defines empowerment as a multi-dimensional concept which may be transactional as it involves a relationship with others. She also agrees that it may be a dialectical concept as within the
process there can be varying positions in the outcomes. Another
dimension she postulates is that empowerment is dynamic as power is
taken, given and shared, and finally she suggests that it is a democratic
concept as the underlying process shows a redistribution of power and
advancement of social justice. This process has become the focus of an
approach to the practice of health care workers such as nurses, health
visitors and social workers and is described by Gibson as one of helping
people to assert control over factors which affect their lives. Although
nursing was and in many settings is still seen as an hierarchical
‘controlling’ profession, the embryonic elements of empowerment may be
found in Henderson’s now classic definition of the role of the nurse in
which she says:

The unique function of the nurse is to help people sick or well from
birth to death with those activities of daily living which they would
perform unaided if they had the strength, will or knowledge. At the
same time and throughout this relationship, nurses help people to
gain and regain their independence with handicaps and irreversible
disease, and finally to die with dignity when death is inevitable.
(Henderson, 1966, p. 15)

The need for unconditional straightforward help when there is a perceived
strength deficit is indisputable but today we would question why the sick
person does not have this will or knowledge. Perhaps it is support and
development in these areas where the nurse’s role also lies.
Malin and Teasdale (1991) argue that there is a tension between the concepts of caring and of empowerment. They use Griffin's definition of caring which suggests an action element and an emotion element. The action is in identifying patients' needs and meeting these needs when the patient is unable to do so. The emotional aspect is having regard for patients as individuals, being concerned about what happens to them and attempting to protect them from harm.

Can this view of caring be seen as embodying the notion of empowerment? The paternalistic inference would appear to be too strong for this.

Malin and Teasdale see the macro level of the caring professions or services as emphasising altruism which implies transference of responsibility from the individual to the experts or the state. They say that empowerment would rather imply a maximisation of the patients' independence and a lessening of their dependence on the expert, i.e., the nurse or health care worker. The new partnership model for paediatric nursing articulated by Casey (1995) seeks to encompass this ideology.

Paediatric nursing, in particular the consumer movement, The National Association for the Welfare of Children in Hospital, now Action for Sick Children (ASC), has been working since 1960 to gain improved care for sick children but above all to allow parents to maintain their control over
child care. This control reflects a grassroots desire for empowerment. With the publication of the Children Act (1989) and the United Nations Convention on the Rights of the Child, control has extended to include children as part of the decision-making process involving their care.

The British government’s recent White Papers (DOH, 1989a) (DOH, 1989b) are attempts to give patients greater autonomy and choice in health care, including freedom to choose where to have treatment and autonomy in decision making during the period of treatment. Unfortunately the depressed state of the National Health Service and the socio-economic climate render this an impossibility at present. Long waiting lists in NHS hospitals make choice unlikely unless one can afford private health care. In this situation choice and the availability of treatment is related to the financial resources with which to take control. Clients who are reliant on the system will experience loss of power and control and a sense of hopelessness and alienation, presenting a threat to pride and self-reliance.

Wuest and Noerager-Stern (1991) stress the need for a balance between individual and socio-political responsibilities. In their study of primary health care they interviewed 12 families with children having persistent otitis media with effusion. The families experienced interruptions of family life because of this illness. Initially they entrusted their children to the health care system. As the illness progressed they became frustrated and a feeling of helplessness ensued with initial trust turning to doubt. There followed an attempt to gain knowledge and skills in order to participate in
the problem. Throughout a process of trial and error these families learned to manage.

Malin and Teasdale cite numerous studies which show that patient dissatisfaction with health care is often related to lack of information. This has led to the belief that information can help relieve stress and anxiety and promote recovery. The giving of information is implicit in the Patients Charter (1991). This is intended to meet the concerns of patients and their families and also to promote family involvement in care. Examples of recognition of this philosophy are to be seen in the development of a Centre for Health Information and Promotion, (CHIP) within Southampton University's Child Health Directorate (Glasper et al, 1995), and a programme developed in The Children's Unit in Nottingham (Fradd, 1994)

The families in the Wuest and Noerager-Stern study experienced several stages which eventually led to gaining control. These were:

1) acquiescing;
2) helpless floundering;
3) becoming an expert;
4) managing effectively.

Desperation and a feeling of powerlessness forced the families to begin to attempt to influence the progression of events through experimentation. ‘We have tried everything’ is often the desperate plea of troubled parents worn weary by problems related to the ill health of a child or difficulties of
child rearing. These problems are discussed with friends, family and acquaintances who may have some suggestions. If the family is supportive, husbands or partners may take turns with mothers on night time duties; grandparents will either baby-sit or take the children for overnight stays to give the family a break. Wuest and Stern found that the families in their study developed managerial strategies that worked for them. They cultivated liaison roles with the receptionist in order to get to talk with the physician. They took the lead when they recognised patterns of illness: for example, if the doctor prescribed ten days of antibiotics and asked the parents to make an appointment for two weeks later, they would make it ten days so that the antibiotic cover would not be broken if, say, the ears were not clear of infection, thus taking control. They also developed strategies for comforting the child when they recognised the onset of pain.

Although such parents feel they are being told to leave management in the hands of the professionals, their own experience and observations tell them that this is ineffective. Therefore they begin to assume the role of the expert for themselves in a purposeful manner.

**Parental Roles in Child Health Care**

Parents take on other roles too, including that of educator informing teachers, family and friends in order that they too understand the behaviour of the child. This is a particularly important role for those parents whose children may have diabetes, epilepsy, eczema or asthma.
The child’s behaviour needs to be understood by teachers in particular, as recognizing symptoms can sometimes save life.

Parents also become managers and negotiators. This often leads them to become assertive and even to adopt an aggressive stance when a child is admitted to hospital. Nursing and medical personnel need to be aware, and able to understand this protective behaviour in order to respond appropriately. Parents empowering themselves in this way illustrate the views of Zacharakis-Jutz (1988) who objects to the concept of empowerment as a passive process charitably handed down. Rather he sees it as revolutionary and agonistic.

Parents with a chronically sick child can feel totally inadequate and de-skilled when the care and management of that child is taken away by professionals. From initial floundering some families may develop the skills which empower them through the facilities of libraries, friends and family. Eventually they may become expert about their child’s condition and develop strategies to manage the demands made upon them and become assertive on behalf of their child. It would be wrong to assume that all families can cope in this way. Many may have feelings of desperation and helplessness in relation their child’s illness. This has been frequently noted by the National Association for the Welfare of Children in Hospital in their Update publications.
The health care workers may need to speed up or assist this process in a more positive way. There is a need to let families define their own problems which are broader than the child's illness. It is necessary for the health care workers to initiate the provision of resources necessary for empowerment and to take into consideration the whole social structure and context of the problems confronting the families. One cannot easily detach the question of empowerment of the individual from the question of the empowerment of communities, says Skelton (1994), for behind both issues are questions of politics and power.

The Freire Model

Paulo Freire (1972) offered a major theoretical framework for empowerment in education. In the late 1950's Freire initiated a successful literacy and political consciousness programme amongst a poor community in Brazil. His central premise was that education is not neutral but takes place in the context of people's lives, and the educational process is one of continual shared investigation, a dialogue in which everyone participates as equals and co-learners to create social knowledge. Wallerstein and Bernstein (1988) describe his approach as being similar to health education's guiding principles in that he starts from problems of the community and uses active learning methods to encourage participation in determining needs and priorities. Freire sees the role of the educator as encouraging the group to raise its own themes for reflection and to contribute information. Rather than imposing their own cultural values, he suggests educators should enter into authentic
dialogue during which people redefine their own social reality. Action and reflection are seen as the keys to this learning process.

Freire’s work was conducted in group settings as opposed to the individual client/health visitor interaction and there is much to commend in his model. His premise that education is not neutral but takes place in the context of people’s lives and that it is a dialogue of equals can be seen to have validity in a one-to-one setting. One could also argue that there is a group identity between mothers in a neighbourhood and certainly within such a close cultural group as the Bangladeshi community in a small town. These networks were evident during this current research. However, a distinct difference from the Freire model might be the health visitor’s position of power in relation to her clients, particularly the Bangladeshi mothers. She is after all a salaried professional with elements of health surveillance and policing in her role. These factors immediately put her clients on a different level in the power structure.

A concern voiced by Skelton (1994) is that under the guise of the rhetoric of empowerment, there lurks an older view that the professional knows best. It is about getting the client to come round to a way of behaving which the ‘expert’ believes is best, while at the same time persuading the client that it was their own idea. This seems rather cynical but this approach has been admitted to both by health visitors in this study and also in the literature, see Foster and Mayall (1989).
The Bristol Early Childhood Development Unit, mentioned earlier, claims that conventional methods of dealing with the mounting level of parenting failure have not succeeded and that health, social and educational professionals have been unable to reverse what they see as a growing human disaster. They feel that every indicator points to increasing rather than reducing social disintegration and that much of this disintegration has its roots in early parenting. The Bristol Unit suggests that parents need support and encouragement to take control over their own lives and their children's development, as support without empowering the parents leads to ever greater dependence and reliance on the professional services. The programme they have evolved is based on semi-structured visiting strategies using a variety of illustrated materials. It is focused particularly on capacitating parents living in conditions of social disadvantage, although the principles have been applied successfully to parents in every socio-economic group.

In implementing this programme there were initial problems in that the health visitors found themselves faced with conflicting demands of commitment from the development programme work with selected families and crisis calls from families in their regular case load. Crisis calls apparently form the bulk of their health visiting work. Eventually a proportion of these health visitors were trained to concentrate entirely on programme visits to all primiparous parents ante-natally and for the first 8 months post-natally, with further visits to those judged to be in further
need of support. It is now estimated that 16,000 new families are brought in to the programme each year, most of them living in social stress areas.

A comprehensive analysis of outcomes has revealed positive findings in health, nutrition, language, social development, early education and child abuse (Barker, 1990). This programme is seen as a workable alternative to other forms of health visiting intervention as it is not only cheaper but uses parents’ own skills and resources. The Bristol Unit are taking this further and introducing the concept of ‘Community Parents’. Community Parents are experienced mothers and fathers whom the Unit see as having a wealth of skills and understanding which they can share with new parents in their own neighbourhood. The idea is that they will provide the support which would in the past have come from close knit extended families, (Barker, 1991).

Gorzka et al. (1991) support this conclusion but point out in their review of the literature focused on anticipatory guidance there were no studies of parental perceptions of anticipatory guidance needs for well children of any age, from infancy through adolescence. In their study they identified three categories of importance to the parents. These were general parenting issues such as children’s problems, safety, first aid, discipline and many other issues of general concern. A second category was concerned with age-specific problems; breast feeding, temper tantrums, sleep patterns, through to adolescent behaviour and family counselling. The third area was to do with parental self care and included such things
as marital relationships, stress management and career changes. They cite Dunst, Trivette and Deal who say that interventions should be based on family-identified rather than professionally-identified needs (In Gorzka et al., 1991).

The key to this process as Freire sees it would be listening in order to understand the needs in their context, then to use problem-posing and engaging in a dialogue in which positive changes may be envisaged. For Freire, listening extends beyond the needs of the assessment stage, it is a continual process during which clients (or community members in Freire’s case) become active throughout the change process. There is a recurrent spiral of action and reflection which enables people to learn from their attempts to change. The problem-posing can be a maturing process as people work on their problems.

A Freirian approach was used in the ASAP (Alcohol Substance Abuse Prevention) programme in the University of New Mexico School of Medicine. It sought to empower youth from high risk populations to make healthier choices in their own lives and to play active political and social roles in their communities in order to effect positive changes.

The New Mexican Indian Youth have very high mortality rates, 233 per 100,000 of population compared with the USA 83 per 100,000 all-race injury mortality rate (New Mexico, 1982-1983: 44). Alcoholism mortality is the most dramatic. The minority group’s (New Mexican Indian) over-
representation in these health statistics has its roots in Hispanic conflicts. Years of powerlessness, limited access to jobs, education, decent housing and health, are coupled with the suppression of cultural values and languages, loss of Native American and Hispanic land, water and mineral rights.

Freire’s ideas are used to encourage young people to participate as co-learners with health professional and patients. Instead of being pleaded with, youths become the subject of their own learning as they ask questions, explore problems, make decisions for their own choices and share the seriousness of substance abuse with friends and the community. They seek to become empowered by looking at the problems of their society in an active way.

The ASAP Team in their evaluation of their programme see empowerment as a long-term process with emphasis on individual emotional growth as a motivator for youth to assume an active role in society. Through its approach mutual growth and change can occur but, as this team acknowledged, the youth alone cannot assume full responsibility for creating a healthy environment. Wallerstein and Bernstein conclude that the empowerment model acknowledges the role of outside leadership to provide resources and experience.

The Bristol Unit seems to be promoting this model and are supporting professionals in using it. Other health care professionals are questioning
whether empowerment and caring are compatible. Chavasse (1992) feels that the role of acting for and on behalf of patients is entirely appropriate when someone is gravely ill or dependent for unavoidable reasons. This type of nursing however has in the past been the norm and carried with it prolonged dependency on the part of the patient and a tendency for nurses to go a step further and take control. Economically speaking, she says, self care and self reliance are cheaper and empowerment from a positive stance seems an evenhanded mode of achieving aims.

Chavasse however sees it as a challenge to nurses. In order to empower they need self confidence, knowledge and expertise. They will also need to be aware of their own feelings and prejudices and to be prepared to relinquish control. Empowering service users, say Ward and Mullender (1991), involves service providers engaging in anti-sexist anti-racist activity and confronting their own oppressive attitudes in order to avoid overt oppression or tokenism.

Chandler (1991) argues that focusing on the individual nurse is not enough. She suggests that it is necessary to have support from the work environment. The reality is that nursing is still hierarchical, with role models who demonstrate controlling behaviour and where conformity is a means of psychological survival. Nurses themselves are still in a position of subservience in relation to doctors, and empowerment must be a process arising from valuing other people. To do this one must value oneself.
Facilitating Empowerment

Kanter (1977) explored how nurses saw their practice environments in terms of their capacity to empower the persons who function in them. Three factors emerged as being most important in facilitating this. These were support, information and opportunity. Kanter predicts that with access to these three factors nurses would respond with an increase in commitment, motivation, risk taking and career aspirations.

For nurses to become empowered then, Kanter says, managers must exchange their traditional roles as controllers and keepers of the information keys for that of facilitators of the work environment. The paradigm shift is from ‘power over’ to ‘empowerment of’ and this will then be translated through to the client or patient. Many of the health visitors interviewed for this study expressed frustration in relation to local management practices. They found the frequent changes in management structure and policy decisions without consultation very disturbing.

Keiffer’s model (1984), of becoming empowered describes four stages in the process.

Stage I) An era of entry where the individual explores possibilities which are unknown, feeling unsure while authority and power structures are demystified.
Stage ii) An era of advancement characterised by supportive peer relationships and a mentor relationship

Stage iii) An era of incorporation activities focused on confrontation and contending with painful structural and institutional barriers. At this stage there is a development of organisational leadership and survival skills

Stage iv) An era of integration of new personal skills and knowledge into the structure of everyday life

Gibson (op. cit.) sees the consequences of this process for the client as personal satisfaction and a positive self concept, together with a sense of control. This she says will minimise the psychological sense of indebtedness. She then goes on to redefine empowerment in relation to Nurse, Client and Client Nurse. For the nurse it is a social process recognising, promoting and enhancing peoples’ abilities to meet their own needs and solve their own problems. For clients it is a mobilisation of the necessary resources in order to feel in control of their own lives. In the nurse client relationship it involves helping the client, family or group construct a critical awareness of the situation and facilitate the emergence of a realistic plan of action.
Empowerment appears currently to be an influential concept for those who are managing health care. To date the significant ways in which citizens have been able to improve their position in terms of health care have usually lain outside the formal agencies, comments O'Neill (1992). It can be seen to be true that organizations such as Alcoholics Anonymous and Weight Watchers have often been more successful than doctors in helping clients tackle their health problems. Ward and Mullender (1991) claim that self directed group work provides the best opportunity for developing self confidence, and recommend the approach to health care professionals working in Preventive Primary Health Care in the community.

One of the most successful support groups for new mothers is the National Childbirth Trust, which seems to be fulfilling a role formally held by the health visitors. This relates closely to the third research question: how do parents perceive the role of the health visitor and does the professional approach appear to meet the needs of the families within the three different groups?

A positive answer depends on whether those health visitor professionals who aim to promote empowerment are fully conversant with the total concept. The question arises of how it influences their practice and whether mothers find the health visitors' approach helpful in child rearing. Do the mothers feel empowered in the fullest sense of the word? As we have seen in Chapter 2, it is necessary to recognise the range and complexity of cultural contexts and understand the extent of individual
differences in attitudes and practices in child rearing and the underlying reasons for these differences. Only then can professionals begin to support, advise and really empower. These issues will be examined later in this study from both the health visitors’ and the mothers’ perspectives.
CHAPTER 4
METHODOLOGY

Introduction to the method

The method used in this research was designed to explore mothers’ views of their own experiences of child rearing, and the role of the health visitor as perceived by both the mothers and health visitors. The inquiry is set in the context of the cultural antecedents of three groups of mothers, and the professional context of the health visitors. The study lends itself to a largely interpretative method but not exclusively so. Quantitative and qualitative approaches are both employed in this study. Questionnaires were used for all the participating health visitors, the total number was 27. Later 10 of these respondents were followed up with in-depth interviews. Interviews were also used for collecting data from the 35 mothers taking part, the rationale here being that different parts of the study were better served by different modes of inquiry.

The health visitors’ questionnaire (Appendix 1), was structured in a formal conventional way, and for the most part a quantitative analysis was possible. Factual data from the questionnaires asking for personal details such as age, qualifications and number of children is dealt with descriptively. Ordinal data were also collected by the questionnaire when respondents were asked to rank perceived problems of clients and resources which they found helpful to their practice. It was appropriate to
analyse this for concordance using Kendall’s Co-efficient of Concordance (Siegel and Castellan, 1988: 262).

However, this research concentrates mainly on understanding the experiences of mothers and health visitors and this involves respecting their subjectivity, which lends itself to qualitative methods. Field and Morse (1985) claim that research into the ‘meanings’ given to experience allows insight into another person’s world and that analysis of several peoples’ perspectives can lead to a greater understanding of the particular phenomenon being explored.

**Gaining Access**

In this study a community local to the researcher was chosen for two main reasons. One was prior knowledge of health care services and venues within the area, as the researcher had been a sister in paediatric nursing at the local hospital. A second consideration was that the City encompassing this community has the advantage of having a clearly defined population made up of several different cultural groups. The local Italian families are the most well established immigrant group and the Bangladeshi the most recent group of immigrants to the city. A large percentage of the indigenous white British families are a socially mobile group who have at some time moved to the City because of improved job opportunities. Their work is either in the locality or they commute to London.
A decision was made to identify three specific groups within the local population with differing cultural backgrounds, and to interview the mothers about their child rearing practices, and their use of the health visitor and perception of her role. The three groups of mothers represented the largest proportion of the population, and were mothers of indigenous white British, Italian and Bangladeshi families.

It was considered that the most ethical and courteous way to gain access to the mothers would be via the health visitors. This helped to establish the credibility of the researcher and reassure the mothers of her authenticity. It also gave the mothers the choice of saying whether or not they wished to be involved in the study without feeling under any pressure. It was therefore necessary to make contact with the local health visitors and to gain their support. There is usually a 'gatekeeper' in any professional organisation and in this instance the Community Nurse Manager was the key person. The Divisional Manager was asked by letter for permission to contact the local health visitors in the three 'patches' which covered the area in which the mothers lived.

Initially permission was refused, as it was assumed that the researcher would want to be present during health visitor client interviews and this was seen as undermining the confidentiality of the discussions. This misunderstanding was cleared up in a follow up letter and telephone call, in which the researcher explained that the intention was to talk with the mothers with their permission about aspects of child-rearing. A positive
response was then received and the researcher was invited to attend the regular meetings of the health visitors in the three different patches outlined in the study, and also to give a presentation to the groups of the intention of the research. These presentations were quite successful. The health visitors showed considerable interest in the research and volunteered to ask mothers with young children if they would be willing to be interviewed by the researcher. It was agreed that the health visitors would either give the mother the researcher's telephone number for contact or would contact the researcher herself with the telephone numbers of the mothers who were willing to be interviewed.

It was also possible to distribute questionnaires (Appendix 1), to the health visitors present at the meetings. The questionnaires explored the health visitors’ professional background, and their perceptions of differences in the way in which the mothers in the three different groups prioritised their child-rearing problems. It also asked for statements about sources of information and literature which the health visitors found helpful to their practice.

The meetings proved a valuable source of contacts, one being the health visitor who had special responsibility for the Bangladeshi Community. This health visitor was extremely helpful to the researcher and invited her to health education sessions with the Bangladeshi women, and to a Bangladeshi women’s social group. Contact was made at one of these group meetings with a Bangladeshi woman who spoke quite good English
and who agreed to act as an interpreter for some of the Bangladeshi mothers in her area.

A degree of persistence was necessary to maintain contacts with the health visitors as they have a heavy case load and busy schedules. It was necessary to maintain a high profile and this was done by accepting invitations to attend further 'patch meetings' and also some of the study days for the health visitors. It facilitated contacts with the mothers, and enabled reminders and collection of the questionnaires. Eventually a response rate of 75% was achieved of completed questionnaires from the health visitors in the three 'patches' from which the participating mothers were drawn.

Contact with the Mothers

The original intention had been to interview 20 mothers from each group, but after several interviews it became clear that the larger the number of interviews the more superficial they were likely to be, and it would be much more worthwhile to go back to the same families several times and obtain more in depth data. Rapport was therefore established with a small group of mothers some of whom were visited several times. Eventually 35 mothers were interviewed, 11 Bangladeshi mothers, 11 mothers from Italian families and 13 indigenous white British mothers.

Although initial contacts with the mothers were made through health visitors, the sample grew as the researcher was referred to other mothers...
expressing a wish to be part of the study. This type of sampling is referred to by Cohen and Manion (1980) as snowball sampling, where the researcher identifies a small number of individuals who have the characteristics required and who identify other participants for inclusion in the study. This practice occurred in all three groups of mothers.

The interviews with the mothers, (Appendix 2), were semi-structured using a focused age range for the children of 1 - 2 years. There were often other children in the family and the mothers talked freely through the list of topics often referring to the other children.

Research Processes
The central method in this research is a small sample study, closely akin to the case study. In a case study it is usual for a general population sharing a common background to be identified. All of these mothers lived in the same city and were served by the same health care professionals. The sample is kept fairly small, as one of the problems can be a massive amount of data, resulting in a long unreadable document. The case study is an in-depth form of inquiry that can investigate phenomena within a real life context and this study sought to achieve this by exploring the social and historical context of the participants. The case study also has the merit of being able to incorporate multiple sources of evidence and is open to a variety of research methods, (Yin, 1989). In this study information was gathered from multiple sources in addition to the data collection by interview and questionnaire.
The investigator’s role, says Yin (1989) is to expand and generalize theories and not to enumerate frequencies. As such the case study is generalizable to theoretical propositions and not to populations. The case study researcher typically observes characteristics of an individual unit. This unit may be an individual, an organisation, a community or - as in this study - four groups sharing the same community and health care services.

Pictures are built up of the participants in the study from evidence collected from relevant literature, by questionnaire (health visitors), by interview (health visitors and mothers) and by contacts with other members of the community. These included informal discussions with outreach workers, mullahs and social workers involved with the local community, and other family members. A meeting of the local branch of the National Childbirth Trust was attended by the researcher as some of the mothers were members. A day was also spent visiting with a health visitor in Bradford whose entire client group was Bangladeshi. The intention was for the researcher to gain a fuller understanding of the health care issues within this cultural group.

Yin mentions lack of rigour and the possibility of biased views influencing the direction of findings as some of the criticisms directed at case studies. One way of ensuring ‘accuracy of understanding’ according to Rew et al (1993) is to feed back to the subjects impressions obtained from the data and to allow them to reflect and clarify their thoughts and feelings. This was done by returning to visit the mothers for a second and sometimes
third time. In the case of the health visitors the researcher sat in on discussions at their meetings, and later following the data collection to reflect back some of the findings for their comments. Views from the literature concerning cultural issues and ideologies were also fed back to the groups for their opinions.

As has been established, when dealing with people-centred concerns the context of the phenomenon being explored is all important. Looking for meaning, says Salmon, is inseparable from our location, and our embeddedness in personal and cultural contexts, and from our social agency within these contexts (Salmon, 1992). It is this stance which is taken, for although each participant is perceived as an individual in their own right, to ignore the widely differing cultural backgrounds from which the participants come would be to deny the influence that these sets of circumstances undoubtedly have on attitudes and practices in child-rearing.

**The Interviews**

A decision was made to use semi-structured but open-ended interviews with the parents.

Since qualitative research frequently involves face to face contact between researcher and participant, open ended rather than closed ended questions and unstructured rather structured interviews are to be preferred (Cannon et al. 1991: 115).
Dempsey and Dempsey (1992) recommend the researcher to use a general framework to elicit responses whilst allowing the respondents to enlarge upon the topics. The merit here is that although the same issues were raised with each mother, an open-ended question technique allowed them to express and develop their views at their own pace and in their own way. These conversations often went beyond the researcher's agenda but the always included these items. Open interview methods have the advantage of allowing participants to change the agenda by bringing up ideas as important which had not occurred to the researcher. They may broaden the frame of reference.

The common focus topics were drawn from the current literature on child rearing, the views of the 'experts'. In particular, a list of professional writers popular with health visitors gave pointers to the most likely issues that concern mothers (see Chapter 4). The focus topics chosen for the interviews were as follows;

- breast or bottle feeding - reasons for choice, attitudes and schedules, weaning practices;

- crying and comforting - family views and practices, use of comforters and dummies;

- sleeping - sleep patterns and bed time rituals;
temper tantrums - reactions and attitudes towards this behaviour;

discipline - what is considered naughty and how is it handled;

toilet training - age at which this commenced and responses towards the child;

habits - what is considered to be a habit, methods of dealing with perceived habits such as genital play and thumb-sucking;

parental roles - how these are apportioned in relation to tasks such as bathing, nappy changing, attention during the night - to what extent the father is involved in the care of the children;

leaving the children to go out - parents’ views and attitudes about going out or away without the children. If they do go out or away without them who are they left with;

help at home - how much help and support do the parents receive and from whom;

how the health visitors’ role is perceived by the parents.

A likely problem with interview data collection techniques is that of observer bias. Care was taken to avoid this by referring perceived
information back to the parents and by attempting to frame the questions in such a way that they avoided any interpretation of the views of the researcher.

Sapsford and Abbott (1992: 110) bring up the question of rhetoric as important for open interviewing. They ask whether we should accept what the participants say at face value, or allow that we may all have a set of verbal beliefs which are sincerely held, but which may not be the unifying principles of practical actions. They suggest that questions and areas of discussion can be introduced to get underneath the rhetoric. This may then elicit the less formally organised and recognized principles which people apply to the social world when making their practical decisions.

This researcher would argue that in research which is a collaboration with the participants and seen as non-threatening and non-judgemental, there can be ongoing discussion between participants and researcher for clarification of the participants’ views and practice, avoiding loaded questioning. However one must acknowledge the important factor of the power of researchers in such circumstances, and their ability to impose their definitions of situations upon the participants, especially when that person is seen to have a professional role in relation to the subject matter being explored. A small sample revisited several times also helps to develop relationships between the researcher and participants and establish actual practice, rather than a larger, once visited sample where often only superficial information can be obtained and the participants are
unsure of the researcher. Exploration of other sources which yield information related to the cultural context of the participants can provide further confirmation and support interview data.

Choice of Venue and Conditions for Parent Interviews

Dempsey and Dempsey suggest that data should be gathered in the participants’ own environment, whereas Sapsford and Abbott say that the choice should be governed by the principle of naturalism. Comfortable rather than natural was chosen as the guiding principle for the current research. The mothers were invited to make the decision where they would like to be interviewed and were welcomed to the researcher's home if this was more convenient or preferred by them. Many of the mothers saw it as a morning out for coffee and called in on the researcher on their way home from dropping older children off at school. There was usually a reciprocal invitation when it was possible to follow up or clarify some of the issues discussed.

Part of the art of interviewing is to be friendly and open without inflicting one's views on the interviewees. It is also felt to be important that the interviewee knows something of the researcher's background and time was taken to explain this and to allow for questions about the researcher's position and role. Oakley (1992) questioned the idea that found that interviewing is a difficult exercise in which the interviewer has to struggle to establish rapport and obtain data, whilst at the same time maintaining distance and striving for objectivity. Many researchers find that
encouraging people to talk about themselves is relatively easy and enjoyable. The success of interviewing, Oakley claims, does not hang on the maintenance of a social distance within the context of an hierarchical relationship. Oakley was struck by the particular insight into the process of interviewing itself in that it could be seen as a socially supporting experience by the mothers.

Note-taking was used to record responses during the interviews in preference to a tape recorder for several reasons. One was that the interviewer had observed that tape recorders can appear threatening to participants. They can always request that something they say is not written down but a recorder can actually inhibit things being said. Secondly in order to establish and maintain rapport it may be necessary to chat inconsequentially occasionally and no notes need be taken. Switching the tape recorder on and off may indicate that this is not important but if it is left on the editing becomes an increasing chore.

A further reason was that the interviews were taking place with mothers with young children and the apparatus would have been a source of curiosity, and background noise a problem. As it was a spare pencil and pad often kept some of the younger children happy. Language difficulties and accents also presented a problem with the Bangladeshi community. It was much easier to listen carefully and check the meaning before writing things down.
Process of Analysis of the Mothers’ Interview Data

Some of this was factual and lent itself to descriptive analysis. Other material needed further interpretation, for example the ways in which the mothers perceived the health visitors role. This information from the 35 mothers was collated and emergent concepts extracted. A comparison is then made between the health visitors’ perspective and that of the mothers. In the analysis of both the health visitors’ and the mothers’ interviews an attempt was made to follow the stages suggested by Sapsford and Abbott (1992), and to link the findings to a theoretical perspective.

Interview material may be used as a basis for classification. The categories which emerge are likely to be conditioned by the focus of the research. They should reflect patterns found and not patterns defined a priori.

Two further stages in the analysis of the data are suggested by Sapsford and Abbott. The next step they describe as second order analysis, which goes beyond the participants’ concepts and begins to build a theory at another level, i.e. beyond the information given. The final stage is to go beyond the emergent patterns and to try and explain them. It is important to test tentatively the conclusions by looking back through the original material for views and opinions which might challenge or question the interpretations that the researcher has put on the findings (Sapsford and Abbott, 1992: 124).
The Health Visitors’ Questionnaire and Interviews

The questionnaire was distributed on a purposive sampling basis (Cohen and Manion 1980: 77). The health visitors were those who served the three groups of families in the study. Some aspects of the questionnaire for the health visitors has already been discussed. An advantage of the questionnaire in this situation was to gain background knowledge of the health visitors and their perception of how child rearing problems were perceived by the three groups of mothers. Gathering data in this way is thought to produce more reliable responses because of the removal of observer bias, and by encouraging honesty through anonymity (Cohen and Manion 1980). Questionnaires were completed by the health visitors anonymously in an attempt to ensure this.

A problem with questionnaires is that some questions may have different meanings for different people. An attempt was made to avoid this by the researcher distributing the questionnaires personally and by taking the participants through the questions at the health visitor meetings which she attended. Another known disadvantage of questionnaires is the low percentage of returns. To avoid this problem it was necessary to follow up the initial distribution either by letter or by other form of reminder. A questionnaire response rate response of 75% was achieved. This was obtained by the researcher maintaining a high profile at health visitor meetings and by personal reminders. This amounted to a total of 27 responses out of a possible 36.
Health visitor Interviews

The in-depth interviews (Appendix 3), carried out individually with ten health visitors, were focused on content specified by the research objectives, and were concerned with the health visitor’s view of her knowledge base, her values, attitudes and beliefs about her clients and practice. The interviews had focus topics in order that similar areas were covered by each participant, but the participants were encouraged to elaborate freely by asking for amplification at certain points and by following up responses with probes. Madge, cited by Cohen and Manion (1980: 259), observes that the focused interview is useful for those who wish to retain the good qualities of the non-directive interview, but at the same time are keen to evolve a method that is economical and precise enough to leave a residue of results, rather than a posse of cured souls. Guba and Lincoln (1981) in a less colourful way, suggest that this approach is the most suitable when dealing with participants who have a specialist knowledge.

The ten health visitors were subsequently interviewed about their attitudes and beliefs in relation to their professional jobs. Issues arising from different client groups were discussed along with their views on child rearing. These interviews lasted from 45 minutes to one hour and took place either in the office of the health visitor or at the researcher’s home, whichever was more convenient for the health visitor during her working day. They were tape recorded and fully transcribed for subsequent
analysis. The structuring of the interviews and the analysis followed guidelines suggested by Turner (1981,1994), as follows.

Analysis of The Transcripts

A modified grounded theory approach was applied to the data, a procedure which Turner (1981) recommends when analysing qualitative data drawn from semi-structured interviews. Turner claims four benefits of a grounded theory approach:

1) it promotes the development of explanations which conform closely to the real world;
2) it brings the creative intellect and imagination of the researcher to the interpretation of the data;
3) it is likely to be understood by those working in the field of study;
4) it is therefore open to comment and correction by the participants.

The structure of analysis of data relating to the health visitors interviews is shown in Figure 1.
Validity was achieved by feeding back issues during the interview to the respondents. Some verification of data was also achieved by sitting in on discussions at health visitor meetings and by presenting findings to health visitors working in other locations.

Supporting Data
Throughout the field work of interviews with mothers and health visitors, the historical and cultural context of the three groups was being pursued.
This led to work in specialist libraries such as the India Office, cultural institutions and centres. Other sources of information came from newspaper articles, television documentaries and visits to local community centres and to personal contact with the outreach worker for the Bangladeshi community, a day of visits in Bradford with outreach workers and health visitors and repeated contacts with members of the three groups and the health visitors.

In sum the method used for this research is a modified case study approach which takes as its sample a small group of mothers who are representative of a larger community and the health visitors who serve this community. The instruments for gathering the data are the questionnaire, the semi-structured focused interview, and other technical and historical sources which provide the context.

In undertaking the task of exploring attitudes and practices of certain aspects of child-rearing one is inevitably only going to achieve limited views, and no great claim may be laid on them. However because this study was approached with honesty and rigour and care was taken to clarify and where necessary modify the information gathered, it may assist in providing some insight for health care professionals raising questions which could be pursued further. An Event Flow Chart follows (Figure 2) which illustrates the main course of the research process and summarises the stages.
Figure 2

<table>
<thead>
<tr>
<th>CONTACT WITH COMMUNITY NURSE MANAGERS</th>
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<tbody>
<tr>
<td>HEALTH VISITOR QUESTIONNAIRE</td>
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<tr>
<td>PATCH MEETINGS</td>
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<tr>
<td>CONTACTS THROUGH HEALTH VISITORS</td>
</tr>
<tr>
<td>EXPLORE CONTEXT, REVIEW LITERATURE AND INTERVIEW 35 MOTHERS AND 10 HEALTH VISITORS</td>
</tr>
<tr>
<td>ITALIAN MOTHERS</td>
</tr>
<tr>
<td>IWB MOTHERS</td>
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<td>BANGLADESHI MOTHERS</td>
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<tr>
<td>HEALTH VISITORS</td>
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GENERALISE FINDINGS TO THEORETICAL PERSPECTIVES
Justification of the Method

This study is for the main part inductive in emphasis. A set of procedures is developed, deriving theory from the phenomenon being studied (Glaser and Strauss, 1967). Grounded theory can form the basis of such interpretive inquiries and data gathered in this way are often described as being rich in meaning. Melia (1982) contends that the grounded theory approach has the appeal of flexibility, in that the emerging conceptual categories can direct future data collection, and unforeseen lines of enquiry can be pursued in a way that is not possible with a more rigid and predictive research design. However Field and Morse warn that any findings or conclusions may only be relevant to the setting in which they are gathered, and that there is a problem with generalizability.

Strauss and Corbin (1990: 50) extend the view of flexibility by elaborating on wider sources which may be tapped in the pursuit of data once a theoretical framework has been established. They cite technical literature where emergent concepts and relationships may be pursued, and non-technical sources such as newspapers, video tapes and diaries can be used and which may add support to primary data. Many of these and similar sources have been used in this study to audit and confirm data. The task is to produce an account of how the participants see the situation or phenomenon in question.

Analysis must go beyond this to the point where concepts are derived and developed beyond the perspectives of the participants. This is
demonstrated in the analysis of the health visitor interviews. The attitudes and beliefs of the health visitors concerning their roles are derived from their practice and their views of their client groups. For Miller and Goodnow (1995), practices often provide an easier basis for reporting than beliefs and values. However they qualify this by going on to say that reports of practices and observation of practices both allow researchers to explore the ‘meanings’ practices hold for people and their degree of commitment to them. This view was influential for the researcher who felt that more reliable data could be gleaned by people saying what they actually did or how they actually handled situations. This seems to be a much more satisfactory way of proceeding than asking people to respond to fictitious or hypothetical situations.

The researcher’s knowledge of the social setting may make it possible to generalise, if not to a wider population then to a theoretical position. The researcher in this study set out to obtain as full a picture as possible by involvement with the families, by exploration of the cultural context and by developing an interpretative concept of empowerment. Semi-structured interviews, such as those with both the mothers and the health visitors, are felt by Guba and Lincoln (1981) to most readily allow belief systems to emerge. Group interviews were avoided because of the possibility of ‘holding back’ amongst colleagues or control of the interview by more dominant members of the group.
The Importance of Context

As Martin Bulmer (1984) sees it, grounded theory as a research process progresses from raw data, to categories, then to their properties, and finally to hypotheses. One of the major criticisms made by Bulmer is of the premature crystallization of concepts in grounded theory, for what is needed following concept formation, says Bulmer, is a further stage to produce explanatory theory. This criticism is illustrated in Leininger's (1981) work on the phenomenon of caring. She produces a taxonomy of 28 constructs containing such concepts as nurturance, compassion and concern to describe caring, which still leaves the reader with the problem of what counts as nurturance, compassion and concern. The problem here lies in attempting to define a phenomenon free of its context, to relate theory and data.

Although grounded theory does not purport to establish cause and effect, examining the dynamics of human interactions within socio-cultural settings can help to explain the relevance of them. The three groups of mothers in this study have behind them widely different cultures and it is necessary to acknowledge these. Oakley has made the point (1992), that qualitative data uncovers the nature of social processes. It can also serve to dispel myths perpetuated around people and their cultures. An illuminating illustration is offered by Meera Syal (1994), in an account of her experience as a young Indian schoolgirl in an English society coming to terms with her background and culture.
For us in England, each change is accompanied by the knowledge that some things we throw away may never come back. So, is this an identity crisis? More like a creative buzz, judging by how many of my unique generation tend to express themselves through creative work, much more fun than the collective nervous breakdown the ‘sociologists’ like to attribute to our ‘cultural clash’ (Meera Syal, 1994).

The basic phenomenological and ethno-methodological position of this study is that a priori or context-free theorising about every day life is inappropriate for achieving a real understanding. There is no way of getting at social meanings from which one implicitly or explicitly infers the larger patterns, except through some form of communication with the members of that society or group (Bond and Bond, 1986). Bond and Bond do not dismiss quantitative methods and concede that there is strength in diversity of method as long as there is rigour.

**The Role of the Researcher**

The relationship of the knower to the known is crucial. A researcher not only collects data but serves as an instrument through which data are collected. This was especially pertinent in the interviews and follow-up discussions with the mothers and the health visitors involved in the study. In this the researcher was influenced by the work of Rew et al (1993), who describes the use of self as an instrument having the following attributes:
appropriateness - asking unambiguous questions and clearly defining one's role as a researcher and not a consultant;

authenticity - using one's personal experience to respond to another and genuinely caring about the informant's experiences;

credibility - in the establishing of trust and rapport;

intuitiveness - the ability to engage with the life experiences of others;

receptivity - a willingness to be taught by participants, this would include an acceptance of feedback and not using one's position to exert power over subjects;

sensitivity - the ability to hear accurately what is reported as data.

The above criteria serve to remind those who research into people's lives, thoughts and feelings that they have an ethical responsibility to the participating subjects. Furthermore, adhering to these criteria can assist the researcher to obtain data which has - as Guba and Lincoln (1981) put it - a 'truth value'. The role of the insider was also considered when interviewing the health visitors. On this issue Lofland and Lofland (1984) have said, that in general, qualitative researchers do not emphasise the need for distance from the research subject. They offer many examples of
studies which have benefitted from ‘inside knowledge’ that the researcher has brought to bear on an issue. Their observation is that while outside researchers have the requisite distance from the setting to ask questions, by definition they lack the closeness necessary to understanding the setting the way the participants do.

**Methodological Rigour**

In the course of this study, the researcher has attempted to combine openness with rigour. Guba and Lincoln (1981) identify four factors which relate to tests of rigour in conventional scientific research and naturalistic inquiry, which are useful as a framework for understanding the differences and similarities in qualitative and quantitative approaches. These are, they suggest;

1) truth,

2) applicability,

3) consistency,

4) neutrality.

The truth value in conventional scientific research is related to internal validity, where we ask whether the research method is appropriate for measuring what it sets out to measure. Guba and Lincoln propose that credibility is the equivalent criterion against which the truth value of qualitative research may be evaluated. Thus a qualitative study is credible when it presents such a faithful description or interpretation of a human experience that the people having that experience would immediately
recognise it as their own. To determine this the researcher reflected back content gathered from the interviews to the participants. Views from the literature were also verified or clarified with the participants of the study, and with other credible sources in the particular communities.

**Applicability**  Guba and Lincoln equate with external validity or generalizability or representativeness in other settings. Eisner (1981) suggests that samples in qualitative research are not representative in the quantitative sense, though the observer will attempt to establish the typicality or atypicality of observed events, behaviours or responses, in order to place them in their proper perspective. Guba and Lincoln use the concept of ‘fittingness’ as the criterion against which the applicability of qualitative research may be evaluated. A study meets their criterion of fittingness when its findings can fit into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences. This was tested by presenting some of the findings to health visitors in a totally different area from where the study took place. There was recognition of the client situations and responses, and also a consensus agreement with some of the findings.

**Auditability** is proposed by Guba and Lincoln as the criterion of rigour relating to consistency. They suggest that a study and its findings are auditable when another can follow the ‘decision trail’ used by the researcher. However while it should be possible to follow the decision
trail, or sequence of events which enable the final research report to be audited. The view of this researcher is, that the very nature of qualitative research and the atypicality of peoples lives which gives the characteristic richness of data of could mean that each piece of qualitative research might follow a different course. Clarity of presentation and thinking is important but replicability is not necessarily felt to be a criterion.

Guba and Lincoln define neutrality as freedom from bias in the research process. Neutrality is related to confirmability and this is achieved when auditability, truth value and applicability are established. They acknowledge that subjectivity rather than objectivity is more valued in the qualitative approach. However they stress that the emphasis should be on the subjective reality or meanings which the subjects give to their life experiences. Neutrality in this study was sought through reflecting back to the participants their initial responses to be confirmed, rejected or modified. In this way the researcher tried to recognise the limitations of her subjectivity.

The presentation of the findings now begins. In the next chapter the professional context of the health visitors is discussed, leading to their questionnaire data. For the three groups of mothers there will be an account of their social and historical context before presenting the data.
CHAPTER 5

THE HEALTH VISITORS - CONTEXT
THE National Situation

The practice of health visiting has been in turmoil for the past few years, and under critical review by health authorities in the current climate of the present government’s policy of an ‘internal market’. Denny (1989) observes that health visiting has progressed from being a public health voluntary service, through an era of maternal and child welfare, to the professional service it is today. Where infant mortality was a concern earlier this century, he says, it is now considered to be at a politically acceptable level. Child welfare is no longer a priority for government. This he says has been demonstrated by the freezing of child benefits and the cuts in the provision of a schools meal service. Earlier, there was also the withdrawing of free milk for school children.

The leap that is required to take the health visiting service into the 21st century is still being debated, complicated by fund holding and non-fund holding practices and the Purchaser - Provider approach to health care. The current philosophy of the present government with regard to health and other issues is one of personal responsibility. In contrast health visiting has been interventionist, specifically developed to provide a preventive health care, home visiting service to children and their families. This ‘universality’ is anathema to government policy of the internal market.
where everything must be costed. But as Catherine Burns, General Secretary of the Health Visitors Association said in a debate on this issue (1991), ‘how do you put a price tag on a healthy baby or on preventive medicine’? Barker (1991), thinks that the move to GP attachment by the health visiting profession is as disastrous as the previous decision to make it part of a hospital based NHS. He describes the move as akin to lambs lying down with a pack of well meaning but hungry wolves. Perhaps some of this dilemma is being sorted out as GPs become more familiar with what health visiting is about. However Barker feels that the health visitors have in the past lost an opportunity to get across to both the public, and health services management, that their role was to promote health through home visiting and community action. Instead claims Barker, health visitors have been pressured into another role based on ever more clinic sessions, meetings and ubiquitous phone calls.

More recently it has been reported that a careful scrutiny of health visiting might ‘lead to a substantial reduction in its volume’ (Day, 1996: 6). In an as yet unpublished report, Professor Colin Roberts of University College, Wales, is quoted as saying of National Health Service spending that ‘the first step is to identify those services whose delivery might be described as irrational’. Health visiting is targeted, he claims, because ‘its untestability is so transparent and documented by its own practitioners’. This comment is part of a pattern of widespread concern over the purpose of health visiting and the role of health visitors.
The Generic Role of the Health Visitor

There have been considerable problems with the traditional style of health visiting since it became a generic service, particularly with the pressures of child related work taking precedence over other commitments, such as visits to the elderly. The structured programme of home visits for children at specific ages can also prove frustrating for health visitors, as their professional performance may be judged on the number of checks rather than the quality of advice given. Consequently both client and professional satisfaction may as a result be low. Health visitors in the Mayall and Foster study, felt so submerged by crisis work, that they were unable to follow guidelines issued by their local authorities with regard to home visits to families at risk or developmental checks (Mayall and Foster (1989: 65). Other problems in the traditional model of health visiting identified by Hull (1989) were time lost on failed visits, variations in clinic attendance, lack of awareness by clients and GPs of the health visitor’s role and equal case-loads not meaning equal work-loads.

Some of these problems could be resolved with a more systematic approach to the service. Hull suggests: telephoning clinic reminders; instituting office hours; reviewing the need for routine developmental tests; examining appropriate place for screening - home or clinic; the number and type of clinics and assessing type and number of clinic sessions required in a particular area - in short, practice profiles. The
aim, Hull says, is to ensure that health visiting resources go to the families with the greatest need. The reasoning behind this is that all aspects of health care have to be justified in terms of cost effectiveness, and health visiting is no exception.

Targeting services for perceived needs has its dangers, according to Denny, who sees this approach as part of the same political strategy as the changes implemented in social security benefits. He also envisages the same pitfalls, those of people in need slipping through the net or not being aware of the services available. There is also the added risk of large numbers of families just above the cut-off point but with low health status. The main criticism of social priority, says Denny, is that there are far more people outside the priority area than within it, many of whom are in real need, and those with little autonomy and control over their lifestyles are usually those with the lowest health status.

New Ways of Working

In searching for new ways of working health visitors need to be sure that what they are doing is in response to the needs of the community and not just a collusion with current political thinking, (Denny 1989). Orr (1989) has said that there is already a blueprint for the way forward, initially by implementing the Cumberlege report on neighbourhood nursing (1986). Barker (1991) agrees and sees the failure to implement Cumberlege as a missed opportunity. The cornerstone of this report was the concept of
neighbourhood nursing services where each health authority identified
neighbourhoods compromising 10,000 to 25,000 people, for the purposes
of planning, organising and providing nursing and related primary care
services. Each neighbourhood would have a team consisting of health
visitors, district nurses and school nurses, and would be managed locally
by a nurse. The team would define the clients and the community’s needs
and decide how these needs could best be met. Orr says the concept
challenges health visitors to work collectively and to emphasise the
primacy of nursing as opposed to medicine. She also supports the Child
Development Programme devised by Walter Barker of the Bristol Child
Development Unit already mentioned.

Walter Barker (1990) would like to see health visitors getting away from
clinics and ‘health authority institutions’ completely, leaving routine
surveillance and developmental assessments to the general practitioner
and the practice nurse. He states the following;

A lot of what health visitors do now does not need to be done by
them. Developmental surveillance, long lists of assessments for
every child; these are issues for the curative services.....Health
visitors have a unique role concentrated in the home and working
out in the community as activists.

Barker is also critical of the trend of health visitors being based mainly in
health centres and clinics, and instead thinks that they should be seen in
the community setting, going into people’s homes, setting up groups and promoting action. The problem of the moment is how one would measure this in terms of ‘Individual Performance Rates’ or productivity? Clinic attendance numbers are easier to demonstrate, but may mean little to health visitor or clients in terms of satisfaction.

Health Visitors’ Views of Their Role

There is a diversity of opinion amongst health visitors themselves about how they view their role. In a discussion forum in their professional journal (1991) quite disparate views were expressed. Beverley Merrington said that she saw herself as a generic worker serving the community rather than the practice to which she was attached, looking at local needs whether they be housing, poverty or public health issues. She also saw herself as a promoter of health and health education. Several participants in this discussion were in favour of routine surveillance, one believing that it was important from the point of view of observing parent - child interaction and picking up safety risks, another because she thought health visitors were better at surveillance than some GPs. Merrington’s feelings were that child surveillance could be task oriented and ritualistic, and did not perceive her role as totally child centred as there were other groups that needed her more. In future if GPs are purchasing the service of health visiting, they will no doubt decide upon the priorities and these will have to be seen as measurable in terms of cost effectiveness.
Watson and Sim (1989) concluded a small scale study on health visiting with the following comment.

It is noteworthy that the continuing national debate about the role of the health visitor has so far centred on whether her function is primarily as a nurse or a social worker. Her role as a teacher or health educator is only beginning to receive the attention that it obviously merits.

Cowley (1991) has addressed this issue in her study showing how health visitors themselves treat health as a process using interventions which are primarily educational or therapeutic caring. The health visitor's activities, she claims, may be directed at the immediate topic under discussion or target the position of one of the 'interactants'. She highlights the proactive anticipatory intent of the health visitor's activity, which may be deemed as necessary by either interactant in order to maintain a positive status, as well as to remedy a situation which may be viewed negatively.

The health visitor's insight into her role says Cowley (1991), and the behavioural expectations she has of herself at work, may derive from her initial professional education and training, ongoing development programmes and input from professional leaders.

Cowley's study of health visiting (1991), suggested that the health visitors generally held a broad based long term view of health. They also tended
to seek contact with individuals when significant life events occurred such as birth, bereavement or marriage breakdown.

**Interventionist Roles**

The interventionist approach to primary health care was accepted as the norm in this present study. Health visitors saw themselves as being proactive in ‘searching out’ health needs and stepping in before medical conditions develop, sometimes by organising health education groups. This attitude reflects in part the four principles outlined by the Council for the Education and Training of Health Visitors in relation to the health visitor’s role, (CETHV 1977), which were as follows;

1. Search for health needs
2. Stimulate an awareness of health needs
3. Influence policies affecting health needs
4. The facilitation of health enhancing activities.

Cowley (1991) comments that these principles do not help to explain the process, or how intended outcomes will be achieved by health visitor practice, and indeed this presented as a problem. The concept of need is fundamental to the understanding of social policy and is described by Luker and Orr (1992) as social, relative and evaluative:

- social because it is defined according to standards of communal
life;
- relative, because its meaning will vary from society to society;
- evaluative, in that it is based on value judgements.

Luker and Orr assert that we must specify the assumptions made about the measurements of needs, the value judgements which underpin them, and the role of the health visitor in utilizing the concept of need. To demonstrate this they have taken Bradshaw's (1972) Taxonomy of Social Needs - normative needs, felt needs, expressed needs and comparative needs - and applied it to health visiting (see Figure 3). The analogy works well with the normative definition relating to the interventionist stance. However normalcy in relation to a perceived health need may differ according to the value judgements of the 'experts' who lay down the standards, and, say Luker and Orr, if clients are to have a greater role in participation in health care, then the health visitors will be faced with making explicit value judgements which underpin how needs are determined (Luker and Orr 1992: 120).
Bradshaw’s Taxonomy of Need Applied to Health Visiting

Normative Needs
- Nutrition
- Self esteem
- Level of depression
- Immunization Schedules
- Housing Standards
- Preventive tests, e.g. breast examination/cytology
- Developmental Screening Programmes
- Schedules of Health Visiting input
- Morbidity rate
- Accident Rate

Felt Needs
- Attendance at clinics
- Client initiated visits

Expressed Needs
- Promotion of self-help groups
- Campaigns on health issues, e.g. smoking
- Interest in health issues in local and national magazines

Comparative Needs
- Range of social/health indicators
- Level of services, e.g. family planning
- Health visiting activities in other areas


These value judgements, as with any other, are subjective estimates of worth, and individuals making value judgements, says Muntz (1988), are
influenced amongst other things by philosophies, political ideologies and peer group views. For the health visitor there is also the funded knowledge and prejudices of her profession. In a truly enabling relationship the clients have the right to know how their needs are interpreted, to acknowledge that there is a need and wish that need to be met. Conflict arises when resources are not available to meet either perceived or felt needs, and behaviour changes are often dependent on these being met first. This puts the health visitor in a frustrating position. However expectations and perceptions about daily experiences, about what may be regarded as normal, and the extent to which a link with health may be perceived may differ between health visitors and clients. These arguments may all become merely ‘academic’ in the future if the health visitors lose control of their own profession.

Recruitment
Compounding the role problem which faces health visitors, or perhaps partly as a result of it, there is a present crisis in both recruitment to health visitor courses and number of health visitors in post. Launching a report on the impact of health visitors on the health of the nation, The Director of the Health visitors Association, Margaret Buttegieg (1994), expressed concern that The Department of Health was failing to meet its own targets for health visitor numbers which were set in the 1980’s. Student health visitors numbers have fallen from 1,106 to 545 with a further planned reduction of another 100 students next year. Since 1988
overall numbers of health visitors in post have fallen by 4.5% against the government’s target of a 15% increase. Some of this shortfall is again due to decentralised funding for secondment of nurses to the courses, and a reluctance on the part of local authorities to accept this responsibility. The Health Visitor Association has called on the government to double the number of health visitors by the year 2004, or, Buttegieg claims, there will be a great loss of expertise and the public, particularly children will be at risk.

The literature would suggest that there is a great deal of confusion surrounding the health visitor’s function both by the health visitors and the community. It seems to have become a far too complex role for any one person to manage. Individual health visitors, health authorities and more recently GPs are interpreting their role in different ways. The clients in the middle, especially if they move between authorities, are equally confused, as is confirmed by this study. The diversity of the health visitor’s role and the lack of clarity resulting from this means their performance is difficult to audit. This makes the profession very vulnerable in the present political climate where cuts in health care spending are a prime concern.

The Local Context

The study being undertaken is focused on an urban district which is part of a larger Health Authority. The total population of this authority is
268,600. It is divided into two localities and six area patches. The area being studied is locality one and contains three of these patches which form the total District. There are at present 52.60 full time equivalent health visitors, 70 health visitors in all to cover the whole authority, which gives approximately 11.5 HVs per patch. Health visitors are attached to general practitioners’ practices. (Since April 1994 this authority has enlarged to almost twice its size by including the South West of the county in addition to the North West.) The health visitor to population ratio in 1990 was on average 1:4,942. The Health Visitors Association recommended levels of 1:2,500.

It was reported in a review carried out of the service in this authority, (Health Visiting Review, 1990) that some health visitors were experiencing perceived stress due to the prescribed home visiting in support of mothers. (This bears out the findings in the study by Mayall and Foster previously mentioned.) It was suggested that perhaps a different presentation of the service would encourage parents to use it more appropriately by visiting clinics or by telephone contact. The review stressed a need for change in practice. The traditional hands-on model was no longer seen as appropriate and a move to a needs based model proposed. This model has an enabling format and it is recommended that:

Individuals are encouraged to take responsibility for their own and their children’s health;
contracts should be negotiable between clients and health visitors; there should be contracts between health visitors and managers to ensure accountability and identification of unmet need.

At present each mother and child in the district is attended by a named health visitor. The focus of the 1990 review claims that it aims at enabling parents to choose the level of service required.

A decision was also taken to continue to visit mothers with new babies in their homes. This was thought to provide, ‘valuable baseline information about health, social and environmental needs of families and is essential to the identification of vulnerability.’ The six percent of the population who were of cultural minority origins were seen to be in need of a link worker as health visitors working with these families were experiencing great difficulty communicating essential health information to them. The proposals recommended in the report were thus extensive and wide ranging. It was in this context of national and local concern over the role of the health visitor that the present study was carried out, though, as far as could be gathered, those mothers who participated were not aware of this change in focus. The first stage of the investigation in the field was to contact health visitors and to gain preliminary information by means of a questionnaire.
Health Visitor Participants and the Questionnaire

The three patches investigated include a small city and its outlying villages, the combined population being approximately 98,500. The researcher attended meetings of the health visitors who served these patches to explain and distribute the questionnaires. A total of 36 questionnaires were distributed and 27 questionnaires were completed and returned. This represented a 75% response.

The questionnaire was intended to determine the extent to which the health care professionals advising and supporting parents perceived the child rearing problems of the mothers in their case loads, and how these problems were prioritised. It also explored sources of information and literature which the health visitors found useful to their practice. Personal background of the health visitors was also included.

Analysis of Health Visitor Questionnaire

The ages of the 27 responding health visitors ranged from 27 to 57 years and was distributed as follows in Table 1.
Table 1: The age range of the health visitors

<table>
<thead>
<tr>
<th>AGE BAND</th>
<th>HEALTH VISITORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 - 59</td>
<td>6</td>
</tr>
<tr>
<td>40 - 49</td>
<td>12</td>
</tr>
<tr>
<td>30 - 39</td>
<td>7</td>
</tr>
<tr>
<td>20 - 29</td>
<td>2</td>
</tr>
</tbody>
</table>

This was checked against a list of the ages of all health visitors in the area and was found to reflect the distribution as a whole. A senior health visitor commented that nurses do not usually enter health visitor training until they are in their late twenties. Then they often have time out for a family. Or they may enter health visiting when they have a family of their own as they find the working hours are more suitable for family life. Only two were without children of their own - the youngest and the oldest. All were registered nurses and qualified health visitors.

All 27 were indigenous white British women. Three were born in other countries as their families were working abroad at the time. There are no Asian health visitors in this area, although there are now some Asian link workers.
Proportion of Health Visitor Training Devoted to Child Development

They were asked to estimate the proportion of health visitor training devoted to child development. Twenty estimated 1/4, three 1/2 and two 1/3. It might be noted that the format of health visitor training has also changed recently and become a more generic community nurse course. New health visitors trained locally complain that the child development content is totally inadequate. They gave the following figures for case load for children of 0-2 years, some would reflect part-time work (Table 2).

Table 2: Case loads - children under two

<table>
<thead>
<tr>
<th>CASE LOAD RANGE</th>
<th>NUMBER OF HEALTH VISITORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>150 - 200</td>
<td>7</td>
</tr>
<tr>
<td>100 - 149</td>
<td>6</td>
</tr>
<tr>
<td>50 - 99</td>
<td>9</td>
</tr>
<tr>
<td>41</td>
<td>1</td>
</tr>
</tbody>
</table>

Perception of Most Common Problems

An inspection of the data resulting from the questionnaire suggests that the ranking by the health visitors of the seven categories - Feeding, Sleeping, Habits, Temper Tantrums, Elimination, General Health and Development - indicates a perception of commonality between the needs
of the national groups. Not all of the 27 respondents had responsibility for children in families from each category. There is a strong consensus between the health visitors in their relative weighting of the need categories of individual mothers. The following figures show overall how the health visitors ranked these problems across the three groups of mothers. Feeding, sleeping, health and elimination are seen as the four main concerns of all mothers. There is one noticeable difference in the perception of the needs of the different groups: sleeping is seen as more of a problem for indigenous white mothers.

Table 3: Overall ranking of health visitors' perception of common problems - 0-1 year age range

<table>
<thead>
<tr>
<th></th>
<th>Bangladeshi</th>
<th>Indigenous</th>
<th>Italian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Health</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Sleeping</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Elimination</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Development</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Tantrums</td>
<td>5</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Habits</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

A Kendall coefficient of concordance gives: $W = 0.82$, $p<0.01$
Table 4: Overall ranking of health visitors’ perception of common
problems - 1-2 years age range

<table>
<thead>
<tr>
<th>Problem</th>
<th>Bangladeshi</th>
<th>Indigenous</th>
<th>Italian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sleeping</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Health</td>
<td>2</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Elimination</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Tantrums</td>
<td>5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Development</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Habits</td>
<td>6</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

A Kendall coefficient of concordance gives: $W = 0.69, \ p < 0.05$
Other Concerns

Health visitors identified the following additional parental concerns - all single statements.

- advice on toddler groups
- sibling rivalry
- interpretation of advice from doctors or hospitals
- immunisation
- behaviour problems
- teething
- maternal separation
- housing
- marital problems
- going back to work
- spots and rashes

Table 5 shows the number of health visitors ranking their own resource sources, the basis on which they feel able to give advice. Medical colleagues do not rank high and personal experience with their own children is also rated low. On the other hand, experience with clients is rated highly. It is clear that they drew substantially on previous experience in their profession and on courses and publications. Personal experience with their own children was not highly ranked and information from medical colleagues seems insignificant as a resource.
Table 5: Health Visitors' rankings of five resource areas when giving advice to clients

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>NUMBER OF HEALTH VISITORS</th>
<th>RANKING GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Experience</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Experience of other clients</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Medical colleagues</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Courses attended</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Books, texts, articles</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

A Kendall coefficient of concordance gives a W of 0.296, p ≤ 0.001.
A number of texts were mentioned by health visitors as being found most helpful as a resource (see below). The most popular of these, referred to by almost all of the sample of health visitors and several of the mothers, was that by Green (1991), *Toddler Taming, a Parents Guide to the First Four Years*. This seems to be the ‘bible’ that has replaced Spock. Green is an amusing writer and the text is sprinkled with funny cartoon illustrations of childhood behaviour. He is also very prescriptive. For example, he advocates smacking and lists times when it can be effective and appropriate.

Smacking has its main usefulness in the younger child. At this age words are less effective than some decisive action. You can debate all day with a 2 year old. you can explain about the finer points of love, example and character building and even your evangelical views against corporal punishment but the chances are that words may miss the mark, while a gentle gesture of a smack may land a centre bullseye right on the target - - - (Green, 1991: 70)

And again:

- - - a well considered smack registers a firm message which states that these are the limits (Green, 1991: 71).

There are some sensible down to earth statements, “all toddlers should be receiving clear uncluttered messages from the mouths of their parents”.
One practice advocated by Green was cited during this study by several mothers. Called in the book 'Green’s patent rope trick,' it involves tying the inner handle of the child's bedroom door to the handle of another door so that children who will not stay in bed at night cannot leave their room. He says that the child may resort to crying but this ploy will fail as the parent can then use the ‘controlled crying technique’ (p. 125-130).

Because of the popularity of this book amongst health visitors and the contradiction which it presents in terms of the health visitors’ ‘no smacking’ campaign for the mothers, further reference will be made to it in the discussion of the parental interviews.

**Texts Which The Health Visitors Recommended to Mothers**


Health Education Authority (1989) *Birth to 5 years.* London: Harper and Row


**Texts Which Health Visitors Found A Useful Source of Reference**

These references were entered by the health visitors on their questionnaires and in some instances the full reference was not given.

**Journals**

*Health Visitors Journal*

*DHSS Manual of nutrition*
DHSS  Manual of immunisations

BMJ   ABC of child abuse

J. Cox. Post natal depression

M. Birch. So you want to be a parent


J.D. Lad. When a baby dies suddenly.

Mowbray. Water bugs and dragon flies. (about death)

These texts, with the exception of the Health Visitor Journal which does contain wide ranging articles, do not seem to reflect cross-cultural perspectives.

In the following chapter these and other issues are raised with ten of the health visitors in interviews. From this it is hoped that a clearer picture will emerge of the attitudes and beliefs of this professional group.
CHAPTER 6

HEALTH VISITORS

COLLATED INTERVIEWS AND ANALYSIS
CHAPTER 6
HEALTH VISITORS - COLLATED INTERVIEWS
AND ANALYSIS

In order to follow through issues raised in the literature and in the
responses to the questionnaire, ten health visitors were interviewed using a
semi-structured outline with focus topics (Appendix 3). In this way similar
areas were covered with each health visitor. These included discussion of
their attitude to their job and related issues, their perceptions of different
client groups, including those in this study, and their views about important
issues. Their role and the future of the service was also discussed.

Interviews took place wherever it was most convenient for the health visitor,
either in her office or the interviewer’s home. They lasted between 45
minutes and an hour and were taped using a small unobtrusive tape
recorder. None of the participants objected to the interview being
recorded. Each interview was fully transcribed (see samples in Appendix 3).

A modified grounded theory approach was applied to the data, a procedure
which Turner (1981) recommends when analysing qualitative data drawn
from semi-structured interviews (see Figure 1, Chapter 4). The scheme of
the analysis is illustrated below (Figure 4).
The analysis of interview data was achieved as follows. The responses to each of the focus topics were collated and are displayed in the first column below. Emergent concepts were then identified from these grouped responses and are expressed in the second column. When the interview data concerns client groups a third column contains summaries of the attitudes and beliefs of the health visitors in relation to the mothers. These data from column three are further condensed into four major categories which identify the roles which the health visitor perceives herself to be fulfilling.
THE SCHEME OF ANALYSIS

<table>
<thead>
<tr>
<th>1st stage analysis - Column 1</th>
<th>Collation of data from the focus topics raised in the interviews with the ten health visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd stage analysis - Column 2</td>
<td>Identification of emergent concepts from the collated responses</td>
</tr>
<tr>
<td>3rd stage analysis - Column 3</td>
<td>Health visitors' attitudes and beliefs elicited from the emergent concepts</td>
</tr>
<tr>
<td>4th stage analysis - Condensation</td>
<td>Categorisation of the health visitors' attitudes and beliefs into four major roles which the health visitors perceive themselves to be fulfilling in relation to their client groups</td>
</tr>
<tr>
<td>HEALTH VISITOR PERSPECTIVES</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td></td>
</tr>
<tr>
<td>COLLATED INTERVIEW DATA</td>
<td></td>
</tr>
<tr>
<td><strong>Reasons for Becoming A Health Visitor</strong></td>
<td></td>
</tr>
<tr>
<td>Hours of work more suitable for family life especially with children</td>
<td></td>
</tr>
<tr>
<td>More practical with children</td>
<td></td>
</tr>
<tr>
<td>Preventive aspects of the work appeal</td>
<td></td>
</tr>
<tr>
<td>Recognised need for health promotion, a proactive approach to health care, stepping in before medical conditions develop, searching out health needs</td>
<td></td>
</tr>
<tr>
<td>Being tenacious</td>
<td></td>
</tr>
<tr>
<td>Holistic approach to health</td>
<td></td>
</tr>
<tr>
<td>Varied and interesting</td>
<td></td>
</tr>
<tr>
<td>Visiting people who are not ill</td>
<td></td>
</tr>
<tr>
<td>Variety in the job</td>
<td></td>
</tr>
<tr>
<td>Like children - I actually like children</td>
<td></td>
</tr>
<tr>
<td><strong>Satisfying Aspects of the Job</strong></td>
<td></td>
</tr>
<tr>
<td>Supporting families</td>
<td></td>
</tr>
<tr>
<td>Developing a relationship with families</td>
<td></td>
</tr>
<tr>
<td>Building up contact with families</td>
<td></td>
</tr>
<tr>
<td>Getting to know families, seeing relationships develop between mother and new baby</td>
<td></td>
</tr>
<tr>
<td>Autonomy</td>
<td></td>
</tr>
<tr>
<td>Being my own boss, Organising own work</td>
<td></td>
</tr>
<tr>
<td>No restraints like there are in hospital</td>
<td></td>
</tr>
<tr>
<td>Freedom of the job, working in the community</td>
<td></td>
</tr>
<tr>
<td>Teaching role - (ante and post natal clinics most enjoyed)</td>
<td></td>
</tr>
<tr>
<td><strong>Frustrations of the Job</strong></td>
<td></td>
</tr>
<tr>
<td>[Nearly all mentioned the administrative work load]</td>
<td></td>
</tr>
<tr>
<td>Computer input - HV's too well paid to spend time doing this</td>
<td></td>
</tr>
<tr>
<td>Not trained to work with computers</td>
<td></td>
</tr>
<tr>
<td>See the information requested as being invalid</td>
<td></td>
</tr>
<tr>
<td>Computer input tiresome: eg. how many visits? how long with each client?</td>
<td></td>
</tr>
<tr>
<td>This information does not describe the visits or measure quality: does not help me with my job, more and more desk bound, less time for home visits</td>
<td></td>
</tr>
<tr>
<td>Difficulty in quantifying the job, can't see what you are achieving, work extends over a long period, difficulty in seeing goals achieved</td>
<td></td>
</tr>
<tr>
<td>We don't know what we are achieving, though visits have to be shown to be cost effective</td>
<td></td>
</tr>
<tr>
<td>Failure of aims</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMERGENT CONCEPTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pragmatic</td>
</tr>
<tr>
<td>Interventionist</td>
</tr>
<tr>
<td>Personal satisfaction</td>
</tr>
<tr>
<td>Human interest</td>
</tr>
<tr>
<td>Personal relationships</td>
</tr>
<tr>
<td>Working with families</td>
</tr>
<tr>
<td>Autonomy</td>
</tr>
<tr>
<td>Teaching</td>
</tr>
<tr>
<td>Administration and computers</td>
</tr>
<tr>
<td>Inadequacy</td>
</tr>
<tr>
<td>Difficult to quantify</td>
</tr>
<tr>
<td>Difficult to see aims realised</td>
</tr>
</tbody>
</table>
Don't feel we achieve what we set out to do - i.e. -
  change peoples attitudes
  increase their understanding of parenting
Not getting the people to come to health groups who should be coming,
preaching to the converted
Lack of support, on your own in the community
Need for regular debriefing in complex family situations
Constant changes in management structure and policy unsettling
Reorganising of management, new managers coming and going all the time, it is absolutely crazy and interferes with me getting on with my work, money being poured down the drain with the continuous restructuring

<table>
<thead>
<tr>
<th>Not achieving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not supported</td>
</tr>
<tr>
<td>Isolated</td>
</tr>
<tr>
<td>Dissatisfaction with management</td>
</tr>
<tr>
<td>COLLATED INTERVIEW DATA</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>View of Client Groups</td>
</tr>
<tr>
<td><em>White indigenous British mothers</em></td>
</tr>
<tr>
<td>High expectations of themselves as mothers</td>
</tr>
<tr>
<td>Not relaxed about the process of child-rearing</td>
</tr>
<tr>
<td>Difficulty of adapting to motherhood after a career</td>
</tr>
<tr>
<td>Conflict between staying at home with the baby and going back to work</td>
</tr>
<tr>
<td>Unrealistic expectations of themselves and their children</td>
</tr>
<tr>
<td>Want quite a lot of attention quick to get on the phone to you</td>
</tr>
<tr>
<td>Loads of phone calls following the Cook Report linking cot deaths to certain mattresses</td>
</tr>
<tr>
<td>They can be demanding in a different way, have to prove yourself</td>
</tr>
<tr>
<td>They can feel very lonely especially if their partners are commuting to London, it is a long day and they can feel very isolated</td>
</tr>
<tr>
<td>There is a danger they can over use you, as I can identify with them married with children and a mortgage</td>
</tr>
<tr>
<td>Because you make yourself available to that family they see it as an opportunity to off-load whatever You have to learn to curb that because anyone will do it even if they are not in a crisis if they have someone who will listen to them</td>
</tr>
<tr>
<td>It bothers me that they are so unsure of themselves: they experience guilt, loneliness, lack of confidence, have unrealistic expectations Everywhere they turn someone is telling them something different</td>
</tr>
<tr>
<td>Perception of Young Single Mothers</td>
</tr>
<tr>
<td>More social problems with younger age group - financial - housing - thrive on volatile relationships - go from one partner to another - have children with different partners - sometimes partners in prison</td>
</tr>
<tr>
<td>Aim seems to be to get a house and a baby, some don't see a partner as necessary Good at coming to clinic Look after the babies beautifully</td>
</tr>
<tr>
<td>More relaxed about motherhood</td>
</tr>
<tr>
<td>Collated Interview Data</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Motherhood a very natural process for them</td>
</tr>
<tr>
<td>Care of the children not a problem</td>
</tr>
<tr>
<td>Need reassuring that health visitor is there to support not</td>
</tr>
<tr>
<td>to police</td>
</tr>
<tr>
<td>Most get a lot of support from their extended family</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Perception of Bengali mothers</strong></td>
</tr>
<tr>
<td>More demanding than other Asian groups, see you as</td>
</tr>
<tr>
<td>someone who helps</td>
</tr>
<tr>
<td>Often request help with -</td>
</tr>
<tr>
<td>- social security</td>
</tr>
<tr>
<td>- financial benefits</td>
</tr>
<tr>
<td>- housing</td>
</tr>
<tr>
<td>Ask health visitor to help fill in forms, read official</td>
</tr>
<tr>
<td>letters etc</td>
</tr>
<tr>
<td>A lot of input into the families from;</td>
</tr>
<tr>
<td>- education</td>
</tr>
<tr>
<td>- housing</td>
</tr>
<tr>
<td>- social services</td>
</tr>
<tr>
<td>- health</td>
</tr>
<tr>
<td>Large families, care of the children is pretty good</td>
</tr>
<tr>
<td>Can switch off responsibilities and concentrate on the</td>
</tr>
<tr>
<td>baby, plenty of family support</td>
</tr>
<tr>
<td>Often concerned about child’s growth</td>
</tr>
<tr>
<td>Difficulties with children’s diet - take too much milk,</td>
</tr>
<tr>
<td>not eating enough food, children not getting enough iron</td>
</tr>
<tr>
<td>Accept information, don’t question</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Perception of Travelling Families</strong></td>
</tr>
<tr>
<td>Need for health visitor to be more pro-active</td>
</tr>
<tr>
<td>Need urging to come to clinic</td>
</tr>
<tr>
<td>Limited literacy so direct contact necessary</td>
</tr>
<tr>
<td>Usually very responsible about child’s immunisation/vaccinations and checks</td>
</tr>
<tr>
<td>Do look after the child’s records, a success story</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Perception of Italian Families</strong></td>
</tr>
<tr>
<td>Different outlook on children</td>
</tr>
<tr>
<td>More child orientated</td>
</tr>
<tr>
<td>Life revolves around the baby</td>
</tr>
<tr>
<td>Family support is there</td>
</tr>
<tr>
<td>Children babied more</td>
</tr>
<tr>
<td>More accepting of breast feeding</td>
</tr>
<tr>
<td>Do come up to the clinic a lot</td>
</tr>
<tr>
<td>Realistic expectation of motherhood and of baby</td>
</tr>
<tr>
<td>prepared to give baby time, family support</td>
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<td></td>
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</tbody>
</table>
### Sensitive Issues
Not sure you would encounter these unless trust has been established

- Initial job to build up rapport with the family
- I would go in overtly, probably would not have done this in my first year, you learn by experience

- You don’t get any information if people think you are being sneaky
- Some difficult situations I haven’t handled well, you grit your teeth and get it out, you can’t go away and come back, there have been situations which I have not handled well. It took a long time to sort out because I had to go back and do a lot of recovery.
- There is a question of personal safety, you don’t know who is in the house, we are vulnerable in many situations, including church halls.

### Types of Issue

#### Contraception

In the case of Asian families contraception can be quite difficult because of their religious beliefs.

- Women receptive but men not, go when the men are out, women sometimes approach HV saying they want contraception but the husband doesn’t. It can look as if I am colluding but then she is my client, and I must treat her as an individual.

### Family Relationships

My concern is with the health of the whole family

- Make it clear can’t take sides, sometimes end up piggy in the middle, you have to remain impartial.
- Personal relationships difficult to discuss with new Bangladeshi immigrants. I don’t want to get them ostracised by the family. Girls who have been educated in this country find it easier.
- You can’t get that sort of relationship going with the Bangladeshi women without a link worker, because of the language – not really deep stuff, just money problems, I had an Asian women who was being beaten by her husband, badly, but she did not want me to visit her at home or be helped by the women’s refuge, just relieve her feelings.

### EMERGENT CONCEPTS

- Initial job to build up rapport
- Need for openness
- Acknowledges clear guidelines
- Personal safety
- Feels vulnerable
- Conflict related to religion and husbands’ attitude
- Does not accept cultural practice
- Is loyal to client
- Family / cultural tensions
- Maintains impartiality
- Feels not able to support the mother adequately
- Lack of resources
- Sees a language problem, need for link workers
**Child abuse**

I don't think I would deal with it any differently with any family. Parents would know why I was visiting. Hopefully no hidden agenda up-front. We usually talk about it.

I am always very honest; I will go in and say I am not happy about what is going on, amazed at how willing parents are to cooperate. I have never had a problem; I think it is sometimes a relief to get it out in the open. One young mother said she had smacked her young baby really hard; I had to tell her that I must share this information with my manager, and then I had to stand back from it. Can't step away from it, something you build up through the years. You have to keep a clear view of what is going on.

I don't see child abuse as a sensitive issue, our role has been very well defined, we have clear guidelines and I make no bones about taking up the issue, the child's interests are paramount.

I am suspicious of a family at the moment where I think something is going on, I think the mother is suspicious too, but she doesn't know that I am suspicious of her, she knows I am concerned about the family, but she has never asked why I have gone there. I have not had to explain that I have had an anonymous phone call (laughs), I find it very difficult, but you don't have to face it on your own.

I have a client who abused his 12 week old baby very seriously; he knows I know all about it, but has never been able to own up to me personally. The clients are used to working with social workers and are present at case conferences from the start.

**Child Rearing Issues**

*Sleeping and Family Relationships*

Not seen as a problem, with Bangladeshi mothers, they accept that young children are wakeful and demanding, part of having a baby. Children are not expected to be in rooms on their own. Plenty of family support.
<table>
<thead>
<tr>
<th>COLLATED INTERVIEW DATA</th>
<th>EMERGENT CONCEPTS</th>
<th>HEALTH VISITOR ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late bed times and being in bed with the parents only a problem if it affects the child's school work, then I talk it over with the parents For indigenous white mothers sleeping is a problem They expect babies to sleep through the night at three months, if they don't it is seen as a problem and expect me to do something about it, expect children to be in bedrooms for long periods on their own Sleep behaviour seen as much more of a problem with the IW middle class mothers, I let them offload as they get depressed about it Bedtimes and taking children into parents bed Difficult if both partners are not consistent Comforting for the child to be in bed with parents who may say it is okay but then bring up other problems in the relationship, sometimes used as a form of contraception. I have had conversations with women who having become mothers find it difficult to go back to being a lover I am not in a position to tell them what to do Sometimes having the child in bed means everybody gets a good nights sleep Wouldn't advise against it unless it is a problem for the family I get worried if the father has to sleep in the spare room or on the settee, this raises questions about the relationship, sometimes draw attention to safety aspects - baby getting too hot and how this has been linked to cot deaths With the Italians it is a cultural problem, children are kept up late, they can't be getting a good nights sleep There is a problem with husbands who work long hours and would not see much of their children unless they wait up</td>
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<tr>
<td>Problem is contextual</td>
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<tr>
<td>Unrealistic expectations</td>
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<tr>
<td>Taking children into bed can lead to a conflict of interests</td>
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<tr>
<td>Conflict of interests</td>
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<td></td>
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<tr>
<td>Needs of fathers</td>
<td></td>
<td></td>
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<tr>
<td>Child-centred culture</td>
<td></td>
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<tr>
<td>Tolerant of young child</td>
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<tr>
<td>Strict with older children</td>
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<tr>
<td>Sees the needs of the child as paramount</td>
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<tr>
<td>Sees cultural differences</td>
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<tr>
<td>Is concerned about relationships unsure about the practice</td>
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<tr>
<td>Need to listen - therapeutic</td>
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<td></td>
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<tr>
<td>Concerned for child's well-being</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognises cultural differences</td>
<td></td>
<td></td>
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<tr>
<td>Approves of realistic expectations</td>
<td></td>
<td></td>
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<tr>
<td>Concerned about harsh punishment</td>
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</tbody>
</table>

Discipline
Temper tantrums not an issue for Bangladeshi mothers, everything is done for the child, there are few frustrations in the early years, they give way to the child then suddenly there is a cut off point when the child is expected to behave, It can be tough on the child, there are some grandmothers who mete out quite harsh discipline, I can think of
<table>
<thead>
<tr>
<th>COLLATED INTERVIEW DATA</th>
<th>EMERGENT CONCEPTS</th>
<th>HEALTH VISITOR ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>one or two older children who have been physically abused</td>
<td>Strong family influence</td>
<td>Aware of other influences</td>
</tr>
<tr>
<td>There are some strong mother figures who give advice to the young mother and can be very influential</td>
<td></td>
<td>Seeks to inspire confidence</td>
</tr>
<tr>
<td>I try to deal with it sensitively and let the mother discuss her own wishes and make her feel confident in her own mothering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>They seem close cultural group, secure family unit, closely knit family set up, plenty of adults for the children to relate to</td>
<td>Unrealistic expectations of children</td>
<td>Would prefer more tolerance</td>
</tr>
<tr>
<td>The indigenous population, mainly middle class talk about behaviour problems with the under fives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>They have unrealistic expectations of the child, other groups would accept what the child does as childish behaviour and not view it as a problem</td>
<td>Smacking a problem</td>
<td>Feels inadequate</td>
</tr>
<tr>
<td>My theme is that different cultures do different things It is up to them to do what is right for them Children do like to know what is what, but it is up to them how firm they are</td>
<td></td>
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</tr>
<tr>
<td>We do have a no smacking guide I could do with a course on that</td>
<td>Mothers need help</td>
<td>Needs to listen</td>
</tr>
<tr>
<td>We are not supposed to condone smacking I would ask if it were working - probably isn't, often doesn't make the mother feel good, but she doesn't know any other way of dealing with it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk about methods with the mother which give her a chance to cool down I can understand mothers doing it, however I would have to say to the mother she should find other ways, don't leave the mother high and dry she will have loads of questions, try to present other options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The people who ask are the ones who are going to think about it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I saw a child being smacked I would have to say something about it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't think a mother would tell me to readily if she were smacking her child</td>
<td>Conflicting advice</td>
<td>Sees the need to act</td>
</tr>
<tr>
<td>There do seem to be conflicting messages, the government seems to be advocating harsher discipline with children , when parents present me with a media issue, I usually sit down with them and ask them how they are dealing with it, usually it is a much more common sense approach than the 'experts'</td>
<td>Mothers' view respected</td>
<td>Believes mothers should consider options</td>
</tr>
</tbody>
</table>
I don’t approve. It doesn’t give the child the right message, I can’t think of an incidence where it is justified.

One person’s tap is another’s hard smack.
Smacking is the mother’s bottom line, other methods need to be found which are equally hurtful to the child so that she will understand that she has done something wrong.

Whose benefit is it for? I encourage mothers to give it some thought.

I must say I am not totally against it.

Involvement of partners.
Fathers generally want to be involved with their baby.
Some of the unemployed men tend to think the HV is just for the mother but I try to bring them in.
Some fathers can be quite shocked and low after the baby arrives.

Breast Feeding.
Breast feeding is the mother’s choice, most mothers think it is the best thing to do, but do not do it for long. They have other agendas.
Going back to work, sharing with partners I would obviously give support to breast feeding, but it is the mother’s choice.

Mothers get a lot of conflicting advice in the first few weeks from different people, but going back to work is a factor.

If I pick up vibes that they want to give up breast feeding and all they are waiting for is your permission, I would rather go along with it than try and put my own views across.
They can also see the baby getting the milk, baby food manufacturers push their products.
Some women say their partners want them to give up so that they can get their figures back.

Bangladeshi mothers see bottle feeding as a good thing, can see how much the baby gets, there is pressure from the family to bottle feed.
In their own country they are flooded with commercial milk - heavily subsidised, they expect to bottle feed if they can afford it.

I suggest that they offer the bottle after the breast if they want to be sure the baby has enough.

<table>
<thead>
<tr>
<th><strong>Collated Interview Data</strong></th>
<th><strong>Emergent Concepts</strong></th>
<th><strong>Health Visitor Attitudes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t approve. It doesn’t give the child the right message, I can’t think of an incidence where it is justified. One person’s tap is another’s hard smack. Smacking is the mother’s bottom line, other methods need to be found which are equally hurtful to the child so that she will understand that she has done something wrong. Whose benefit is it for? I encourage mothers to give it some thought. I must say I am not totally against it.</td>
<td>Need to punish</td>
<td>Feels some confusion</td>
</tr>
<tr>
<td>Involvement of partners. Fathers generally want to be involved with their baby. Some of the unemployed men tend to think the HV is just for the mother but I try to bring them in. Some fathers can be quite shocked and low after the baby arrives.</td>
<td>Needs of father</td>
<td>Is aware of father’s exclusion</td>
</tr>
<tr>
<td>Breast Feeding. Breast feeding is the mother’s choice, most mothers think it is the best thing to do, but do not do it for long. They have other agendas. Going back to work, sharing with partners I would obviously give support to breast feeding, but it is the mother’s choice. Mothers get a lot of conflicting advice in the first few weeks from different people, but going back to work is a factor. If I pick up vibes that they want to give up breast feeding and all they are waiting for is your permission, I would rather go along with it than try and put my own views across. They can also see the baby getting the milk, baby food manufacturers push their products. Some women say their partners want them to give up so that they can get their figures back. Bangladeshi mothers see bottle feeding as a good thing, can see how much the baby gets, there is pressure from the family to bottle feed. In their own country they are flooded with commercial milk - heavily subsidised, they expect to bottle feed if they can afford it. I suggest that they offer the bottle after the breast if they want to be sure the baby has enough.</td>
<td>Mothers have dilemma</td>
<td>Need to listen</td>
</tr>
<tr>
<td></td>
<td>Sexual concerns</td>
<td>Accepts concern</td>
</tr>
<tr>
<td></td>
<td>Conflict between attitudes and practice</td>
<td>Takes an educational role</td>
</tr>
</tbody>
</table>
### Eating

Eating is a major problem for Bangladeshi families, they are confused about what to give children, conflicting messages from the media, not sure about western food, feel safer sticking to milk. They say child is not eating but give it a bland boring diet or lots of milk, need convincing that some of the food they eat is fine for the child. A problem with anaemia in Bangladeshi children.

### Health Visitors' Specialist Knowledge

- **Families and their psychology**
- **Looking wider than at someone with an illness**
- **Research at your finger tips**
- **Updated with things that are going on**
- **Health visitor can look at things more objectively**
- "My mother says" or the Post Natal Group is often quoted but HV can sit back and say that all of these views may have an element of truth but what do you think is right for your child?
- Health visitors can help mothers to realise they have to find the right way. We can tell them about available research and they must find their own way.
- I would like to think it is a family service. We do not have all the answers but we know where to direct people.
- We have a broad training and build up a lot of experience in the community.
- Aspects of child care and family relationships or knowledge from other experiences which we can use if someone is meeting that experience for the first time.
- Broad based personal relationship knowledge.
- Pick up things from experience.
- If you take things away from the family you can look at them in a more objective way.
- We look at different aspects of life, a more holistic approach.
- How everything affects everything else.
- We can pick up problems and be pro-active.
- Nursing and medical knowledge background.
- Experience of being a parent.
- We are more experienced than the clients' mothers and families who often give lots of folklore advice.

<table>
<thead>
<tr>
<th>Confusion about diet</th>
<th>Critical of diet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerned about diet deficiency</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Theory base</th>
<th>Claims access to expert knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research base</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Feels able to stand outside of the family</td>
</tr>
<tr>
<td>Professional knowledge</td>
<td>Feels ownership of special knowledge</td>
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<tr>
<td>Experience</td>
<td>Feels widely experienced</td>
</tr>
<tr>
<td>Personal knowledge</td>
<td></td>
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<tr>
<td>Holistic</td>
<td>Confident in specialist professional knowledge and objectivity</td>
</tr>
<tr>
<td>Pro-active</td>
<td></td>
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<tr>
<td>COLLATED INTERVIEW DATA</td>
<td>EMERGENT CONCEPTS</td>
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<td>------------------------</td>
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</tr>
<tr>
<td>More impartial, (Monday mornings are notorious after visits from grandmother) Interpersonal skills Experience with lots of normal children Able to identify health care needs Experience, updated knowledge from journals Child development Health needs Experience with other clients We can be more detached, not emotionally involved More rational approach than families We build up a vast reservoir of experience over the years We are good at facilitating groups and group dynamics Families differ a lot, sometimes conflict between what mother in law is saying</td>
<td>Impartial</td>
</tr>
<tr>
<td>Knowledge of child development</td>
<td>Feels able to bring a wide experience of normal children</td>
</tr>
<tr>
<td>Objectivity</td>
<td>Believes she has a less biased perspective</td>
</tr>
<tr>
<td>Aware of family differences</td>
<td></td>
</tr>
<tr>
<td>How the Health Visitors' would like to see the service develop More health promotion groups Geographic patches - look after a defined community Geographic case loads - better idea of what is going on in the area Keep individual role within the community, not a generalist community nurse GP fund holding worrying, may mean disappearance of health clinics GP's may want to centralise their services Community based child health clinics There are good things about working with the GP's, such as getting to know the families whole health histories, but it can be a waste of time when several different health visitors are visiting in the same area from different practices I would like to continue to exercise my own judgement Public health to remain an important part of our job, it may be at risk because it is difficult to measure financially HVs as a group need to remain autonomous and have direct management from someone who understands the service GP's may not fully understand the real work of the service and it may become more medically orientated</td>
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<tr>
<td>Wants geographical case load Approves of distinctive community role GP firms taking over the service</td>
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<tr>
<td>COLLATED INTERVIEW DATA</td>
<td>EMERGENT CONCEPTS</td>
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<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Keep health promotion going, we are in danger of losing it</td>
<td>Health promotion is of prime importance</td>
</tr>
<tr>
<td>No way of knowing if you have changed someone's way of thinking, but sad if primary health goes. You would have to take us out of the country for five years and look at the consequences</td>
<td></td>
</tr>
<tr>
<td>Geographic case load looking at the needs of the whole family, can't be experts in everything but a resource to be tapped</td>
<td>Family centred work</td>
</tr>
<tr>
<td>Jack of all trades at the moment, bogged down with people</td>
<td>Jack of all trades</td>
</tr>
<tr>
<td>Because we have to focus on families so much it doesn't free you up for research, and to develop health promotion I feel we should keep as many skills as we can</td>
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<tr>
<td>I think we have a political role and also should be champions of women's rights</td>
<td>Keep home visits</td>
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<tr>
<td>No further reduction in home visits</td>
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<tr>
<td>I would not like to see home visits disappear. The ones I do now are more effective. I don't really want to see any changes.</td>
<td></td>
</tr>
<tr>
<td>Practice attachment has its advantages, it has improved their opinion of us and they understand our work more, but slight worry about GPs having their own, more medical agenda</td>
<td>Holistic approach</td>
</tr>
<tr>
<td>Holistic approach to community health</td>
<td></td>
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<tr>
<td>It will have to be cost effective, which will mean chasing immunisations, vaccinations, and child surveillance</td>
<td></td>
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<tr>
<td>I would welcome a skill mix</td>
<td>Needs more practical support</td>
</tr>
<tr>
<td>I can sort out my priorities and I would like to pass on the more practical aspects of the job to an assistant</td>
<td></td>
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</tbody>
</table>
FOURTH STAGE ANALYSIS

From the above analysis, four major categories can be seen to emerge in relation to attitudes and beliefs. These affect the way in which the health visitor may be seen to function as an ‘interventionist’ in health care, a situation already identified in the literature (see Chapter 5).

Therapeutic: listening, attending, supporting, reassuring, approving, confronting, impartiality

Educational: teaching, proactive on health issues, advising, giving options

Expert: specialist knowledge, experienced, confident, autonomous practitioner, judgemental and critical of mothers’ practice

Empowering: loyalty to clients, accepting of some cultural aspects, inspiring confidence, respecting mothers’ point of view, resourcing

Health visitors do not consistently exercise all of these roles equally with each group of mothers. This is considered as part of a further analysis which follows the course of the interviews and begins by looking at attitudes towards the job of health visitor.
Attitudes Towards the Job of Health Visitor

The age range of the ten interviewees was representative of the health visitors in the questionnaire sample. In the past the route to becoming a health visitor has required three separate nursing qualifications, general nursing, midwifery and health visiting, involving three different courses. Health visitors have been seen as being over qualified for their role, but the interview data suggest that experience is seen by the health visitor as the most important preparation for dealing with some of the complex family situations they face. Pragmatic reasons were given by the majority of the group for becoming a health visitor, in that the hours and style of working fitted in well with family life, especially if they had children.

Autonomy appeared to be a highly desirable feature of the health visitors’ job, having the freedom to organise one’s own work and being free of the constraints which the hierarchical structure of nursing in a hospital imposed. It was expressed as an important reason for choosing this branch of the profession and also valued as worth retaining in any further restructuring of the profession.

The health visitors seemed not only to have autonomy with their time and how it was organised but also with expressing their personal views and values to mothers. An example from an interview with one of the health visitors is shown below.
One of my major concerns is the mushrooming of bright shiny private day nurseries locally. The mothers are impressed by them. They receive children from 7 a.m. to 7 p.m. and I feel it is nothing more than institutionalised care for these children. The mothers see it as an opportunity to go whizzing back to work in London. When I take my antenatal classes I make sure the subject is discussed and make no bones about my own view that a nanny or good child-minder is a preferable arrangement.

This ‘preferable arrangement’ of course may be neither available nor may it be desirable for the mother. There also appears to be an element of disapproval in mothers returning to a work place which could be their only choice for pursuing their career, for example, mothers working in the City, for the BBC or in the law courts.

And a second health visitor...

I always have a specific remit in my mind about what we are going to discuss when I visit a mother...and I tick them off in my mind.

Interviewer: Do the mothers ever bring up different issues?

HV: Oh absolutely, but I always make sure I cover the things I have got to deal with.
Robinson (1992) has previously noticed that home visits were highly organized encounters, in which the practitioners took the leading role, deciding how long the visit would last, what sort of topics should be talked about and who should talk about them.

Cowley (1991a) also observed that in clinic discussions between mothers and health visitors the health visitor appeared to hold a list of questions in her mind, for example topics such as breast feeding. The same questions were asked of mothers, usually in the same order, and any attempt by the mother to raise a topic was gently but firmly discouraged. The health visitor seemed unaware that she was acting in this way, or of the feelers put out by the mother. Cowley comments that whilst the clarity of purpose by the health visitor may assist the process, approaches which place exclusive emphasis on topics previously identified in isolation from the context may inhibit rather than promote awareness of health needs.

Personal satisfaction was experienced by the health visitors in the varied and interesting nature of the work in the community. Contact with people who for the most part are not ill made the work less urgent and stressful than hospital nursing. Getting to know families by developing relationships with them was also a satisfying experience as was seeing mother infant relationships develop. The
reciprocal concept of ‘getting known’ was equally important, demonstrated later when trust between health visitor and client in some situations is imperative.

Frustrations and Difficulties with Health visiting

There were feelings of inadequacy and difficulties in quantifying the job.

Frustrations seemed to be mainly concerned with the administrative side of the work and the introduction of computer records. Inexperience with computers engendered feelings of inadequacy which was dissonant with the health visitors’ view of themselves as experienced practitioners. The emphasis on quantifying their work to be accountable to an internal market was also disturbing. They saw health education as a long term process with outcomes not immediately apparent or measurable in terms of ‘cost effectiveness’, neither is it possible to quantify the value of a home visit. Health visitors saw this part of their work as being under-valued, while mechanical tasks such as immunisations and developmental checks which could be demonstrated in numbers were assuming greater importance.

The achievement of long term aims was not always visible and there was also an added frustration of health education programmes not succeeding. The comments below made by the health visitors during the interviews illustrate this;

When we run courses the converted come and even if others come from a different social group they don’t really fit in. I don’t know that we are
achieving what we aim to do, that is, change people's attitudes and
behaviour. I don’t feel that we achieve that at the end of the day.

If we want to run groups for people with older children, what stops us is that
we don’t have money for creche facilities.

Resources are fundamental to the enabling and empowering process. In this
respect educational opportunities and the raising of awareness of health needs are
lost to the health visitor.

Dissonant with the desire to be autonomous was the feeling of isolation in difficult
situations and the perceived lack of support from management. Strong feelings
were expressed by several health visitors with regard to management problems,
see below;

In the three years I have worked here the Trust has had three different
changes of name. The money being poured down the drain in the
restructuring, reorganising of management with new managers coming and
going all the time is absolutely crazy. It interferes with my work.

Management seems to be in a mess. It is one directive after another with
no grass roots support. This definitely needs sorting out.
Management changes have been frequent with the restructuring of the service and managers were thought by the health visitors not to be sure of their own role.

Attitudes Towards Client Groups

The therapeutic role

White Indigenous British mothers form the majority client group served by the health visitors in this study. They are described by the health visitors as being middle class and well informed. However the consensus view among the health visitors was that they lacked confidence as mothers, particularly first time mothers, having unrealistic expectations of themselves and of the behaviour of their children. The health visitors also observed that there was a considerable amount of conflict for some of the mothers between staying at home with the baby and returning to work. Returning to work meant making child care arrangements with outside agencies and curtailing breast feeding, as many of the mothers live some distance from their families.

There was an ambivalence by the health visitors between the concern for the loneliness, guilt and conflict felt by the mothers, and the demands made on them as professionals. They saw a danger in that they could identifying strongly with the mothers’ problems, and this could lead to being overused by them for the purpose of off-loading their anxieties. A further experience with these mothers was that the health visitors felt the need to prove themselves to have their advice
respected, and they acknowledged that these mothers would go to other sources for advice until they found a solution which suited them.

The Edinburgh Post-Natal Depression Scales, EPNDS, (Appendix 4) were seen as a useful tool for facilitating the expression of anxiety. These scales were developed by Cox et al (1987), as a tool for detecting postnatal depression, which in previous studies has been confirmed to be present in 10 to 15 percent of new mothers, (Cox et al 1982, Watson et al 1984). The EPNDS are a ten-item self report scale which covers the common symptoms of depression. The scale does not replace a full psychiatric assessment, but defines a population which needs further evaluation, and is easy to administer. Validation of the scales was carried out on 84 mothers living in Edinburgh. The mean age of the mothers was 26 years. Seventy five percent had normal deliveries, 15 percent caesarian sections and 10 percent forceps deliveries. Within the sample 81 percent were married, 13 percent had permanent partners and 6 percent were single parents. The social class distribution was according to the husband or partner’s occupation, or the mother’s in the case of single parents, and was as follows; social class II - 7 percent, III - 35 percent, IV - 31 percent and V - 27 percent. No mention is made of standardization for other cultural or ethnic differences, other than the instruction that the mother should complete the scales herself unless she has limited English or difficulty with reading. In these scales a series of statements are made and
mothers are asked to respond on a Lickert type scale scored from one to four about how they have felt in the last seven days, for example;

1. I have felt sad or miserable:
   a. most of the time
   b. yes quite often
   c. not very often
   d. not at all

2. The thought of harming myself has occurred to me.
   a. yes quite often
   b. sometimes
   c. hardly ever
   b. never

If the mother scores high, which is towards a negative response, the health visitor will make a contract with her to go in at weekly intervals and listen to the mother while she focuses on the things which have made her feel low.

Below are some comments on the scales made by the health visitors during the research interviews.

I called on a girl whose baby was born in April and in July she scored high on the Scales. This is usually over 12. I gave her six weeks listening and her score went down to four. She called me again today to say that she had gone down again, but that meant that she had the courage to ask for help. It is usually due to unrealistic expectations.
The Post-Natal depression scales really help to bring things out into the open; how they feel their partner isn't really interested in the baby; they are tired and don’t get out together. I don’t think there are any instant solutions. They need to get together and sort things out for themselves, but I think once aired she will feel safer to bring it up with her partner.

However this therapeutic approach is not consistent across the groups of mothers, as one health visitor said,

... we have the EPNDS which we use at the moment, and I suppose I could be accused of being discriminatory as I do not complete them with all my Asian mothers. Some of them do not understand the questions and I think I would cause more problems than I solve by embarking on them.

And a second health visitor...

The vast majority of ethnic minority families I have are Bangladeshi and it depends how long they have been in the country. There are some subjects related to personal relationships which are almost impossible to bring up in newly arrived families.
The implication here is that a problem of post natal depression which has been identified as being present in 10 to 15 percent of mothers following childbirth is not being addressed in one section of the community. It is a situation where a perceived need is not able to be met because of insufficient resources, the resource in this instance being skilled link workers.

A further example of this occurring is given by another health visitor,

One Bangladeshi family I have are plonked right in the middle of a new private housing estate.... I feel sorry for them as they would be much better in a community where people could communicate with them. They are not able to ask for the right kind of help and the communication problem has meant that they haven't had the dental care they need.

There are many such examples in the transcripts of the Bangladeshi mothers not having the opportunity of a therapeutic relationship with the health visitor, and the suggestion did not arise that this might be facilitated by more link workers.

The support asked for by the Bangladeshi mothers is often help with filling in forms associated with social security problems. The mothers are seen as being very demanding in this respect and the majority of the health visitors regard it as inappropriate use of their time.
Young single mothers experienced similar social problems, but they were generally seen as being confident in their mothering and also to have some support from their extended families. Support and reassurance was seen by the health visitors as their main role with these young mothers as one health visitor explained,

We have to get over to them what we are not, as a lot of them think we are checking up on them, you know, whether their homes are clean or not....It is convincing them that we are there to help and to be looked on more as a professional friend, rather than someone from the authorities.

The approval by the health visitors of the realistic attitudes towards motherhood, and babies, held by the Bangladeshi, Italian and the young single mothers may also been seen as a therapeutic response.

A therapeutic relationship may of necessity encompass challenging behaviour, and most of the health visitors saw the issue of child abuse as one which had to be confronted openly. The adoption of this position was aided by the clear guidelines of procedure laid down by the profession. Guidelines were welcomed for other awkward situations, such as smacking, which produced a great deal of ambivalence in the health visitors attitudes. Several were concerned about how to approach this problem. This dilemma was expressed by one health visitor thus,
We have our ‘No Smacking’ guide. I could do with a course on that. It is trying to present them (the mothers) with what the options are, but it is a difficult one.

Interviewer...What about smacking? I know there is a policy related to EPOCH, but what about your own views on this?

HV... I think it brings up some useful discussion about whose benefit it is for, and perhaps they should give it some thought, but I am not totally against it.

The official line on smacking is laid down for the health visitor, and I would have to suggest alternative methods of discipline, but again one has to be realistic about the odd smack.

When child abuse was suspected and not confronted openly by the health visitor it produced similar covert behaviour by the parents, as these two health visitors illustrate;

I find it very difficult. I still have a client who abused a 12 week old baby very very seriously. He knows I know all about it, but he has never been able to own up to me personally.
I am suspicious of a family at the moment where I think that something is going on, I think the mother is suspicious as well....She knows I am concerned about the family, but she has never asked me why I have gone there, and I haven’t had to explain that I have had an anonymous phone call (laughs).

The above situations would be described by Glaser and Strauss (1964) as having a symbolic awareness context rather than the concrete social context of a client’s home or health clinic where such interactions usually take place. An awareness context goes beyond the concrete structural unit and surrounds and affects the interaction taking place. Glaser and Strauss (1964) describe four types of awareness contexts:

- **open**, where each interactant is aware of the other’s true identity, and his own identity in the eyes of the other;
- **closed**, where one interactant does not know either the other’s identity or the other’s view of his own identity;
- **suspicion**, in this situation one interactant suspects the true identity of the other or the other’s view of his own identity or both;
- **pretence**, where both interactants are fully aware of the true situation but pretend not to be.
Closed awareness has much significance for the interactant, especially in a health-care setting, for being unaware of the other’s view of his ‘identity’ he cannot act as if he were cognizant of his situation. In a sensitive health visiting situation it would require great tact and skill to manage the interaction, and to achieve an outcome satisfactory for client and health visitor.

The use of the word identity appertains more to the beliefs, intentions and agenda of the interactants in most health care contexts. For example in a case of suspected child abuse a health visitor may feel confident enough of her own knowledge and relationship with the parents to confront them openly with her suspicions, and the parents may be prepared to accept and discuss these suspicions. This seemed to be the general stance taken by the health visitors in this study.

On the other hand, as we have seen, in a closed situation the health visitor may or may not be sure abuse is taking place, and visit a client with a hidden agenda. The client may not suspect the real objective of the visit. There could however be suspicion of intent by both interactants making for very uncomfortable posturing and a loss of any trust by the client. In a pretence awareness context both interactants are fully aware of the suspicions of the other and the real reason for the visit but fence around the situation, and as one health visitor said, ‘you don’t get anywhere by being sneaky’.

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The theoretical framework proposed by Glaser and Strauss for Awareness
Contexts is concerned with social structure and social interaction. Both of these components are implicit in an intervention between health visitor and client.

Cowley (1991) comments that a long standing aim of the Council for the Education and Training of Health Visitors (1977) has been to raise the awareness in health visitors of how the socio-cultural context of behaviour not only influences lifestyle, but also the receptiveness to life enhancing behaviour.

In any health visiting interaction with a client, says Cowley, the health visitor represents a whole formally organized system for delivering a service. Equally as influential may be the clients' family structure, social class and peer group. These influences may be at an immediate personal contact level or socio-cultural influences from a societal level. Each interactant therefore may hold a 'position' which to some extent reflects a commonality with an aligned culture or power structure, but also encompasses values, beliefs and attitudes which make it unique to that individual. The difficulty for the health visitor in some of these situations may be the dissonance between her own and the client's socio-cultural context, and the perceived support she receives from the system she represents.

The Health Visitor as Expert and Educationalist

The roots of concern with occupational knowledge, according to Wilding (1982) lie in the relationship between exclusive knowledge and professional power.
Hitherto, he claims, professions have had the exclusive knowledge in particular areas of life. This monopoly, says Wilding, can be used to benefit the occupation in arguments about resource allocation and policy making; to define and control the client; and to organize control and extend the area of work.

The main claims made by the health visitors with regard to their specialist knowledge was that it had a psychological and sociological theoretical base, utilized current research, was grounded in a great deal of community experience and the ability to make objective assessments from outside of the family. Their expertise in being able to identify health care needs they maintained was the result of wide experience with normal children and other clients. A nursing background and updating from their professional journals was also cited as a source of knowledge. Personal experience of being a mother was referred to, but not given such strong emphasis as professional knowledge. This may only have been for the researchers benefit as one young health visitor who had no children said, reference was continually being made by the health visitors about what their own children had done at certain ages, and she found this most irritating.

It has been noted by Luker and Orr (1992:120) that any tendency to see our own family experience as a standard from which to judge others, constricts and colours how we see other families and how we make assessments. The weakness is that our own experiences may be limited and biased. This may be acknowledged by
the health visitors and be their reason for not emphasising this sort of experience
as a source for their practice. Alternatively it may be seen as lay knowledge in
contrast to what the health visitor sees as her professional knowledge. It is this
professional knowledge which gives the health visitors their professional status,
and this in turn is, according to Robinson (1992), intrinsically a claim for the
superiority of the professional perspective, which has implications for relationships
with clients and colleagues.

At home, they say, people expect well understood, tried and tested knowledge, as
it is through this knowledge that their world is made understandable and
amenable to control. She goes on to say that the professional attempt to replace
this lay knowledge has serious consequences and makes the following points:
professional knowledge can destroy confidence in lay knowledge and thereby
create a vacuum; secondly, it can impose oppressive definition of the client, and
thirdly, it represents the needs of the state and acts as an agent of social control.
It can also act in favour of dominant interests or classes. Robinson takes this
further saying:

Insofar as any occupational group claims to have special knowledge which
is unavailable to any other group or the client, and amenable only to
evaluation by that group, it is excluding others from the power to define,
describe and control an area of life: The implication is that the expert is right and the client is wrong (1992:41).

Muntz (1988) asks the rhetorical question, given that a health visitor has no claim to a better philosophy of health based on a subjective estimate of worth than does the client, on what can or should professionals justifiably base their practice? One answer she suggests lies in the scientific method, that is, everything that a health visitor does in relation to her client is based on a soundly researched base of knowledge, which is measurable in terms of health visitor activity and client outcome. The health visitors indeed referred to research papers, and welcomed any opportunities to attend ‘update’ courses. However Robinson’s response to this is that a mother with a crying baby is not interested in a scientific explanation of why babies cry in general, she merely wants to help her baby. The importance of research is not disputed here but findings will not be useful applied indiscriminately. In all types of health care situations behaviour occurs within a social context, and this must be explored with the mother for a satisfactory outcome.

The social science model of health care based on psychology and sociology presents the expert definition of how the social world impinges on the individual, a model which is not generally available to the general public, and therefore wields power. Dingwall (1977) describes this model as an ‘evangelical model’, affording
an understandable and sympathetic role for the health visitor. It provides, Dingwall claims, precise definitions of what constitutes desirable social change. These usually involve practical social and personal changes. A medical model on the other hand, which is feared by the health visitor as becoming the future model, can only accommodate them as subordinate personnel whose function is screening and surveillance. Some of the health visitors were hopeful that a better understanding of their work was developing by being attached to GP practices, but the economic considerations of the Trusts may force the more mechanical and pragmatic options of the service to dominate. These options are more readily quantified, but do not encompass the therapeutic, educational and empowering parameters of the service.

**Empowerment**

There does seem some dissonance between the concepts of empowerment for the client and autonomy for the health visitor. An autonomous person is said to be able to choose, be self determining and to carry out their own plans and policies (Downie and Calman 1987: 50). This could be in conflict with the ‘best interests’ of the client. However the UKCC (United Kingdom’s Central Council for Nurses and Midwives) *Code of Professional Conduct* (1992) requires nursing professionals to foster the independence of the client. In an enabling relationship autonomy should be equally afforded to the client who then has the ability to choose whether or not to comply with another’s wishes. In Dworkin’s view (1988:10), one type of
attitude to which health workers are prone is paternalism. This can be patronising and conveys the message that the person doesn’t understand. Dworkin feels that autonomy is related to the notion of respect and should oppose paternalistic views. Autonomy also carries with it responsibility and accountability which may be afforded both to health visitor and client. Gibson (1991), as we saw in chapter 3, defined empowerment as a dialectical and transactional process. This was not always apparent in the health visitors’ interactions. An enabling and empowering role was acknowledged by some of the health visitors but did not emerge as strongly as their declared ‘expert’ professional position. Neither was it exercised consistently across all groups of mothers. This was particularly noticeable with the Bangladeshi mothers where the approach was most often prescriptive.

It would seem that for an empowering relationship to develop any interaction between client and health visitor needs to be a negotiation between the professional and personal knowledge of the practitioner, and the client’s lay knowledge, values and beliefs. To be truly empowering it must also be negotiated within the context of the client’s situation. It has also been argued in Chapter 5 that where a ‘Needs Model’ is in place clients have the right to know how their needs are being interpreted, to acknowledge that there is a need, and have the desire for that need to be met.
Occasionally the mothers in this study were 'presented' with options, which the health visitors saw as giving choice, but more often than not these were the health visitor's options and not the mother's. An enabling and empowering role in the nurse client relationship is summed up by Thompson, Melia and Boyd (1994: 45) as one of mutual partnership, which should promote autonomy of the partner and respect for the person's rights. Otherwise, as they say, it can result in exploitation, discrimination and marginalisation of people.
CHAPTER 7
THE MOTHERS OF THE ITALIAN FAMILIES
CHAPTER 7

THE CONTEXT OF THE ITALIAN FAMILIES

Italians are possibly the longest and most well established immigrant group in the UK. In order to understand the strength of the Italian culture amongst the British Italian Community, it is perhaps helpful to have a pen picture of the continuing flow of Italian immigrants to Great Britain which has taken place over the years. Immigration from all parts of Italy and all walks of life has meant that many aspects of the culture are represented in Great Britain. Added to this the steady flow of new immigrants due to chain migration has meant that much of the values and traditions of the culture are maintained.

The work of Colpi (1991a and 1991b) has been drawn on extensively to provide this background picture as she has become the leading authority on the Italian presence in Great Britain today. Born into one of the oldest Scottish Italian business families, Colpi gained a doctorate at Oxford University researching the Italian immigration to Great Britain. She has since worked for five years at the Consolato Generale d'Italia in London and has written extensively on the Italian Community in Great Britain (Colpi, 1979, 1986, 1987, 1991a and 1991b). According to Colpi (1991) the Italian population in Great Britain today numbers approximately 250,000. She talks of ‘Mechanisms of Migration’ being the crucial devices for the transference of large numbers of Italians to Britain. The two mechanisms she describes are chain migration and impersonal recruitment. In chain migration families move to a new country or city and
then assist their immediate family and sometimes other relatives to join them. The prospective migrants are informed of job opportunities and may be helped initially with accommodation and possible employment contacts. In impersonal recruitment migrants may have no personal contacts but may be recruited by agencies working on behalf of sponsors and industries (Colpi, 1991: 18).

Immigration Following the Second World War

The Italian communities which had been established prior to the second World War were severely disrupted by the traumatic events which followed Mussolini’s declaration of allegiance to Hitler in June 1940. The two major consequences of this stance were arrests and anti-Italian rioting in Great Britain. Colpi alleges that there remains a long standing muted grief and humiliation within the old Italian Communities which is still not talked about openly (Colpi, 1991: 99).

Although the British government had for some time been considering the possibility of an Italian - German alliance and discussing ways of dealing with the Italian immigrant community should it arise, the issue was very complicated and had not been resolved. There was the problem of long-established residents whose families might have been in Great Britain for several generations and the newer immigrants who might have had contact with the fascists. Winston Churchill, the prime minister at the time, brushed aside the complicated details of who should or who should not be interned and issued his now infamous edict, ‘Collar the lot!’
(Cesarani, The Guardian 1990). This referred to the German Jews as well as the Italians. In the event no attempt was made to sort out the fascist sympathizers from the non or anti fascists. Police were asked to arrest all known Italians with less than twenty years residency in the UK. Colpi gives a graphic, detailed and well-researched account of the outcome. Some of the Italian men were sent to Canada, some to the Isle of Man and others to Australia.

One of the most tragic incidents to occur at this time was the sinking of the Arandora Star. The ship was bound for Canada with over 700 Italian deportees on board together with some young German prisoners-of-war and some British soldiers, 1,564 men in all. It was torpedoed by a German U boat in the Irish Sea and 729 men lost their lives, 446 of these were Italian (Cesarani, 1990). Wives and mothers within the old Italian communities in Great Britain were left to carry on as best they could, dependent mainly on charity for their livelihood.

With the end of the war the old communities began to re-establish themselves and chain migration was re-activated. There was also a rush of new immigrants from the South of Italy where unemployment was higher than in any other country in the European nations. (Ginsborg, 1990: 236.) These immigrants were encouraged by the expansion of the British economy to seek work in the UK and were offered jobs in the brick yards, coal mines and the tin and steel industries. Italian migrants arriving in Great Britain peaked in 1951 to 200,000.
Not all the migrants stayed but by 1981 the Italian born population in Great Britain was 97,848 and it was estimated that the British born second and subsequent generations equalled this number (British Census 1981, cited Colpi: 167). The British Italian community had quadrupled in size and almost completely changed in character. Instead of the old-established Italian business families the men from the poor South of Italy were coming for skilled and unskilled labouring jobs. However there was also a revival of chain migration in the catering trades with a mushrooming of Italian owned cafes, trattoria and restaurants. It is from this mixture of backgrounds that the families of the mothers and fathers in this study come.

The Italian Family

Jordanova (1989) considers it important to consider the social circumstances of families in a particular time or place, as well as their contemporary beliefs. Therefore in an attempt to understand child rearing practices, the role of the family in the Italian culture will be discussed. Attachment to the family has probably been a more constant and less evanescent element in Italian popular consciousness than any other (Ginsborg, 1990: 2). Ginsborg describes working class families in the 1930’s and 40’s in Italy as being nuclear in structure but with very strong kinship networks. The family units were quite large with three or more children. He cites the second world war as having a devastating effect on many Italian families with children being sent away from their families into the countryside for their safety. Both the Communist party and
the Church tried to hold families together at this time for different reasons. The Church was concerned that the family should be protected from outside ideologies such as fascism and Communism. The main concern of the Communist party in the very poor South of Italy was to try to get families to enter into collective action to farm the land, but the old were suspicious and although inter-family ties were strong, individual families were isolated. Jealousy and dissent and the dominant values of the South could not easily be submerged by collective action (Ginsborg: 127).

After the second world war the average size of the Italian family declined and authority structures within the family became less rigid. The young people living in isolated villages in the rural south gained a new-found freedom with the advent of the Vespa and Lambretta, small affordable motorised scooters. There was also a shift in the woman’s role. Industry there, as in the UK, no longer required the help of women which had been needed during the war, and many more women became full time housewives.

As Italy became more urban and secular with the beginnings of what was described as an economic miracle by Turani (1986), individualism became more important and the family unit was strengthened. Ginsborg stresses that Italy’s modernization was not based on collective action as the communist movement would have wished, but on the opportunities afforded to families to change their lives. Success was measured in material and consumer terms.
Although most Italy families have tended to get smaller, in the rural south the average size is generally larger. This compounds the economic problem for these families who still face a severely depressed labour market. The family remains a necessary refuge from a hostile environment (Mingione, 1986). Family life in the south has been severely disrupted by migration as men have sought work in other countries. The most common problem is that the aged are left behind (Reyneri, cited by Ginsborg, 1990: 418). However according to Balbo et al (1984), grandparents wherever possible remain closely involved in the care of their grandchildren. This has remained the practice amongst the Italian families involved in this study where grandparents are living near their children in the UK. Balbo et al also found that sons and daughters were tending to stay at home well into adult life. Two surveys by Cavalli and De Lillo (1984 and 1988) cited by Ginsborg (p. 414) of young people in Italy between the ages of 15 and 24 years suggested that all sections of Italian youth put the family at the top of its scale of values.

**Child rearing**

In Italy the nurturance of the infant is a social affair with family, friends and neighbours all contributing to social interaction of the infant (Craig, 1992: 213). This is seen to be so in the families of the parents interviewed, and was borne out in a study by New (1988), who examined the child rearing practices of Italian parents in a small central Italian industrial town. She took a sample of 20 infants and their families. The
average family size was 2.2 children and the families ranged from working to professional class.

Family life seemed to be nurtured and protected by the community with businesses closing down and school days organized to accommodate family midday meals. There also seemed to be a strict adherence to traditional sex roles amongst the adult men and women. To some extent this was seen to continue to exist in the Italian families in this study, although perhaps more women had part-time jobs than they would have done in New's sample, probably due to the higher cost of living in a commuter town and greater expectations with regard to home ownership. Extended family networks included both maternal and paternal kin, in New's study, a pattern also borne out in this study.

New found that there were numerous encounters throughout the day between adults and children with no distinction made between activities suitable for children or exclusive to adults. One of the major characteristics of care was a wide range of opportunities for the infants to interact with individuals other than the mother, although the mothers were present for 100 percent of the observation time and performed 85 percent of the child care tasks.

There was also a marked uniformity of parental attitudes, with a conscious rationale for infant care based on health and assumed physical needs. However caretaker responsiveness was oriented more towards the
ongoing family routine rather than the child's present state. Actual infant needs were often disregarded in favour of family routines. This was particularly apparent at family meal times, when infants might be wakened to eat or ignored when hungry until the family were ready to eat. This practice was not observed by the researcher in this study who was often present when infants were responded to immediately when hungry by being fed. Older children in the family did eat together with their parents and accompanied them on social occasions.

Play sessions, in New's study, were usually initiated and terminated by an adult with little opportunity given for voluntary locomotor activity by the infant as they were usually on someone's lap. This was also apparent on outings when elaborate grooming preceded an excursion but the child was kept in the pushchair to be admired and not allowed to get out. There was also vigorous handling and teasing by adults which often resulted in the infant becoming distressed. New felt that because of this the infants developed tolerance to a high level of physical stimulation.

Mothers were quick to acknowledge frets and cries and would respond by talking and holding the child. It was also considered to be unkind to put infants to sleep in a room alone and they commonly shared the same room as their parents. Infants and children were put in separate rooms to sleep by the parents in this study, but they were quickly either brought down to be with the family, or taken into the parents' bed if they became distressed.
Sufficiency of food was of great concern and many grandmothers reportedly played a major role in persuading young mothers to switch from breast to bottle feeding so that the infants intake could be monitored. Certainly food and feeding were found to be major concerns for this group both by the mothers and the health visitors.

The reason for quoting this study at length is to illustrate the strength of the culture which remains evident in the Italian community in this research as the subsequent analysis of the data will show.

The Local Italian Community

According to Colpi (p.72), the South of England experienced a rapid growth of Italian communities post war. In the 60's there was an estimated 100,000 Italians living in Hertfordshire, and at present in the urban community on which the study is centred there are 160 Italian families. With an average of three persons per family this would be approximately 500 Italian people actually living in the town, and additional Italian families in the satellite villages around the town. (Consolato Generale D'Italia, London, 1993).

There are approximately eight family-run Italian restaurants in the town as well as several multi - chain pizzerias which have a staff mainly composed of young Italian men. There are four Italian delicatessens and several women’s and men’s hairdressers owned by local Italian families. The majority of the families come from the Naples area of Italy and came to
this country for work. There are both first and second generation immigrants and the children of many of the young families in this study will be the third generation.

Two local Italian associations organise regular dances, trips and in the summer, barbecues. There is also a football team organised by a local Italian restaurateur and publican, and a yearly wine making competition. The families do not always grow their own grapes but they have special deliveries of Italian grapes which are collected from Covent Garden. Twice-weekly teaching sessions are held in the town for Italian language and culture. These are organised by the Italian Consulate in London which also provides the teacher.

According to one of the young mothers in the study, a second generation immigrant, approximately 80 percent of the young people marry Italian partners. In this study there are examples of two mixed marriages which serve to demonstrate the strength of the Italian culture, as both of the families have adopted an Italian lifestyle. Socialisation within the family is still strong and many of the younger people still live an Italian lifestyle as far as is possible within the community. The young people do have English acquaintances but according to the mothers interviewed socialization is mainly within the Italian community.

Colpi (p. 209) comments that the separation of roles between husband and wife is still common as are relationships with the same sex kin, that is
cousins sisters and *comare* (accepted established and approved - of friends and godparents.) Women rely very strongly on these relationships for support. This was acknowledged quite often by the mothers in the study.

**The Family Background of One of the Mothers**

Maria (pseudonym), one of the young mothers in the study, recounted her family's background. Her mother and father were born in 1938 in a small town called Benevento, which is inland from Naples in the Abruzzi mountains. After the second world war there was great poverty and no work for the men. Many left to find work elsewhere, and at 17 years of age her father went to Switzerland to find work. The men sent money home to their families and the women managed as best they could with the children.

Maria's father came back from Switzerland to marry her mother and in 1961 they came to England. Her father already had a sister living in Birmingham and she organised an interview for Maria's father at an Italian pasta factory in the urban community in which this study is centred. By this time her mother was pregnant with Maria. Many of the Italian families were living on a caravan site in the town but all hoped to buy their own homes eventually.

For many, Maria said, the dream was to earn enough money to return home but the cost of living in England was too high to make this possible.
There were also better opportunities for the young people. Eventually another aunt and uncle joined them. Although Maria's mother was one of seven children the only member of the family left in Italy is her mother's father. He is in his eighties and refuses to leave Benevento. This makes it difficult for the family as he does need caring for and at present her aunt has gone to Italy to look after him. There is still a very strong commitment to caring for the older members of the family. This is discussed later in a section on the family.

Colpi's comments about the treatment of the Italians by the English during the second world war were put to Maria. She said that her family accepted that it was a war and that they were seen as aliens. One of her uncles had commented that being an English prisoner-of-war had saved his life. The family as far as she knew bore no grudges.

Maria describes her father as being very old-fashioned, believing in the old Italian ways about the family, but some of the more recent immigrants from modern Italy, she said, had different, more modern attitudes, towards the male and female roles within the family.

The above vignette of this family's experiences is included to provide an insight into the type of background from which the mothers in the study come.
Analysis of Interview Data

For some of the responses to the interview questions it was possible to group the data and use tables to display it. However in two of the sections i.e. 'Leaving the children to go out' and 'Uses of the health visitors', individual responses have been included as these were often quite strong and it was felt they added to the richness of these data. The data from the question on the way mothers used their health visitors has been collated across all three groups of mothers. This is analysed and discussed in Chapter 10.

Eleven young mothers of Italian families were interviewed using a semi-structured interview with focus topics (see Appendix II). The analysis proceeds in the order of the interview topics and follows the personal information concerning the parents below in Table 6.
### Table 6: Parents’ Occupations, Age and Number of Children

<table>
<thead>
<tr>
<th>Mother</th>
<th>Father</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age and Occupation</strong></td>
<td><strong>Age and Occupation</strong></td>
<td><strong>Number and Age</strong></td>
</tr>
<tr>
<td>I/A  24 - Secretary</td>
<td>29 - Financial planner</td>
<td>1  5.5mths</td>
</tr>
<tr>
<td>I/B  32 - Waitress</td>
<td>31 - Factory cook</td>
<td>2  4mths/7yrs</td>
</tr>
<tr>
<td>I/C  24 - Dept. manager</td>
<td>28 - Restaurant manager</td>
<td>1  15mths</td>
</tr>
<tr>
<td>I/D  26 - Care assistant</td>
<td>27 - Production worker</td>
<td>2  6mths/5yrs</td>
</tr>
<tr>
<td>I/E  32 - Domestic supervisor</td>
<td>32 - Care assistant</td>
<td>4  2/6/7/10yrs</td>
</tr>
<tr>
<td>I/F  33 - Care assistant</td>
<td>33 - Supermarket assistant</td>
<td>2  8mths/7yrs</td>
</tr>
<tr>
<td>I/G  24 - Hair dresser</td>
<td>29 - Builder</td>
<td>2  8mths/2.5yrs</td>
</tr>
<tr>
<td>I/H  25 - Shop assistant</td>
<td>27 - Warehouse foreman</td>
<td>1  15mths</td>
</tr>
<tr>
<td>I/I  27 - Nursing assistant</td>
<td>30 - Mechanic</td>
<td>2  1yrs/2yrs</td>
</tr>
<tr>
<td>I/J  25 - Care assistant</td>
<td>26 - Manual worker</td>
<td>3  15mths/3yrs/5yrs</td>
</tr>
<tr>
<td>I/K  24 - Secretary</td>
<td>28 - Mechanic</td>
<td>1  2mths</td>
</tr>
</tbody>
</table>

#### The Italian Families in the Study

**I/A.** This couple were born in England of Italian parents and have lived here all their lives. Their parents are Italians who have lived in England for 30 years.

**I/B.** The husband of this couple came to England 17 years ago at the age of 14 years to find work. He was looking for work as a furniture maker. His wife came 14 years ago. Her parents still live in Italy near Naples. The husband’s father is dead but his mother still lives in Italy.

**I/C.** This mother has lived in England all her life. Her mother is French and father Italian. The parents have been living in England for 25 years.
and 30 years respectively. The husband is Italian and has also lived here all his life. His parents are both Italian and have lived in England for 30 years.

I/D. This mother and her parents are Italian and have lived in England for 15 years. Her Italian husband came to England four years ago. His parents are both still in Italy.

I/E. A mixed marriage of an English mother and Italian Father. The wife's parents have lived in England all their lives. Her husband came to England at the age of eight with his Italian parents. His father has since died but his mother still lives in England. They were referred to the researcher by the health visitor as an ‘Italian family, and seem to consider themselves as such.

I/F. The husband of this couple has lived in England for 32 years and his Italian parents for 36 years. His wife came to England from Italy eight years ago and her parents are still living there.

I/G. This mother has lived in England all her life. Her Italian parents came to England 24 years ago and still live here. The husband came to England from Tuscany 7 years ago. His parents are Italian and live in Sicily.
I/H. The mother has lived in England all her life. Her parents came and settled in England 33 years ago. Her husband and his parents came to England from Sicily 14 years ago. They all speak Italian at home.

I/I. Mr. S is Sicilian. He was born in England. His father came to England to find work 30 years ago and the family settled here. His wife came to England with her parents 20 years ago. They were from a village near Naples.

I/J. Although this couple are not both Italian their life style is dictated very much by the Italian husband. This appears to be so for two reasons; The mother is totally unsupported by her own parents who live locally. Her mother is Scottish and her father Irish. They have had a hard life and feel they have done their share of child rearing. Secondly the Italian husband takes a very major role in caring for the children, cooking and generally organizing family activities. The husband was born in Naples and came to England 10 years ago. He was put into an approved school in Italy when he was quite young because his parents could not manage him. His mother died when he was 16 years old and he still feels very angry and upset that he saw so little of her as he loved her so much. He still talks a lot about his mother and his love for her. The family are involved with the Italian community locally but the mother feels left out occasionally as she does not speak Italian.
I/K. Most of this mother's extended family live in England. She was born in England the year her parents came to this country from Italy and has lived here all her life. Her husband came to England 10 years ago but his parents have remained in Italy. The couple live next door to her parents and brother and there are several aunts and uncles in the vicinity. They all come from the area around Naples. The family have a restaurant and an Italian delicatessen both of which are joint family ventures.

Comment
This was a young group of parents with ages ranging from: Mothers 24 years - 33 years, clustered mainly in the mid-twenties; Fathers 25 years - 33 years, clustered in the late twenties and early thirties.

The first babies were born when parents were in their early twenties. Five groups of parents had two children, four had only one child, one couple had three children and one couple four children.

Occupations
Seven of the men were in skilled manual jobs, two were in managerial positions and the remaining two were in unskilled work. There were no women or men in professional posts. Amongst the women only one was working full time as a manageress of a department in a large store. The remainder were either in very part time employment outside the home or not in paid employment. No one mentioned being on maternity leave. There is a general reluctance to leave the children with anyone for any
length of time, even with the family, and the mothers, five of them, who were working as care assistants in an old peoples home, (The Villa Scalabrini) were working on night duty so that their husbands could care for the children.

The Villa Scalabrini is situated in one of the satellite villages close to the town, and was the first old people's home for the Italian Community in Britain. It is a registered charity funded from the wealthy business community. It became necessary as there were a few old people in the community without family support. There are about 40 places available for the elderly.

Analysis of Interview Topics

For some of the responses in the interviews it is appropriate and possible to group the data. In the section on 'Leaving the children to go out' the comments were often quite strong and it was felt that richness was added to the data by recording the individual statements. Comments on how the mothers used their health visitors is collated with those of the mothers in the other two groups and analyzed jointly.

Feeding

In all but three instances the mothers chose to breast feed their first child. Periods of time ranged from one month to nine months. One mother who bottle fed all three of her children said she did so because they were all born by caesarian section and it was painful to hold them and breast feed.
Her husband had wanted her to breast feed, as he felt it was the natural and proper thing to do. Another mother who had had a caesarian section for the birth of her second child said she was advised to bottle feed in hospital. She had successfully breast fed her first baby.

One set of parents continued to bottle feed after their baby had been fed in a Special Care Baby Unit with a bottle by the nurses. Two infants who had a cleft lip and palate at birth had also been fed in hospital by the staff with a special feeding bottle, so these parents continued to bottle feed.

This seems to be the practice of the local hospital, as mothers in both the Italian and the Indigenous White Population with infants born with cleft lip and palate reported this. This is not generally the practice in specialist children’s hospitals where mothers are encouraged to breast feed babies born with cleft lip and palate whenever possible. It may be that being a specialist hospital the incidence of this condition is seen more often and the staff are more confident in dealing with it.

Some of the comments made about breast feeding were that it was better for the baby, more natural and convenient. Other remarks were that it was embarrassing, two mothers said this, and that you did not know how much milk the babies were getting. All the mothers said that they fed their babies on demand whether breast or bottle fed.
Weaning

Eight mothers said that they weaned their babies at between three and four months of age. The remaining three said six weeks. The practice at six weeks was to crush a biscuit called Plasmon, which is similar to a soft rusk, and stir it into the bottle of milk to thicken it. These biscuits are obtained from the local Italian food shops. Later as the child grows older they can be chewed. All the mothers knew of these biscuits, and all but three used them for weaning. Two mothers used rusks and one mother used some flakes bought in France called Faringallia. Her mother was French and recommended the flakes. These are also added to the bottle to thicken the milk. Health visitors do not recommend giving the babies anything other than milk until 3 to 4 months and some of the mothers said that they would not tell the health visitor that they did this.

Pastina, a fine pasta, was also used for weaning instead of the ‘baby rice’ or rice used by the mothers of the other cultures. Pastina is boiled with stock cubes and then grated cheese, minced meat, pureed vegetables or fruit added. Very few of the mothers in this group used proprietary brands of weaning foods. The children ate the same food as the family as early as eight months of age.

Sleeping patterns and bedtime rituals

One mother said that the general feeling in Italy was that children will not sleep so why bother to put them to bed early! This mother said that she will try and get her child to bed by nine o’clock when she is older. In the
early months mothers talked of using mobiles, rocking, talking, staying with the child and prayers as ways of settling the children. Two mothers cuddled their babies off to sleep in their arms. Seven mothers said that their children ended up in bed with them at night.

The commonly expressed pattern was that if the children cried they would be brought downstairs or allowed to stay up until they dropped off to sleep on the floor or sofa. In one family all three children stayed up at night until they fell asleep on the settee and then they usually all ended up in the parents’ bed for the night. This became a problem and for a time the mother stayed on the settee for the night with one of the children.

Several mothers said that they could not bear to leave their children to cry in their bedrooms if they woke. They considered this cruel. Only one parent said that a child cried himself to sleep. In general this seemed anathema to the Italian mother. However one mother said that Italian parents keep their babies and children up for their own pleasure and she did not agree with this. This view reflects New’s observations cited earlier.

**Crying and comforting**

Cuddles and dummies were the most commonly described comforting practices. Two mothers said they did not like to see dummies and would not use them. They both said that they preferred to give bottles of drink to settle the babies. Most parents took the children into their own bed at night if they could not get them to sleep. The Italian father who had spent
time in an approved school as a child and still deeply mourned his mother was said by his wife to have infinite patience with the children if they were unhappy. He would cuddle his children and sing Italian nursery songs to them to comfort them.

**Temper tantrums and discipline**

Few mothers said they had problems with temper tantrums. One infant did bang his head on the floor when frustrated and two other young children would have a tantrum when being restrained from touching things that they were not allowed to. However smacking was very common and firmly believed in by eight parents as a form of discipline. One mother said that she felt the father smacked too much, so she did not tell him when the child had been naughty. A mother who worked on night duty was concerned that her husband smacked their 6-month-old baby if she cried in the night when the mother was not there.

Two parents talked of ‘good smacks’ and ‘hard smacks’ as being the way to discipline a child. Neither of the parents of the family where the father had been to an approved school for misbehaviour believed in smacking as a discipline. The husband did sometimes threaten or raise his voice. Mother said that the household with three boys was generally noisy and boisterous anyway.

Other forms of discipline were withholding treats and privileges, sending children to their rooms or banning television. Two parents said that as
their children got older they would forbid them to go out as a punishment. There did not appear to be any feelings of guilt attached to using smacking as a punishment as there was with the indigenous white group.

Toilet training
It needs to be remembered, said one mother, that in the South of Italy where most of the families come from, because of the heat and the unpleasantness of dirty nappies babies are potty trained very early. This mother intended to start training her baby as soon as she could sit up. She remembers her brother sitting on the potty ‘all day’ when he was young. Other mothers echoed this intention of early potty training their babies; one said she had commenced at 10 months, one at 7 months and another 6 months. The remaining seven mothers mentioned the middle of the second year as being a good time when the child could understand the activity. Three of the mothers said they had been given advice by their own mothers to start training their babies early. However no one suggested that they felt pressurised by what their peers were doing with their children, as was so with the indigenous white group of parents.

Habits
When asked if their children had any habits which the parents found undesirable three mothers referred to thumb sucking as a habit which they did not like. One of these mothers said she would prefer her child to have a dummy rather than thumb suck. However two other mothers considered dummies undesirable habits. One child was said to be difficult about
food, refusing her meals and then wanting snacks. Her mother described her as always wanting to ‘win’ in any confrontational situation. Only one mother mentioned genital play. This particular child does not enjoy going to school and has developed a nervous cough. He also initiates genital play with his two brothers at bath time. His father is concerned but mother deals with it in a matter - of - fact way saying it is private and should not be displayed to others. The father is also concerned that the child is unhappy at school and thinks he should not be made to attend. The mother’s comment is that the father is ‘very soft’. Again this is the father who was sent away to school as a boy and whose mother died whilst he was away at school.

Parental roles
Three couples said they shared the role of child care. In these three families both of the parents had work outside of the home. One mother said her husband loves to do everything for their little boy. He would bath, feed, change nappies and take him out in the pushchair.

One husband would change the nappies occasionally and feed the baby when his wife was out at work at night but, said the wife, Italian men do not like to do this and he is an Italian man.

Two other mothers made similar comments. One said her husband would do it under duress, ‘but he is a typical Italian man and does not like sharing the child care’. The second mother said that her husband would play with the children but was not keen to bath them or to change nappies, ‘Italian
men prefer not to' was her comment. Although another father was happy to help bath the older children, he felt his hands were too rough to handle the baby without clothes on and he hates pushing the pram. 'He thinks this is a women’s job', said his wife.

The remaining three fathers were happy to give a hand when they were around, although one of them was apprehensive about picking up his eight month old baby for fear of hurting her with his rough hands.

**Comment**

The general feeling seemed to be that the Italian male sees child care as the woman’s designated role and although some men are willing to help in the privacy of their own homes there is obviously some stigma attached to being seen in public taking over this role. As three women commented ‘Italian men do not do this' and it seems that it is their image as a ‘macho' Italian man that is at stake. Where the men did share care, in four instances, it was usually necessary because the wife went out to work. Also, because many of these men have manual jobs, there was a genuine concern amongst three of the men about being able to handle the children gently enough or hurting them with their rough hands.

The mothers were asked if it were possible to go out without the children and whether or not this was desirable. If they left the children behind who were they left with (Table 7).
Table 7: Leaving the children to go out

<table>
<thead>
<tr>
<th>Possible</th>
<th>Desirable</th>
<th>Children left with</th>
</tr>
</thead>
<tbody>
<tr>
<td>I/A</td>
<td>Yes</td>
<td>Short periods</td>
</tr>
<tr>
<td>I/B</td>
<td>Yes</td>
<td>Prefer not to</td>
</tr>
<tr>
<td>I/C</td>
<td>Yes</td>
<td>For work only</td>
</tr>
<tr>
<td>I/D</td>
<td>Yes</td>
<td>Occasionally</td>
</tr>
<tr>
<td>I/E</td>
<td>Yes</td>
<td>Not without children</td>
</tr>
<tr>
<td>I/F</td>
<td>Yes</td>
<td>Not without children</td>
</tr>
<tr>
<td>I/G</td>
<td>Yes</td>
<td>Short periods</td>
</tr>
<tr>
<td>I/H</td>
<td>Yes</td>
<td>Very occasionally</td>
</tr>
<tr>
<td>I/I</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>I/J</td>
<td>No</td>
<td>Not without children</td>
</tr>
<tr>
<td>I/K</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Mothers Comments on Leaving the Children

As these mothers differ so much in their attitude to this aspect of child care from the indigenous white mothers their comments are included. Their reasoning seems helpful in supplying a context for the data.

I/A. Both sets of parents live nearby and the couple are happy to leave the children with them for a short period of time, but not overnight.

I/B. The husband of this couple does not believe in baby sitters. If they go out to friends they prefer to take the children with them. This also applies when they visit family in Italy they still prefer to take the baby out with them. Very occasionally they have left the baby with the maternal grandmother, but the mother said it makes her feel miserable if she goes out without them.
I/C. This young couple both work outside of the home and leave the baby with the maternal grandmother in the day. However they feel that work is a necessity but going out for pleasure is not essential and they have only done this once. They would only leave the baby with family.

I/D. These parents do like to go out occasionally but would only leave the children with the maternal grandmother, no one else. Friends have offered to baby sit but the mother said she would worry all the time if she left the children with a baby-sitter. She went on to say that the English had a different attitude towards their children, 'they did not come first'.

I/E. Although this couple like to go out socially they prefer to take the children with them whenever it is possible.

I/F. This family do go out socially but would never leave the children with baby-sitters. The mother said that she feels more secure if the children are with them. They most certainly would not leave them to go away on holiday. Sometimes they all go to Italy to visit the wife's sister and the mother said that although it would be more of a holiday for her if she went alone, she would not sleep if she had left the children behind.

I/G. It is nice to go out alone occasionally, say this young couple, who have two children, but they have a large supportive family around them and they are able to leave to leave the children with the wife's mother. If they do this they will always telephone to check that the children are
alright and they would not stay away for more than two hours. However, if there is a party where they can take the children then they prefer to do this. They would not leave the children with anyone outside the family. This happened once when all the family had to go to a funeral and the mother said she worried all the time.

I/H. This young couple have one child and do not believe in leaving him to go out too often. On special occasions the husband’s mother who lives nearby will baby-sit for them. They also have a very close neighbour who is a nursery nurse and speaks Italian fluently, having lived and worked in Italy as a nanny. They are happy for her to look after their son very occasionally as she is regarded as an honorary aunty.

I/I. These parents do like to go out together and they will ask their In-laws to baby-sit. They would not leave the children with anyone but their parents, not even friends, as the mother thinks the children would be very upset.

I/J. The husband in this family does not like to leave the children with anyone or to have baby-sitters but the mother who is English thinks it would be nice to have the opportunity. Her mother will not look after the children and the husband has no family locally. The husband prefers to take the three boys out with them. They sometimes go to Italian restaurants, and occasionally on Saturday mornings for a treat some he will take the boys to an authentic Italian coffee shop in London.
I/K. These parents have been out in the evening without their baby girl and have asked a friend or relative to baby-sit. However the mother’s parents disagree strongly with this, saying that other people will not have the same love for the baby as her parents. Although this young mother said she was determined the baby was not going to change her life, she and her husband do not feel happy about going out and leaving their daughter with anyone but close family.

Comment

There was a very strong consensus amongst this group of parents that they are generally happier to take the children with them if they go out to social events rather than leave them with anyone else. Apart from the family who had an Italian-speaking nanny for a friend none of the parents would leave their children with baby-sitters who were non-family.

Several parents made the point that children would never be excluded from adult parties and festivities, it was usual for Italians to invite the whole family to any social occasion. One mother said that she would be miserable if she went out without them. She thinks the English are, ‘a bit cold.’ Her friend who was also present said she was invited to her brother-in-law’s wedding. He was marrying an English girl. She replied to say that all five of the family would be coming and was then informed that the children were not included in the invitation. This upset her very much. Although she could accept that this was the English culture she felt mean about leaving the children behind when she was going out to enjoy
herself. Italian children, she said, would be expected to join in any parties or celebrations.

Two families voiced the opinion that they thought the English were cold and one mother said that she felt that they did not like children. This mother elaborated by saying that in Italy children always came first. They were welcomed everywhere and in restaurants no one minded children being there or wandering about. They found this in marked contrast to a holiday they had spent recently in the North of England. The hotel had said that children were welcome but this was obviously not the case. They felt that their little boy received frequent disapproving looks or was ignored by some of the residents. They felt so uncomfortable, they could not wait to get back home. On the journey home from the North, a four hour journey, they stopped for refreshments at an Inn to find a notice saying, 'children not allowed.' Their comment was that this country has no heart for children.

Help with the Children

Any help was usually from immediate family. Grandparents were especially important and several mothers mentioned that their parents or in-laws would help, especially if the mother worked outside of the home part of the time, as many of the women did. Daytime help was occasionally needed for some of the mothers who were working during the night in the local nursing home. Five of the mothers were doing this sort of work.
Three families had no help at all, family or otherwise, for two of these families it was because close family on both sides were still in Italy.

The third family who have three boys have a maternal grandmother living nearby who is Scottish. She had a hard life as a child herself and feels she has had her share of hard work so will not help the mother in any way. This mother had all three of her children by caesarian section and would have welcomed some support but her mother was adamant about not getting involved. Both of the husband’s parents died in Italy and he has no close family in England.

None of the mothers said that their children were attending nursery or play groups.

**Uses of the Health Visitor**

Health visiting among these families seemed to be very haphazard. Two mothers said that they had never been visited by the health visitor following the births of their second babies. One of these mothers said that she feels the family are being ignored. Another mother said that they had not been visited since they moved into the area, at which time their infant was a year old. He is now three years old. One family had been visited once when their baby was two weeks old. They have not been visited since and their infant is now eight months old. Two other mothers had had upsetting experiences with their health visitor and preferred not to consult them with problems.
The health visitor was described as being helpful by two mothers, one of whom had a baby born with deformed feet and the infant needed frequent medical attention. Four mothers spoke positively about their health visitor, describing her as supportive and non-threatening, even so almost all the mothers said they would prefer to take advice from their family, usually mother or mother-in-law or friends. Some said they would listen to the advice and then make up their own minds about what to do.

Further comments on the perceived role and support given by the health visitors made by these mothers will be discussed collectively later, together with the comments of the other mothers in the study (Chapter 10).

Literature and other sources of advice

There were very few literary sources of advice on child-rearing mentioned by these mothers. The most common book referred to for information was a book which is given out with a bounty pack by the hospital or ante-natal clinic to all mothers, which is called, 'Baby's First Year.' This is a book on child development and common problems experienced by parents with their children. The only other books used were a child development book which was given to one mother by an Italian paediatrician and a growth and development book given to another mother by her health visitor.

One mother said she did not use books for advice, only family. Two other mothers also said they would use their parents or older people, not books.
Many of the Italian mothers spoke of more experienced, older people and seemed to value advice from this source. Green's book on Toddler Taming which was so popular with the indigenous white mothers, was not mentioned once, which seemed strange as the health visitor had been the main source of recommendation of it to the other mothers. There seemed to be a different level of interaction between the health visitors and these mothers.

Comment

We have seen from the above data that there is a strong bond between children and parents in Italian families which extends across generations, and although many families have been living in the UK for a considerable number of years the Italian culture still remains a strong influential force in the child rearing practices of the younger generation. This may be reinforced by the regular visits to family still in Italy and also by the continuing trickle of new immigrants to the UK, who are often related to the existing families.

The Italian mothers in this study saw their own mothers or immediate family as the 'experts' in child care and do not refer to the literature on child rearing and rarely to the health visitor for advice. There were strong feelings about including children on social occasions and a reluctance to leave their children with people other than the immediate family if they did go out without them.
CHAPTER 8

INDIGENOUS WHITE BRITISH MOTHERS
INDIGENOUS WHITE BRITISH MOTHERS

The participants

Thirteen mothers were interviewed in this group. The names of the mothers with young children were given and the contacts initially made through the health visitors. Other sources were friends of the mothers interviewed and a local nursery. These mothers were representative of a middle income group of young parents in the city. Although both parents were welcome to take part in the discussion none of the fathers in this group actually did. Many of them were at work at the time of interview, which was at a time chosen by the mother. In three instances where fathers were at home they remained in other parts of the house.

Nationality

Of the thirteen mothers interviewed all the parents except for one mother had lived in England all of their lives. The single exception was a mother who had moved to England from Scotland at three years of age. Eleven of the families declared themselves to be English in spite of the fact that two of the parents had an Irish parent, one a Welsh parent and one mother had a Polish father and an Italian mother. The parents of the latter had lived in England since the end of the second world war and the daughter had been born here 35 years ago.
The location
The town, situated about 20 miles from London has a population which is largely middle class. Many of the employed inhabitants are professional people who commute to London daily. There are a number of small industries in and around the town but a major source of employment for people working locally are four large psychiatric hospitals situated on the outskirts of the city.

The mothers in this sample are characteristically representative of a socially mobile group. Giddens (1992) describes social mobility as the movement of individuals and groups between different socio-economic positions. Vertical mobility which is generally upward, has been combined in many of the families of these mothers with lateral mobility between towns or other areas of the UK. Moving from a working class background to higher status jobs is common in this section of society and indeed it is a characteristic of many young couples in this town.

The pattern occurred in several of the families of indigenous white origin. Ten of the fathers would be described as white collar workers. Two are psychiatric nurses working at first line management level, and one is a betting clerk.

Amongst the women, four have a professional qualification and a further three are registered nurses in part time posts. At the time of interview seven of these women had part time work outside of the home and one
was in full time paid employment as a bank manageress. The remaining five were full time housewives, although some of these mothers were intending to return to their previous employment. Goldthorpe (1983) makes the observation that although women often have lower paid jobs than their husbands they are still regarded as being in the same class. He emphasises that this is not a view based on sexism but one which recognises that women tend to withdraw from paid employment for lengthy periods to have and bring up children.

**Analysis of Interview Data**

This will be expressed in tables and charts wherever possible for easy scanning. However, as the study is qualitative in nature, there will be summaries of the verbal responses and individual comments included so as not to miss material which is believed to emphasize a feeling within the group.
### Table 8: Parents’ Occupations Age and Number of Children

<table>
<thead>
<tr>
<th>Mother</th>
<th>Father</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age and Occupation</td>
<td>Age and Occupation</td>
<td>No</td>
</tr>
<tr>
<td>IWB/A 28 - SRN</td>
<td>29 - Financial planner</td>
<td>2</td>
</tr>
<tr>
<td>IWB/B 30 - Biochemist</td>
<td>31 - Advertising director</td>
<td>2</td>
</tr>
<tr>
<td>IWB/C 40 - Occ. therapist</td>
<td>44 - Computer programmer</td>
<td>2</td>
</tr>
<tr>
<td>IWB/D 33 - Childminder</td>
<td>30 - Antique dealer</td>
<td>2</td>
</tr>
<tr>
<td>IWB/E 32 - Ass. bank manager</td>
<td>30 - Manager Res. Home</td>
<td>2</td>
</tr>
<tr>
<td>IWB/F 31 - Manager shop</td>
<td>33 - Betting Clerk</td>
<td>1</td>
</tr>
<tr>
<td>IWB/G 29 - Transcript typist</td>
<td>30 - TV Producer</td>
<td>3</td>
</tr>
<tr>
<td>IWB/H 35 - Secretary PA</td>
<td>34 - Accountant</td>
<td>1</td>
</tr>
<tr>
<td>IWB/I 30 - Teacher</td>
<td>31 - Solicitor</td>
<td>2</td>
</tr>
<tr>
<td>IWB/J 30 - SRN</td>
<td>36 - RMN</td>
<td>2</td>
</tr>
<tr>
<td>IWB/K 30 - Window Dresser</td>
<td>35 - Computer Analyst</td>
<td>2</td>
</tr>
<tr>
<td>IWB/L 30 - Playgroup leader</td>
<td>30 - Marketing Rep.</td>
<td>2</td>
</tr>
<tr>
<td>IWB/M 27 - RMN</td>
<td>30 - RMN</td>
<td>2</td>
</tr>
</tbody>
</table>

The parents’ ages ranged from:

- Mothers: 27 years - 40 years
- Fathers: 29 years - 44 years

Ten of the couples had two children, one couple had three children and two couples had one child. The most common age for the birth of the first child was mid or late twenties.

### Choice of feeding methods

Breast feeding was the most common choice of early feeding. The number of children in this group totalled 26 and 22 of them had been breast fed in the early months of life, a total of 85 percent, 18 of these, 69
percent, for three or more months. The reasons for choosing this method were given as:

- better for the baby
- most natural
- right thing to do
- convenient
- normal
- for the immunity.

Some mothers gave more than one reason for breast feeding. Although the majority of mothers breast fed initially, some of the mothers who returned to work outside of the home after maternity leave found it inconvenient and difficult to continue. The babies were then bottle fed until fully weaned. The first mother interviewed said that her second baby was very colicky and she was at her wits’ end trying to continue with breast feeding so she changed to the bottle after a month.

One mother who had fed her first baby successfully for 7 months had very sore cracked nipples with the second baby and gave up after only a few weeks. She was in a lot of discomfort and also under pressure because of returning to work. One mother who had breast fed her first baby for only two weeks and her second child for 7 months had done so because she had developed mastitis with the first child. She had wanted to breast feed her first child because of the extra immunity it would give to the child but
no one encouraged her to keep trying when she had difficulties and she lost confidence.

There was only one mother who found breast feeding totally unacceptable. She felt it tied her down and did not like her changed body image. She said that it prevented her from regaining her (very slim) normal figure and made her feel depressed. The mother who worked as an assistant bank manager was on maternity leave and had bottle fed both of her children. Her first child had had a cleft lip and palate and she was not given any other option at the birth of her child in hospital but to bottle feed. Consequently when the second child arrived she said that she had a mental block about breast feeding and did not attempt it. This mother had a full time nanny and was soon to return to work in the bank.

Pressure from the National Childbirth Trust to breast feed her first baby had resulted in another mother bottle feeding her second child. This mother had suffered from Crohn’s disease for a number of years. Crohn’s Disease is an inflammation of the digestive tract, usually the small bowel. It is characterized during an attack by frequent painful diarrhoea often with the passing of blood per rectum. It can result in a significant weight loss. There is also often a low grade fever and anaemia present.

There had been an exacerbation of symptoms prior to the birth of the first child and after the birth the mother became very run down. The baby was being fed on demand two hourly and the mother lost a lot of weight. She
also had persistent vaginal bleeding for ten weeks post delivery. The mother felt pressurised by her health visitor, who was a member of the NCT, to persist with breast feeding. Eventually the husband, who was very concerned about his wife's state of health, became very cross and insisted that she should stop. Consequently when the second child arrived the couple made the decision to bottle feed, not wanting a repeat of the previous unpleasant experiences.

**Weaning**

Weaning was commenced between 3 to 4 months by all of the mothers in this group. One mother said she had started weaning earlier and had not realised she 'should not'. Baby rice was the initial weaning food of choice for all but three of the mothers. This was followed by pureed fruit, bananas and proprietary baby foods. Three mothers pureed their own food from the start of weaning. Returning to paid employment often influenced the use of ready made baby foods.

**Potty training**

The majority of mothers started to think seriously about potty training their children at around two years of age. Five mothers mentioned pressure from mothers or mothers-in-law to begin earlier. In one instance the mother felt pressured from other mothers in the NCT and tried unsuccessfully to train her first child at 14 months. She said it was a waste of time and she will leave her second child until he shows signs of being ready.
Most of the mothers said that they were prepared to leave their children until they were ready and did not think children should be forced to use the potty or that an issue should be made of it. One child who had been potted regularly after meals from the age of 18 months was still in nappies at the age of three and often had his bowels opened during the night. All of the mothers used disposable nappies and had washing machines and dryers. This may have influenced the differing attitudes between them and their parents.

Sleeping: schedules, patterns and bedtime rituals

As the health visitors noted in their questionnaire, getting the children to bed and asleep is a major concern of this group of mothers. Most families aimed at a bedtime of 6.30 p.m. to 7 p.m. Bedtime rituals are often long-drawn-out affairs with bath, stories, musical mobiles, staying with the children until they are asleep, and leaving a light on. One child had four bedtime stories, prayers and a cuddly. Mother then stayed with him until he was quite sleepy and crept out of the room leaving a tape recorder playing with further stories.

Another child, now three years of age, who had had evening colic as a baby, was being put to bed with a bottle at 8 p.m. but persisted in coming downstairs. The parents resorted to tying his bedroom door to another door on the landing which allowed him to open it a crack but not wide enough to get out. This method of restraint is advocated by Green (1991),
Leaving the baby to cry in an attempt to break the habit of not wanting to go to sleep was mentioned by four mothers. One mother was advised to do this by an aunt with whom she stayed after the birth of her first child. She said it stressed her greatly to do this but felt it was the best thing to do. This child is now three years old and mother has to stay with her every night until she is asleep. A second mother also used the method of leaving the baby to cry in order to break a habit established by the baby, who had had severe colic for the first four months of life. The mother said she was at her wits end but after one bad night of listening to the baby cry it did the trick.

The National Childbirth Trust recommended using sheepskins in the bed to one mother as it prevented the children from feeling cold. She found this a very effective practice in settling both of her daughters off to sleep.

Only one mother said that her child came into her bed. The remaining mothers said they promptly put them back if this happened. The most general comment was that children should be out of the way in the evening as the parents had had enough of them by that time. Furthermore one mother commented that she did not like to go to friends in the evening and find their children still up.
Crying and comforting

Crying and comforting was linked to waking in the night. Most parents would soothe their children by patting and cuddling after checking there was nothing physically wrong. Four of the mothers said they would then leave them to cry. One said she went into the child but made the visit as boring as possible in hopes that this would discourage the child from demanding this sort of attention. Only one of the mothers was happy to take her child into bed with her, but father did not agree with this and believed in setting boundaries.

There were several negative comments about the use of dummies. Only two of the thirteen mothers used them. Five of the mothers would offer drinks or breast feed.

Evening colic

Colic was a very common complaint. For babies with evening colic mothers tried giving warm baths, driving around in the car, rocking, walking about and giving the breast.

Temper tantrums

Sibling rivalry or not getting their own way were the commonest causes of temper tantrums. Screaming, throwing themselves on the floor or attacking siblings were the way these were described. All thirteen mothers said that they experienced this to some degree with their children.
Of the three children who attended a Montessori Nursery School the reason given in each case for choosing the school was that the child needed a disciplined environment. Fiery and strong willed were phrases used to describe the children. One of these children also attends a child guidance clinic. She was a child who had multiple experiences of hospitalisation early in life due to a cleft lip and palate deformity as a baby. The mother also works long hours outside of the home, and the child has had several different nannies to care for her. The mother made no connection between the child’s experiences and her present behaviour.

One child was apparently difficult about clothes so eventually, after innumerable scenes about getting dressed, the mother took away all the child’s clothes and told her she had none. This seemed to solve the problem. A mother of three says her eldest daughter aged three years is tough, insistent and demands a lot of attention. She is also very difficult in shops and makes frequent scenes. The mother suspects that her behaviour is affected by food colourings and tries to avoid giving them to her. One mother thought that children should get their own way sometimes.

Punishment and discipline
The mothers mentioned a combination of methods which they used to either punish or maintain discipline. Eleven of the thirteen mothers smacked or tapped a young child’s hand, usually after a prior verbal warning with a raised voice. Two said they smacked for dangerous
activities such as running across the road. One mother said she had
smacked in a fit of passion after one of her children had pushed a younger
brother down the stairs. After this incident she had decided not to smack
any more but rather withdraw privileges such as bedtime stories, TV,
sweets or visits to the park. This was the second of two mothers who
declared they had made a conscious decision not to smack, both felt that
nothing was to be gained by it.

Sending out of the room was a popular form of punishment. Three
mothers said that they sent the children to their bedrooms, others used
the hall, kitchen or garden. One mother had read that it was wrong to
associate the child’s bedroom with punishment, so used other areas.

Reasoning with older children was mentioned twice and one mother said
she had started to keep a star chart for good behaviour in order to
concentrate her mind on fairness. A star chart had also been suggested
by the Montessori Nursery for the little girl who had had long periods of
hospitalization and whose parents were finding her difficult to manage.
The mother felt that this was proving effective. This child also had a new
baby sister to adjust to but the parents did not refer to this as an issue.

One mother was very emphatic in saying that she believed in a good hard
smack that really hurts. Her husband and in-laws were against physical
punishment but mother said that she was a disciplinarian. Her daughter
attended the Montessori Nursery and the teacher had complained that the
child was smacking other children. Mother, not acknowledging the
incongruity of her action, said that she was making a book with the child
which was about a little boy who smacked other children and had no
friends.

Parental roles
Two of the mothers said that they unequivocally shared the care of their
children with their husbands. One mother said that she did everything.
She said her husband would help if asked but he was either not around or
mother just did it out of habit.

The remaining ten mothers said that husbands would help but they had
demanding jobs and were content to leave it to the mother if she was
available. One mother felt her husband exaggerated his role in the care of
their children when there were visitors around. However he did enjoy
cooking and often took over this role. He would take turns at getting up in
the night when the mother returned to her former employment.

One mother categorically stated that ‘we have a baby therefore we have a
responsibility’. Both of these parents went out to work and had a nanny
for their little girl.

Help with the children
When this topic was discussed with the mothers general issues relating to
social support arose. Five mothers said that they received some regular
help from their own or their husbands' parents. Three mothers had parents who lived some distance away and they were only able to help occasionally or not at all. One mother said that although her mother visited weekly it was definitely defined as a visit, and not a help session. This mother had three small boys. Two of the mothers had a nanny and two said they had reciprocal arrangements with friends. One mother commented that she was reluctant to use her mother too much as she had helped her out a great deal when she was working full time and she now wanted her to enjoy her 'granny role'.

Grandparents seemed to be the main support in terms of help with the children, if they lived near enough and were willing to do this. There were two sets of grandparents who actually said they were not prepared to help out, saying that they did not feel ready to do this or, that they had already done their share of child-rearing. Friends and neighbours were relied upon much more by this group of mothers for casual help with the children.

**Leaving the children to go out**

Parents were asked if it were possible to leave the children with anyone while they went out. They were also asked if this would be desirable, and if so who would they leave the children with and what their attitudes were to leaving the children. The responses are shown in table 9.
Table 9: Leaving the children

<table>
<thead>
<tr>
<th>Possible</th>
<th>Desirable</th>
<th>Children left with</th>
</tr>
</thead>
<tbody>
<tr>
<td>IWB/A</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/B</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/C</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/D</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/E</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/F</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/G</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/H</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/I</td>
<td>?</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/J</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/K</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/L</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IWB/M</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

All of the mothers found going out without the children a very attractive option. Many said they liked to do it as often as possible and other comments included, ‘I would have no qualms’ and, ‘I would not hesitate’. One mother said that she really valued time out from mothering. Two sets of parents had left their children with grandparents for lengthy periods whilst they went away on holiday. One couple who were away for 10 days said that they would not do it again as both of their children wanted to come into the parents’ bed at night after they had returned, and the oldest child began to stutter. One young mother confessed to being very
frustrated as her husband worked long hours and did not want to go out when he returned in the evenings. She sometimes leaves her daughter with friends and goes out alone.

Grandparents were used for baby sitting whenever possible otherwise baby sitting circles, nannies and friends. With the latter there was often a reciprocal arrangement especially where mothers belonged to organisations such as the National Childbirth Trust. It was often stressed that the baby sitter was preferably someone the parents and children knew.

Sources of help and Advice

The mothers in this particular cultural group looked for information and advice from a variety of sources, but relied mainly on their close family and the current literature on child rearing for guidance. Leach (1989) was frequently mentioned in this respect. There were very mixed responses about how professional help from the health visitors was perceived. Seven of the mothers in the group found the advice either unhelpful or they did not choose to contact their health visitors. Two of these mothers saw health visiting as having a policing role. They made the following comments:

As a nurse I feel I might be seen as a professional with expert knowledge by the health visitor and one could become paranoid about this. Health visiting may also be seen as having a policing role which might make some parents uncomfortable.
I don't see the health visitor as being concerned with the whole family. They could be seen as powerful and reporting on parents. There is always the feeling that one is being observed for child abuse. My husband and I have discussed this and think that parents feel afraid of being accused of child abuse, and it affects their attitude towards their children.

Another mother, also a nurse, was particularly bitter about her experience with her health visitor. Initially when her first child was born she had consulted her health visitor about the infant’s sleep problems and had not found her helpful. With the second child the mother said that she was in agony with cracked and sore nipples and desperately wanted to be reassured that she could give up breast feeding. The health visitor did offer advice, and choices of options, but with the implicit assumption that the mother should continue to breast feed. At a later date this mother called the health visitor in desperation as her baby had severe colic and was not sleeping. The health visitor apparently spent the visit talking to the husband about a patient she and the husband both knew. (The husband was a psychiatric nurse). This marriage eventually broke up and the mother called her health visitor as she wanted to discuss the right things to do with the children to protect them from any mental trauma. She rang the clinic to find it no longer existed and she had no idea of how to contact her health visitor. Subsequently she did not see her health visitor throughout the breakup but received immense support from friends.
Three of the mothers found their health visitor helpful with sleeping, feeding and child development problems, and one mother whose child was born with cleft lip and palate received advice and support from both her health visitor and doctor.

Interestingly, one of the mothers referred to a ‘Plunkett’ nurse she had when living in New Zealand. She commented that they were very organised, and visited the mothers regularly by appointment. Since this mother arrived back in England she has had a second child and has not consulted her health visitor. Mothers sometimes found their health visitor pleasant to chat to but used other sources for help and advice. The views of all the mothers in relation to their perception of the health visitors’ role will be discussed collectively later and compared with those of the health visitors discussed earlier.

**Discussion of data**

The views of these mothers were fairly homogenous. There was a general consensus on many issues such as feeding, weaning and potty training. Bedtime rituals and perceived sleep problems were common to most of the mothers. The percentage of the babies of these mothers being breastfed for three months or more was 69 percent which compared with 61.1 percent of the babies of mothers living in affluent suburbs in While’s (1989) study. The pattern of parenthood fitted largely into the current ideology, this being that the ideal circumstances in which to have and rear children are with the father and mother being over 20 years of age but not
above 40 years old, and the couple married before the birth of the children. The ideology also supports a gender division of labour following the birth of the children with mothers staying at home with the children whilst fathers are employed outside the home earning enough money to make adequate economic provision for the wife and family (Busfield, 1987). Although five of the mothers had some part time work outside of the home only one mother was in a full time post.

According to Richardson (1992), in our society motherhood is associated with a number of important psychological losses. Some of the most commonly expressed losses, are: loss of status and loss of independence, particularly if this means the woman giving up her job. Other losses experienced are loss of privacy, loss of social networks and in some cases a loss of an idealized vision of motherhood.

When talking to a group of young mothers, some of whom were participants in this study, at a National Childbirth Trust meeting, two mothers expressed other losses to the author in relation to child rearing. These were a loss of physical dignity, and a loss of a structured existence which work outside of the home provides but which unpredictable babies can devastate.

Richardson also believed that opportunities for women to maintain a sense of identity are limited because of the assumption that motherhood is central to a woman’s identity. What Richardson fails to mention, and
some of these women did, is that some women find motherhood a very positive experience and perceive very definite gains in relation to their life and relationships.

Several issues related to motherhood were brought up by the mothers when discussing the roles of each parent. Although they were not directly concerned with 'role tasks', they were very important to the mothers and it was felt that they should be included as they express some of the difficulties encountered in the role division of child rearing in this group of parents. One mother said that she and her husband had led a very busy active social life prior to the birth of their children. She found the loss of this freedom along with the feeling of losing her own identity very difficult to cope with. Neither was she prepared for the loss of time for herself. Another mother, who was a Registered Nurse, said that she was not at all prepared for what parenthood would be like. Fortunately the first child was contented and easy to manage, but the second child came along sooner than expected and everything became too much. Her comments are below:

I did not have room in my head to cope with everything and would have welcomed some straight-forward help and advice from the health visitor, but because I was a nurse it was assumed I knew everything and could cope.
This mother went on to say that the second baby was very difficult with feeding and sleeping and the pressure of going back to work made her panic. She totally lost her libido but was not able to talk about it. After a while her husband developed a series of minor illnesses which she now thinks were cries for help but at the time merely increased the pressure on her, and she felt she was caring for three children, and not two. Unfortunately the next time I met this young mother the marriage had broken up.

A second nurse of IWB origin also expressed the view that young parents are not prepared for the extent to which motherhood can change their lives. In her own situation she found going back to her job so soon after the birth of her two children put a lot of pressure on her to cope with both the job and the family. She felt that women who had to do this needed a good support network, and as we have seen with the increased social mobility grandparents are not always near enough to help in this way. Neither are some grandparents prepared to do this as some of the mothers stated.

In general the women interviewed seem to regard child rearing implicitly as their responsibility. The reason may be, as Cohen (1987) suggests, that the strain on young mothers today is disproportionately higher than in earlier times. The reason for this is that the child rearing period is more concentrated, and likely to coincide with the period of the husband’s working life where he is least able to give assistance.
Some jobs, say Young and Wilmott (1973), are more likely than others to inhibit men’s involvement with the family. Job categories such as those of senior management executives may physically remove men from the home for a substantial period of time. In the last decade job insecurity due to increased competition has also become a factor in men working longer hours, often needing to be seen to be working. Many of the mothers in this group said that their husbands had demanding jobs, working long hours which meant that they were not often available to share the care of the children. Help and support from other mothers was often mentioned.

Help with the children and other sources of help

In this study friends were the main source of help and social networking. Five of the mothers had help from grandparents but for the remaining eight mothers the grandparents either lived some distance away or were not prepared to become involved in child care. All of the parents liked to have outings without the children and had no qualms about leaving them with family, friends, baby sitters or in two cases the nanny. Most emphasised that they would not leave the children with strangers.

The role of social support networks was explored by Hill (1989) in a study of two parent households in Edinburgh. Half of the families were middle class and half were working class. There were no single parent families or any ethnic diversity amongst the sample. This study demonstrated that children spent as much time away from their mothers with network carers as they did with their father alone. The reasons were usually adult
orientated like shopping, dental or medical appointments. Other circumstances were what some parents saw as a legitimate need for mother to have a break, or needing crisis relief from the stress of caring for a demanding child.

In Hill’s study not all of the parents could accept that they were entitled to such separations and had strong guilt feelings about abandoning what they saw as their responsibilities. They talked of ‘palming the children off’ or the children being ‘dumped’. This was usually due to values from their own upbringing. Hill does mention some more acceptable child orientated care arrangements such as toddlers going to play with others of the same age to promote relationships between children or good friends. This was more common amongst the middle classes, and seemed to be customary amongst the parents in this study who talked of reciprocal play and baby sitting arrangements with other mothers.

The fathers’ Role in Sharing the Child Care
As we saw in the analysis only three mothers in the group said that they felt the care was shared equally between them and their husbands. The remaining ten mothers referred to their husband’s work demands as making sharing the care a difficulty.

Men’s paid work say David and New (1985) sets the parameters of their help with the children by severely curtailing the opportunity they have to help. Also because fathers may be away for most of the child’s waking
day, children become used to their mother's care and comfort and look for this if they wake in the night. Apart from this some mothers may feel that requesting help from the father is an admission of incompetence. One young mother, who had gone back to a busy academic demanding job after maternity leave, was feeling very stressed. She was getting very little sleep because of a wakeful baby and was desperately tired but did not like to admit this to her husband, who was a doctor, because she thought he might think she was not coping. Cohen (1987) notes Burgoyne and Busfield on this issue, who say that the extent to which fathers remain peripheral within the household may well depend on the way in which mothers cope with child rearing problems in the early stages.

In a study by Henwood (1987) it was seen that 87 percent of the basic care was provided by the mothers. This finding does not correspond to the Newsons' (1977) earlier findings in Nottingham where they found that 709 fathers (52 percent) in their study were rated as highly participant but with clear differences between the socio-economic groups. Shop and clerical workers rated 61 percent highly participant, professional fathers slightly less and unskilled labourers 36 percent. According to Henwood the husbands saw themselves as doing less in the way of child care than their wives credited them with. Non employed wives thought that their husbands shared half of the child care but 64 percent of the husbands thought that their wives did most of it.
Harman (1993) addressed this problem of women juggling with home, family and paid employment. She wrote that women have redefined what it is to be a mother and this includes working for their children as well as caring for them. She links the increase in marital breakdown as being in some part due to these added responsibilities and claims that marriages will have a greater chance of success where women who share the responsibilities of bread winning can count on men sharing the responsibilities of bringing up the children.

Although women are now nearly half the workforce, the world of work remains based on the assumption that the worker is a man supported by a non working wife. Harman thinks that by the middle of the next century we will see changed roles in the home, with men and women sharing responsibility for bringing in the family income and caring for the children. However in order to achieve this successfully, and as she sees it, prevent many more decades of marriage breakdown, there must be a choice of high quality affordable child care, and an acknowledgement that part time work is a positive choice for many women.

Professional Help and Advice

The mothers in this study as we have seen reported diverse experiences with their health visitors. An analysis of home visiting practice undertaken by While (1986) demonstrated that health visitors appear to give priority to families with infants under six months of age who had experienced adverse childbirth factors rather than to families in poor social
circumstances. Certainly the mothers in this study who had had medical problems at birth with their child seemed to have had good contact with the health visitor.

This study also confirms While’s findings that few families received frequent regular contact with their health visitor. The vast majority of families according to While received six or fewer home visits in the first year. There was then a dramatic decrease during the second year of only one or two home visits. She felt that the reason for this was because health visitors were using a medical model to organise their practice for infants, in the early months of life, as they lacked an alternative framework for practice. Consequently visits were linked to prophylactic health measures such as developmental assessments, hearing tests and immunisation programmes but she queries whether any meaningful health promotion programme could be maintained with such minimal contact.

Many of these prophylactic health measures are carried out in the Child Health clinics in the health visitor ‘patches’ involved in this study, and the onus, in many instances, was for the mothers to seek them out themselves. Contact was poor in many cases both in terms of visits and notification of clinic whereabouts and times. This was a particular aspect of the attitude towards the mothers in this group. The Bangladeshi women received much more solicitous attention from their health visitors on these issues.
While argues that health visiting may not be fulfilling its potential because not only is the extent of home support limited, but it is not wholly directed towards disadvantaged families. One might query who the disadvantaged families are, and should this be the health visitors' total area of concern.

The mothers in this study were not necessarily financially disadvantaged, but several of them spoke of times when they were in need of help and support with their children or with personal problems. Support had either not been readily available or their personal needs had been ignored by the health visitor.

While thinks that health visitors vacillate between a relationship approach and a problem orientated approach to their practice. The reason for this, she says, may be the dependence upon an apprenticeship model for practical training, where the student health visitor sees only one model of practice. There is also, she feels, a lack of a theoretical framework in health visiting which may mean that health visitors return to their nursing origins to assess need.

There may be a simpler explanation in that it is much easier to approach a family with a definite objective in view than to turn up at homes with no specific appointment and with no clear agenda. Unfortunately unlike the Plunkett nurses in New Zealand, in this country we have only recently moved towards a more organised appointment system for health visiting which should make it less of a hit-and-miss affair. If mothers know when
to expect their health visitor they can prepare themselves for a discussion of their concerns. This would permit time and space for the parents’ agenda.

As it is, mothers are often unprepared and feel more vulnerable, or they are not in, and the health visitor can waste time on fruitless home calls. There is also the problem of the visit being perceived as family surveillance in the narrowest sense. Two of the mothers who had no contact with their health visitor saw them as having a policing role. Another mother said she felt guilty about mentioning a bump or bruise because of the current concerns about child abuse.

The five mothers who were positive about professional help from their health visitors talked of straight-forward advice. This would be contrary to the enabling approach of the new empowerment model proposed. However the Newsons supported a straight-forward approach way back in 1977. They were of the opinion that the plethora of information on child rearing could confuse young mothers who lacked the confidence either to reject it or formulate their own strategies. Consequently they sought the reassurance of friends, family or the father, from whom they no doubt received straight-forward advice. Twenty years on, perhaps we should expect more consideration to have been given to the ‘lack of confidence’ which is still so apparent in some young mothers.
Parenting manuals can increase confusion especially if they clash with the parents’ own values or by the diversity of advice. Books which confirmed the mothers’ instinctual responses in a non-condemnatory way were welcomed by some of the mothers in this study. Green’s (1991) book was the most popular text for the IWB mothers. It was welcomed and used because it was light hearted, reassuring and relieved guilt about the odd smack. Discipline was certainly a major concern for many parents.

Cohen (1987: 19) observes that the stress on individualism within the middle classes has had the effect of encouraging families to adopt child rearing practices designed to further internalize constraints and control. Whereas working class child rearing patterns, according to the Newsons (1968, 1974) are more likely to emphasize moral responsibility and postponement of immediate gratification. The dilemma of discipline was a predominant problem voiced by mothers at a meeting of the local National Child Birth Trust (NCT).

The National Child Birth Trust
The author was invited to attend and speak at a meeting of the NCT, an organisation to which several of the mothers in the group being studied belonged. It was attended by approximately twenty young mothers. After listening to several speakers on subjects related to child rearing the mothers were unanimous in saying ‘but please tell us what we do with a bolshie child who will not obey verbal commands and still insists on being naughty’. It was obvious that there was a great deal of guilt and confusion
in relation to disciplining young children. This anxiety has probably been exacerbated by the current debate on making physical punishment of children by their parents illegal by the ‘End Physical Punishment of Children Campaign’, EPOCH, (Cook, James and Leach 1991). This campaign is supported by the Health Visitors Association, the official professional body of health visiting.

Hollen (1982) looking at parents’ support systems said that because of the onus of responsibility and press of guilt, the mother may experience more feelings of inadequacy in parenting than the father and turn to the ‘expert’. Seeking expert advice can be a mother’s defence against internal and external accusations that she has not done as well in her role of mother as she should. However, says Hollen, professionals are not always reassuring, some parents sensing a subtle blaming or an attitude of ‘rescuing’ the child from its parents’ incompetence. Therefore many mothers turn to other sources for their help and support.

The power of the ‘experts’ as standard setters and advice givers has increased according to New and David (1985) as the links between generations has loosened. Most women, as is shown in this study, would prefer to ask their own mothers for guidance but because of distances it is not always possible, and consequently they look to other sources of advice.
Further Field Work

In order to verify some of these statements from the literature a questionnaire was devised containing eight statements from the current literature on motherhood. (Appendix V). These were circulated to 20 young mothers at a meeting of the National Childbirth Trust mentioned earlier. The mothers were all from the indigenous white population of the locality and seemingly middle class. Several of them had been participants in the main study.

Twelve of the questionnaires were returned completed, a 60 percent response. Two of the non-returners had been interviewed previously by the researcher and may have assumed they were not required to respond. Two were health visitors in the locality and were interested in seeing the statements from the literature questionnaire but did not complete it. The remaining non-returners took the questionnaire away with them to think about it.

Follow up questionnaire on mothering

The following statements were taken from Western literature on Motherhood. The mothers were asked to say whether they agreed or disagreed with the statements.

Q1. The home has become a more private place with smaller families and relatives living at some distance away. For many women this means that
the day to day care of young children is an isolating and lonely experience (Richardson, 1992: 8).

**Comment:** Eleven mothers agreed with this statement, one disagreed. Of the comments made by the mothers: one said it was a huge shock, especially in her case where the woman has had a busy career surrounded by adults. Three said it was true but women had to make an effort and join groups such as the National Childbirth Trust or mother and toddler groups. One person said that women are less prepared to allow themselves to become isolated.

Q2. Many mothers look for other sources of parenting support other than that offered by the professionals (Hollen, 1982, New and David, 1985: 70).

**Comment:** There was total agreement about this statement with mention of friends, family, parents and of course the NCT all having an important role to play.

Q3. Professional sources of parenting support are not always reassuring and can make mothers feel guilty. (Hollen, 1982)

**Comment:** Ten mothers agreed with this and two said it had not been so in their experience. One mother said she had found this to be especially so in the first few months of her baby’s life. A further comment was that
the professionals did not know the baby as a person but as someone who had to fit into their statistics.

Q4. The mothers were then asked who in the following list was most important to them in providing a support system.

- Father
- Parents
- Friends
- Professionals
- Others, state whom.

Comment: Nine said friends, eight said husband/father, three said professionals and one ticked parent. The reason why parents /grandparents feature so low in this sample may be because, like other participants in the study, many of the mothers are not living near their families.

Q5. On becoming a mother many women experience feelings of loss. The most commonly expressed losses are:

- loss of status
- loss of independence
- loss of privacy
- loss of social networks
- loss of an idealized concept of motherhood
Comment: There were more additional comments to this statement than to any of the others. Nine mothers cited loss of independence as the highest perceived loss. Privacy and status both rated seven. Six mothers agreed with the loss of an idealised concept of motherhood. This view is consistent with that of the mothers in the study who said they were not prepared for the vast changes in their life style brought about by becoming a mother. Four mentioned loss of social networks and loss of physical dignity. Loss of a structured existence and loss of contact with the ‘real’ world were also experienced. Only one mother mentioned gains in relation to motherhood. This may have been because the question as taken directly from the literature was biased in the direction of losses.

Q6. Mothers may experience more feelings of inadequacy in parenting than the father because she sees the onus of the responsibility on her (Hollen, 1982).

Comment: Nine mothers agreed with this statement, one commenting that society also held this view. Two said it depended on the husband and one disagreed. There was a plaintive cry from one mother who said, ‘mothers always get blamed for any problems the children develop’. One mother said it was not so much the onus of responsibility but the inability to escape from physical contact with the children. ‘I can’t escape to work.’
Q7. However much husbands help with the children it remains help in what is ultimately the woman’s responsibility (Boulton, 1983).

**Comment:** There were six agreements, four disagreements, one not sure and one who said physically but not emotionally. One mother said, ‘Because I do it 24 hours a day’. Again there were comments that it depended on the husband/wife relationship.

Q8. The individuality of the child plays a large part in the developing relationship between mother and infant. It is an aspect of child care in which previous experience does not necessarily transfer from one child to the next, and can be unhelpful if expectations are inappropriate (Munn, P. 1991).

**Comment:** Everyone agreed that this was so which emphasises what Hardyment said, that telling mothers how to bring up their babies (in the literature) was like sending false teeth through the post! There was a very emphatic endorsement from one mother who said, ‘absolutely, my first baby was a very unhappy child for the first six months but my second is very placid and contented and I now do not believe it was my fault’. This once again demonstrates the guilt mothers take upon themselves in relation to the state or behaviour of their children. Much of what was expressed by these mothers confirms the findings of other studies cited in the literature, and supports the views of other participants in the study.
Differences are beginning to emerge between the groups. As we shall see in the analysis of interview data, attitudes towards mothering and the relationship between this role, social life and work are diverse, as are views about the role of the health visitor and the use that is made of her.
CHAPTER 9

BANGLADESHI MOTHERS
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BANGLADESHI MOTHERS

The immigration of the Bangladeshi people to Great Britain has been a product of the history of Bangladesh. For this reason, to look at Bangladeshi mothers in the context of their historical background and culture is helpful in gaining a fuller understanding of their child rearing practices.

There has been difficulty in obtaining a clear and unbiased history of Bangladesh and the Bangladeshi people possibly because Bangladesh as a State is a relatively recent creation. A visit to the India Office revealed literature on the history of Bangladesh to be biased towards particular authors' Nationalist stances. In an attempt to clarify diverse opinions in the literature, notes were taken from various literary sources, and a discussion arranged with teachers and leaders of the local Bangladeshi community where the study is taking place. Contacts were made through the local mosque and the community leaders, which included both men and women. A meeting took place between the researcher and the community leaders. Issues in the literature were explored and responded to critically at the meeting, and other texts suggested. Reference to these texts will also be included. What follows is an attempt to gain a balanced picture of the Bangladeshi people and their culture, as a context for the Bangladeshi mothers taking part in the study.
The tragedy of Bangladesh has been described by Kennedy (1973) as epochal. He reminds us that within the short span of little more than a year in 1971, Bengal faced natural disasters of flood and famine together with repression and civil war. Hundreds of thousands died in the violence of 1971, and ten million refugees fled to India in less than 8 months.

Bangladesh is the world’s second largest Muslim state. Over 86 percent of all Bangladeshis are Muslim with Hindus, with Christians and Buddhists making up the other 14 percent of the population. Muslim rule had been continuous from the 14th century until the British took over in the 18th century. When the British Raj left the sub-continent, Muslim majority East Bengal became East Pakistan and so it remained until the country became independent in December 1971 (Kahn 1990).

Bangladesh has been independent for only just over 20 years. Before this time East Bengal was ruled by Pakistan. The main language spoken in the East was Bengali whilst in the West, which is Pakistan, the language is Urdu. East and West were also separated by miles of Indian territory which made it difficult to join them together. After the civil war East Pakistan became the new State of Bangladesh. Bangladesh was seen as an independent state whilst other Bengalis are members of the Great Indian Union.

For a brief overview of the history and culture of the Bangladeshi people
the leaders of the local Bangladeshi community recommended Lily Kahn's (1990) book, an account acceptable to the local Bangladeshi community.

The socio-political history of the country is obviously very complex. However the Bangladeshi communities in Great Britain are Muslim, and the majority are from the Sylhet district in East Bengal which is a relatively poor agricultural area. Sylhet is described by Kahn as the land of ‘Two leaves and a bud’, distinguished for its natural beauty in the well-cultivated plains of the Surma river. There is a population of about 6 million people in an area of 5000 square miles. The land is mainly cultivated by families who have small holdings and who supplement their income with basket making, boat building and by making cane furniture. The humid climate also makes Sylhet the main tea producing area of Bangladesh and ideal for the manufacturing of textiles. According to Tully (1991) the Muslims are the traditional weavers, and crisis in the textile industry meant that thousands lost their source of income. This, and the poverty brought about by the wars of independence, were the main reasons for Bangladeshi men emigrating to Great Britain to find work.

Health policy

Bangladesh is a member of the United Nations and the Commonwealth of Nations, and as such the global strategy of the ‘Health for all policy by the year 2000’ aim of the World Health Organisation has been adopted as the national objective for Bangladesh. At present the population boom is recognised as the major national problem. The National Council for
Population Control provides policy guidelines and directives for this. The aim was to reduce the existing birth rate to 1.8 percent by 1990. In a discussion programme on BBC radio (27/9/1993) Mark Tully - a BBC correspondent who lives in India - mentioned that this project had been most successful. He also recounted a discussion about family planning with a group of Muslim women, whose comments were:

we know all about family planning, and if we want to, we adopt it......all the men are actually happy, because, once you have a son, who wants a big family in these days of such expenditure?

Tully also stressed that not enough credit was given to the people themselves for their own efforts to improve their country's social and economic situation. He felt that in countries such as Bangladesh where aid was being directed, the general assumption was that the people themselves were passive and not proactive in trying to sort out their own problems. In his observations this was not a true picture of the situation. Indeed one Indian lady said to him:

If you want to believe that we are not doing anything to help ourselves, that's your business. One should not be worrying about what other people think of you. But there is a feeling of mistrust about the foreign agencies here. They have their own priorities, which are not ours. (Tully, 1991: 266).

This statement seems to emphasise yet again a misguided view of
empowerment, with the helping agency starting from a position of fulfilling its own objectives rather than seeking those of the people it is setting out to assist.

Although the situation with regard to self-sufficiency, education and social problems related to over population, seems to be improving in some parts of the subcontinent, in the rural areas of Bangladesh there is still a considerable amount of poverty.

Migration to Great Britain

The Bangladeshi are one of the many Asian cultures represented by immigrant groups in Great Britain from the Indian Subcontinent. Migration had already begun in the 50's and 60's from the Sylhet district of Bangladesh. The intention of the immigrants was to make their fortune in England and then to return to their homes and families. Men often came alone in the first instance, leaving wife and children behind with the extended family, a very similar picture to that of the Italian immigrants.

In the 70's, following the great disasters in Bangladesh the flow of immigrants increased. The main areas in which they first settled were Bolton, Bradford, Dundee, East and North London, Keighley, Luton, Oldham, Scunthorpe, Sheffield and Thameside (HMSO 1991). A pattern of chain immigration was established with members of the extended family coming to Britain to join the original immigrant. The attraction in the North of England was the textile industry with which many of the immigrants
were familiar. Others went to industrial areas for work. In Luton it was the car industry and in Sheffield steel. In the location of this study it was a large rubber works factory which offered employment not particularly attractive to the local people.

The Bangladeshi men scrimped and saved to send money back home to their families. It was a depressing life style for the men, living in a strange country in a strange culture apart from their close family. The factory in this location closed down during the recent recession and many of the Asian men were unemployed as a result of this (information provided by a Bangladeshi outreach worker in 1993). This young outreach worker described her own family’s experiences of immigration which she said were common to many of the Bangladeshi families coming to Great Britain.

Family history of a local outreach worker

N, the young outreach worker with the local community recounted her own family’s experience. Her father initially came to England alone to find work and to send money back to his family, but became depressed living apart from wife and family until his wife eventually joined him. Originally she did not intend to stay and left her two children behind with relatives in the extended family. She became pregnant and it became more difficult to return home. She had two children in this country and then tried to bring the other two children over, but immigration officials would not allow this. Many families began to experience these types of difficulties as immigration laws became tougher. What this young outreach worker
stressed was, that the families still saw Bangladesh as their home, and the
dream was to return when they had saved enough money to support the
family. It proved difficult to send money home, to save for returning
home, and to keep enough to live on. Consequently many never returned.

Bangladeshi population in Great Britain, 1986-1988

All Persons - 108,000  Born in Britain - 32,000

Distribution of Bangladeshi People in Great Britain;

Greater London       -  51,000
Manchester            -  4,000
West Midlands         -  17,000
West Yorks            -  5,000
Other Metropolitan Counties -  7,000
All Metropolitan Counties -  84,000 (HMSO 1991)

The Sylhetis generally come from relatively poor agricultural areas. They
tend to be more traditional and have less education than other Asian
migrants to this country. It must be remembered that the second
generation migrants in this country are being brought up by parents whose
own upbringing was in rural India, in large households and often as one of
several adults sharing the responsibility for making decisions affecting the
family. Running the household economy and caring for the children would
also be shared responsibilities  (Ballard 1979).

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Background of Bangladeshi family life

The family, according to Kahn, is the most important part of a person’s life. The members of the family do not see themselves as independent individuals but as a part of the family. The interests of the family group will always take precedence over those of individual members, with relationships within the family being affectionate but hierarchical.

Decisions are made jointly, with older members having the greater influence over the extended family. Stopes-Roe and Cochrane (1990) in their study found that the indigenous white British and Asian cultures differed particularly in the emphasis which the IWB placed on personal independence and the Asians on group obligations. This difference they found persisted, though not as strongly, with the second generation of young Asian people in Britain today.

The family structure, says Kahn, is extremely traditional and very slow to change. It also has a conservative element in it which works against change. This structure is that of a joint or extended family consisting of three or four generations living together. The traditional pattern is that all related men with their wives and children live in one large self contained household. This might also include any unmarried daughters or other unsupported relatives, widows and orphaned children. The bonds between family members are strong and extend to relatives who may be living at a distance. The necessity for this interdependent structure of the family has been demonstrated in an earlier chapter to have an economic function.
As each generation of children grow up the sons bring their wives into the family home. Daughters however leave the home when they marry and move in with their husband’s family. This is usually a permanent arrangement. Daughters cannot contribute to the family income and a good marriage is sought. Families are also expected to provide a good dowry with their daughters. It is accepted that any possessions belong to the whole family and any income is pooled and shared, (Henley 1979).

If male members of the family by necessity have to work away from home, the wife and children will usually stay with the extended family and any income will be contributed to the pool. This continues when the family are split up through migration. Consequently the burden on the male members in Great Britain who may be unemployed and living on social security is very great. The Health visitors whom the researcher accompanied for a day of visits in Bradford at the beginning of this study and the health visitors in the locality of the study, both commented on the hardship brought about by this situation especially where older children are not allowed to join their parents through immigration laws. The male members living in Britain will still be expected to support the children financially. Some do this from their social security payments and live very frugally themselves.

The roles of men and women within Bangladeshi culture

The roles of men and women are very clearly defined. Men are responsible for working in whatever family business there is and for
bringing in the income. In Great Britain many have opened small
restaurants as some of the larger industries have contracted during the
recent recession. Traditionally the men make contact with the outside
world and are spokesmen for the family. If families can afford to educate
their children, and many cannot, boys will be given preference, even if the
girls are seen to be more intelligent. Sons have more freedom but carry
the burden of the livelihood of the family on their shoulders. They must
however adhere to a strict moral code of behaviour and are brought up to
become responsible and to be authoritative. (Kahn 1990; Henley 1979).

Within the Islamic faith the natural role of women is said to be as great
and as important to society as that of men. Women by tradition are wives
and mothers and Islam as a practical faith pays due regard to this. Ideals
and standards are laid down to which women should conform if they are
to fulfil their duties to God and society. Loyalty to the family is a woman’s
primary duty, but she is not forbidden to take employment outside of the
home should there be an economic or vocational need.

Loyalty to the family is rated very highly in this community. A health
visitor described how one of the women, who is now taking part in the
study, was found to be being physically abused by her husband. She
discussed her situation with her local health visitor and was subsequently
ostracised by other women in the community, as she was seen to have
been disloyal to her family. They showed their disapproval by not
attending the local community social group, run by the health visitor, and
by not speaking to the woman.

Bangladeshi women are traditionally responsible for the day-to-day domestic care of the family and the household. In the extended family the woman's duties are under the control of the wife of the head of the family. Some of the mothers in this study were living with their mother or mother in law, but only one of the mothers had work outside the home. However the pattern was changing, and two of the mothers had older daughters who were in paid employment.

The economic, social and political status of women
Kahn claims that in Bangladesh women are more oppressed than any other women in the world. This she says is not done deliberately but women tend to stay in the background and take inferior positions in society. This situation is more obvious in the rural areas than in the cities and is certainly the focus of a changing perspective amongst the second generation of Asian girls living in Great Britain.

According to Henley of the 60 million women in Bangladesh approximately only one percent take up a profession outside of the home. These are usually posts such as teaching, nursing and medicine. Very few women apparently take up administrative or business jobs. Although women have the right to vote in Bangladesh they are minimally involved in politics and therefore until recently have had no organised voice for women's issues. This as we have seen is changing, and as more and more girls and women
become educated in this country no doubt the change will become more rapid and widespread. Certainly the young daughters, and sisters of women who were involved in this study complained bitterly of the freedom allowed to their brothers. They also expressed great enthusiasm to become educated and train for a career. Their fathers seemed keen for this to happen too.

In 1972 an organisation called SEWA, or Self Employed Women’s Association was founded by Ela Bhatt in Bangladesh. It is described by Tully (p.241) as a co-operative founded to protect women cloth workers from being exploited by middlemen and to help them upgrade their skills. The organisation provides women with sewing machines and finds them outlets for the quilts they sew. It has also established its own bank to avoid bureaucratic procedures necessary to get loans from the nationalized banks. A recent BBC news report, (BBC1 News 8/9/95) has also shown that women in the rural areas of Bangladesh are becoming more active in the economy. The women were taking out bank loans, independently of their husbands, to establish weaving co-operatives, and were making profits. It seems that if the women manage the money the family situation improves.

Another feature of SEWA is that it has been instrumental in raising awareness amongst the women of issues such as birth control. This organization and other feminist movements are growing according to Tully, and beginning to make their voices heard on women’s issues.
Women and marriage

Marriages are still arranged for 90 percent of the young women. This usually takes place between the ages of 16 and 20 years of age and is considered to be desirable. The arrangements are left to older members of the family whose experience is accepted by the girl. Their choice is usually respected and accepted by the young girl. Sometimes with educated girls an element of choice is given but care is taken to ensure that this choice is within the family’s own social class. Asian parents still see arranged marriages as the only sensible way to proceed. This is still strongly felt to be so in the Moslem faith. An unmarried daughter is of great concern to her parents (Henley 1979 and Kahn 1990 and evidence from local Bangladeshi people).

Muslim women do have the right to divorce under Islamic laws as marriage is a contract. The law also makes provision for the support of the divorced wife should the marriage break up, but the family and the community have a duty to try to preserve the marriage. The women may keep the custody of the children but the husband remains the guardian. Women also have the right to inheritance both from their fathers and their husbands. From her husband the woman is entitled to one eighth of his property and from her father half of the amount her brother or brothers would receive. Often women give up the right to inherit from their own family in order to protect them financially. On the death of a spouse a Muslim must remain secluded for 3 - 4 months but after this time may rejoin the community and is actively encouraged to remarry.
Child rearing practices

In the sub-continent children are brought up communally by the extended family and according to Ballard (1979) an Asian child in Britain learns very early in its life that it is part of a wide and stable family group. From early infancy children will receive attention and care from a number of adults and older siblings. Families spend much time exchanging visits with relatives and friends, who, in the absence of the extended kinship group back home in Bangladesh, have taken on the role of quasi-kin. Indeed this practice of visiting is the major and probably only social activity of many of the Bangladeshi women interviewed in this study.

Small children are constantly carried and cuddled by members of the family and kept amused. They are always included in festivities and outings and there are no special sleep schedules. Children in Bangladesh go to bed with their parents; indeed it is considered cruel to make a young child sleep apart from its mother. Toilet training is not seen as a problem. The children wear few clothes and their needs are often anticipated by the many adults around them. Discipline too is very relaxed with the younger children but as the child approaches five this changes. The child will then be expected to be more independent and also to help care for any younger siblings. There is little separation of adult and child activities in the home. However with the advent of formal schooling for the children being born in the UK a widening of their social contacts and experiences inevitably takes place. Discipline then becomes an important element in child rearing (Henley 1979 and Kahn 1990).
Children generally are much more involved in family affairs than their UK contemporaries. They are always taken along on family outings and included in adult functions and discussions, as are the Italian children. Allowances are made for children but their needs are not seen as being very different from those of other family members. Because they are involved in all family events they learn to behave responsibly at an early age.

As a member of the family group the child is expected to share everything with others, the emphasis being on 'We' rather than on 'I' or 'Mine'. This was evident in the Stopes-Roe and Cochrane (1990) study. Demanding exclusive attention from parents is not encouraged. An Asian child's experience of the mutual co-operation which binds the family together is very intense, and constant exposure to the social life of the community is very effective conditioning, says Ballard (1979).

In conversations both with the local Bangladeshi outreach worker and the daughter of one of the Bangladeshi women interviewed in the study, the researcher was told that Asian parents with children at school in this country worry a great deal about the corruption of their children by Western values and behaviour. Girls have always been under stricter surveillance than boys, as families fear that too much freedom might spoil a girl's reputation and chance of making a good marriage. Asian parents were also concerned about the development of relationships between their children with young people of the opposite sex from other cultures.
Other problems faced by members of the family according to Henley are the loneliness and separation from close community support. One health visitor described such a family in this study who happened to be housed apart from the main Bangladeshi community. However it would appear that in general great positive efforts are made to maintain a sense of community. It is felt that the men may face problems as they are no longer seen to have the authority which they once had, as the social structure in Britain takes over some of this. They are also often forced to take low status jobs or in the present economic climate become unemployed. Although their children will be able to receive an education the choice is limited and very few will have access to an Islamic school.

Parents of Bangladeshi children feel that their family codes of behaviour are questioned and sometimes ridiculed by non-Asian members of the community. Racism can also be a real threat both from the white indigenous community and from other Asian groups. Men and women may feel threatened in an alien culture, and women especially can feel isolated after the experience of a large extended family. Compromise in many things becomes a necessity (Verbal discussion with Asian link worker).

The Bangladeshi participants involved in the study

Introduction to the local Bangladeshi Community was gained through a health visitor in the District whose client group and main responsibility was with the Bangladeshi population. This health visitor had developed
excellent rapport and trust with the group. One elderly father said she was
their ‘best friend’. She ran mothercraft and family planning sessions with
the young mothers with the help of two mothers who could speak English.
Apart from the obvious health education role she had, families used her to
read and interpret official mail and documents, and generally sought
advice from her on many issues.

A visit was arranged by this health visitor to a Bangladeshi womens’ group
where the women gathered for weekly sessions of English language, keep
fit (which they found very amusing, and did fully clothed) and shopping
expeditions. Transport was arranged for this. The atmosphere was very
warm and friendly. The researcher was introduced to R, a mature
Bangladeshi woman who has lived in the UK since 1976. She spoke
English quite well and was able to explain to the group the aims of the
study. There was a general acceptance to be part of the project and R
invited the researcher to her home to discuss how she could be of help.

As members of the Bangladeshi Community in this locality tend to be
living in close proximity to each other on two council housing estates, it
was relatively easy to make contact with the mothers. R seemed to know
all the mothers with young children and also those who were about to
have babies. She offered to meet the researcher on a regular basis to
arrange visits and appointments for an interview with the young mothers.
R agreed to make the initial arrangements with the family prior to the
interview. The researcher suggested this as R felt it was quite in order to
Five mothers were interviewed with R present, but then other contacts were made through the health visitor. Some of these interviews were more difficult as many of the mothers spoke very little English. Another problem was that they often were not able to provide some information, such as their husband’s age. This was not due to a reticence on their part but often because they did not know.

At all times the researcher was received warmly and hospitably into the households. The older children were particularly friendly and interested in the study. On several occasions an older child would write down the names of the children in the family. Tea, sweetmeats and sometimes meals were offered. At times the trouble that had been taken to prepare for the visit was embarrassing. Some of the families asked the researcher to come again for a social visit. One father wanted a regular visit to enable his daughters to have conversations to improve their English. Another family telephoned and offered an invitation to join them for a meal during the festival of Eid. During follow up visits to the families it was possible to return some of the hospitality.

An informal discussion with a group of Bangladeshi women

In order to repay hospitality and to facilitate an informal discussion the Bangladeshi women were invited to a social gathering at the researcher’s home. Four of the women came plus one 8 year old boy, the son of R.
This lady has been very helpful in making contacts with the other mothers. She seems to have some maternal status with the women in the Bangladeshi community, because of her maturity in relation to many of the young wives.

R. also helps occasionally at the local primary school which her son attends, and has additional contact with the mothers there. She brought her daughter with her, RK., who was 18 years old. The daughter has lived in this country for fifteen years having come to England with her mother at the age of three. It was very helpful to have RK there as she spoke very good English and was able to involve the other women in the discussion. At present she is completing a nursery nurses course at the local college and therefore has a good knowledge of child development and child-rearing both in the UK, and within her own culture.

The other two women were sisters, who have been visited three times by the researcher, twice at their invitation following the initial interview. One of the sisters is married and has a 16 month old child, her husband has never been able to come to this country because of the immigration laws. The younger sister, aged 15 years, attends the local comprehensive school. They live with their mother who has three other much younger children. The father has returned to Bangladesh. According to a community social worker he has gone to take another younger bride. (Islamic law allows men to have four wives but legislation in the
Indian Sub-continent prohibits polygamy except in certain situations. It is rare for Bangladeshi husbands to have two wives in this country, (Handbook for Health workers in Bradford). The family are totally dependent on social security for their livelihood.

The younger sister expressed the view that she was not going to get married, but was going to be a business women. The subjects she enjoyed most at school were maths, science and business studies. The two years spent at the local comprehensive school since she came to England seem to be influencing her views on womens’ roles in society. The two sisters have been in this country for about two years. They both speak a little English and were actively involved in the conversation with the help of RK’s interpretation. It was a happy, lively and informative afternoon.

Some of the conversation which took place during this social gathering is reported below. It provides first hand insight into aspects of family life and child rearing practices in the local Bangladeshi community, and serves to confirm data.
Gender differences within the Bangladeshi families

This topic was introduced by the younger women who vociferously declared that boys had much more freedom than girls. They said the boys were allowed to go out together in the evenings but the girls were not. None of the women had ever been to the cinema. They said they did not mind as they waited for the films to come out on video and watched them at home. They did not appear to be resentful about this.

They accepted that the freedom given to English women was our (The English) way, and claimed that their community did not attach values to it, or see it as uncaring. However they explained that Bangladeshi parents did not wish their own daughters to have this freedom because it may affect their prospect of marriage.

Child rearing

Child rearing practices in their culture were discussed and summarised by RK as follows: babies in general were weaned later than English babies, usually on the family’s rice at first and later bananas. This was probably due to the fact that mothers felt that not much of the food the adults normally ate was suitable for the babies. The babies tended to be kept in the same room with the family most of the time, unlike the IWB mothers who would put their babies into another room to sleep or even upstairs. The babies did not go out in prams very much. They were cuddled a lot by other members of the family and were kept around with the family.
Much of this information was in agreement with that found in the literature.

In a long follow up discussion with RK at a later date we discussed several issues about family life using her family as a model which was fairly typical of the other families in the local Bangladeshi community. The issues discussed follow.

**Status of Boys and Young Men**

RK commented that although her brothers were allowed more freedom to be out and about, they would be having arranged marriages. She pointed out that they totally accepted this and that there would be discussion with the boys about the choice of bride. The men tended to marry at about 25 years of age but for the women it was younger. However, gradually the girls were beginning to become more career-orientated and less willing to marry so young. She herself hopes to work in a school nursery initially and then to take further qualifications, and eventually become a teacher.

**Television Viewing**

The family watch quite a lot of television and video films at home. There are several local video hire shops owned by Asians, which are a meeting point for many young Asian boys. Video viewing seems to be a popular source of entertainment for the young people, especially women and girls, who do not go out in the evenings. The young people in RK's family liked the 'soaps' on television, but she did not know whether her mother fully understood them. The boys in the family had two computers and spent a
Family Activities

This family visited the mother's sister in London quite frequently and RK liked to stay there during vacations from college. There were cousins of similar ages to her own five brothers. Sometimes the whole family went to the mosque in Regents Park. Apparently there is a separate room there for the women. The local mosque is too small to accommodate the women, so they are not allowed to attend.

This led to a discussion of the religious festival of 'Eid'. In the Muslim Faith this takes place twice a year, once around Easter time and again near Christmas, although there is no connection with the Christian festivals. The family celebrate by having new clothes and visiting friends and relatives. There are celebration meals and it is customary to give the children new clothes rather than toys.

The discussions, with R, her daughter RK, the group together, the outreach worker, the Mullahs and the community social worker helped to provide a much fuller picture of the community than would otherwise have been gained by a formal questionnaire. It also provided further insight into some of the child rearing practices, an example being the delay in weaning which health visitors are often concerned about within the Asian community. This is more easily understood when looked at in the context of their diet, which as RK explained, is not really suitable for babies, being too spicy and hot. The proprietary baby foods used in Great Britain are

lot of time using these.
not readily available in rural India and it takes time for the young mothers, fairly new to Great Britain, to become familiar with them. These foods are also relatively expensive and they can be confusing in terms of content.

It is within this cultural and historical context that the data from the interviews with the eleven Bangladeshi mothers is considered below.

**Analysis of Interview Data**

Data is presented by the use of tables and charts wherever possible for easy scanning, or by summarising comments when this is more appropriate.

**Table 10: Age of parents, occupation and number of children**

<table>
<thead>
<tr>
<th>Mother</th>
<th>Father</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age and Occupation</td>
<td>Age and Occupation</td>
<td>No Age</td>
</tr>
<tr>
<td>B/A 20 - Housewife</td>
<td>30 - Own business</td>
<td>2 3yrs/7mths</td>
</tr>
<tr>
<td>B/B 33 - Link worker</td>
<td>50 - Restauranteur</td>
<td>5 6mths/5 of school age (translator in schools)</td>
</tr>
<tr>
<td>B/C 21 - Housewife</td>
<td>26 - Unemployed</td>
<td>1 18mths</td>
</tr>
<tr>
<td>B/D 21 - Housewife</td>
<td>? - in Bangladesh</td>
<td>1 9mths</td>
</tr>
<tr>
<td>B/E 29 - Housewife</td>
<td>? - Mullah</td>
<td>2 8yrs/7mths</td>
</tr>
<tr>
<td>B/F 30-35 - Housewife</td>
<td>80+- Retired</td>
<td>5 2yrs - 13 yrs</td>
</tr>
<tr>
<td>B/G 39 - Housewife</td>
<td>50s - Unemployed</td>
<td>8 6mths - 15 yrs</td>
</tr>
<tr>
<td>B/H 44 - Housewife</td>
<td>? - Hospital porter</td>
<td>7 6 - 19yrs</td>
</tr>
<tr>
<td>B/I ? - Housewife</td>
<td>? - Unemployed</td>
<td>6 6wks - ten</td>
</tr>
<tr>
<td>B/J 22 - Housewife</td>
<td>Bangladesh community worker</td>
<td>3 18mths/2.5yrs/4yrs</td>
</tr>
<tr>
<td>B/K 22 - Housewife</td>
<td>? - Unemployed</td>
<td>3 2mths/2yrs/5.5yrs</td>
</tr>
</tbody>
</table>
Ages of parents: comment

It was not always possible to obtain the ages of the parents without being too intrusive. The Bangladeshi woman who helped to interpret was a member of the local community and it did not seem appropriate to press her to ask for ages of the men. Some of the wives did not know their husband’s ages and occasionally were unsure of their own. The mothers’ ages ranged from twenty years to 38 years. This was broader than the indigenous white British mothers. The Bangladeshi women tend to have larger families and consequently were still having babies later in life. The men were generally older than their wives, in many cases much older, except for one young couple of 21 and 26 years.

Family background

As the families have such varied backgrounds, a vignette of each family seems helpful in supplying a context for the data.

B/A This mother and her parents have lived in England for 10 years, the father for 25 years. The father’s mother has lived here for 10 years and his father for 35 years. The couple live with the husband’s parents.

Children’s names; Shadnum and Abdul Kayum.

B/B The mother has been in England for 13 years and works as a translator in schools. Her parents are both in Bangladesh. The father has lived in England for 25 years and is a restaurateur. His parents are both dead. Their four older girls are at school and are said to be very helpful in looking after the 6 month old baby, Jordan.
B/C This was a very sad family. The young mother had lived in England for 2 years, the father for 13 years. The young father’s restaurant has recently closed down due to bankruptcy and they have had to sell their house and move into a council flat. He said he had had more ideas than expertise, and had opened the restaurant in an area where people, because of their economic situation, would not regularly eat out. He had become very depressed after the failure of the business and missed his parents badly. The mother’s parents are both dead. The father’s parents had lived in England for many years but have returned to Bangladesh since the business failed. They telephone his parents but this is upsetting, as his mother cries on the telephone because she cannot see the baby, Ema. He desperately wants the family to be together again.

B/D This mother has lived in England for 1 year. Her baby, Minadudim, was 8 months old. Her husband was still in Bangladesh waiting to join her. She lives with her own mother who has 5 children, and who has also only been in this country for a year. Her father has lived in England for 30 years. Later in this study the father returned to Bangladesh to take a younger bride. M has a younger sister who attends a local comprehensive school, and who is beginning to speak English well. Eight months later at a further visit M’s husband had still not joined her.

B/E This mother has been in England for one year and the husband for six years. Both sets of parents are still in Bangladesh. The father is a Mullah
at the local mosque. They have a 7 month old baby, Ashfaq.

B/F The father of this family is 80 plus years old. He came to this country in 1958. This is his second wife. He has three grown up children from his first marriage, and five children with his second wife. She came to England two years ago. Her parents remain in Bangladesh but she has a sister living in London. Mother spoke no English but the older children were quite fluent. The children's names were; Hasnara, Momina, Bushra, Halima, and Hafisa. Two year old Hafisa was a bouncy lively baby but the five year old Halima concerned the father because he was of small stature, and 'would not eat rice' with the father. This father was very proud of their home and vegetable garden which faced the sun, and reminded him of Bangladesh in the evenings.

B/G The mother of this family has been in England for 13 years and the father for 22 years. The mother's parents are both in Bangladesh. The father has a mother in Bangladesh but his father is dead. The children, Farhana 15, Sharifa 11, Shanaj 10, Sharmin 9, Rasheda 7, Atickur 6, were at local schools, returning during my visit. They were very bubbly, communicative and offered to write down names and ages of the family. Anisur 3, and Shamisia 6mths, are at home with mother. The older children go to Arabic classes from 4 - 7pm after school several times a week. There were no visible toys in the house.

B/H This mother has lived in England for 14 years but her parents are still
in Bangladesh. The father is older and has been in the country much longer, mother is not sure of the length of time. His parents are both dead. He works locally as a hospital porter. They have seven children whose ages range from 7 years to 19 years. They all still live at home in rather cramped conditions in a small council house.

B/I The mother came to this country with three daughters, Ruhana, Jutsna and Ruma 4 years ago. Two attend a local comprehensive school and the third works in a small factory. Two older boys live away from home. This is unusual, but it is probably with a relative helping in a restaurant as a young boy in another family did. and the third boy is 6 week old baby Jubel. Mother’s parents both died in Bangladesh. The father has been here for 30 years and is unemployed at present. His mother still lives in Bangladesh but his father has died. The father is anxious that the other two girls gain a good education. He would like them to become teachers. The girls are keen about this too.

B/J The mother has been in England for 4 years. Her parents also live here. The father has lived in England for 21 years, he is obviously much older than his wife but because of his position in the community ( He is the chairman of the community and acts as an interpreter and spokesman for community on any important issues.) the Bangladeshi lady interpreting did not like to ask his age. His parents both live in Bangladesh. They have two preschool girls and a baby, Mijanoor, who is 15 months old. The father said he welcomed the opportunity to share information about our
respective cultures, and felt it was important to understand each other’s
customs more fully. He stressed that Bangladeshi women had the choice
whether they worked outside of the home or not. It was the woman’s
decision, he said, and not ‘Islam’, if she chose to stay at home.

B/K D has lived in England for 7 years; her parents both live in this
country. Her mother has been here for 10 years and her father for much
longer. D’s husband is a very quiet shy man, has lived in this country for
14 years. His parents both live in England and have done so for many
years. They have three children; Runela a girl, Shahan a two year old boy
and 2 month old baby daughter Sheila.

It may also be noted that six of the mothers had been in England for less
than five years, one for seven years and the remaining four for ten to
fourteen years. It seems to be common practice for the men to come over
to the UK, get established, and then to return to Bangladesh to bring over
a young wife, or the sons of established immigrants, return to marry a
young Bangladeshi woman whom they then bring to the UK.

Analysis of Interview Topics

Choice of early feeding methods

Nine of the mothers had breast fed or were breast feeding their babies for
varying periods of time ranging from 6 weeks to 9 months. One mother
said she hoped to continue for 2 years. The mothers said that they
thought breast feeding was good for the baby. Two mothers bottle fed
because they had found breast feeding difficult. One said it had been too painful and the other that she had given up after two weeks because the baby did not like the breast.

A Bangladeshi community social worker said that breast feeding could be a problem with some of the mothers as they would keep the baby on the breast for too long (four years in some instances) and not wean early enough. This was also reported by the health visitors in the Asian community in Bradford on a day spent with them visiting the mothers. These health visitors said that they tried to stress the importance of introducing vitamin and iron-containing foods at an earlier age.

**Weaning**

When discussing weaning however with the mothers most of them said that they weaned their babies between 3 and 6 months. Only one mother said 9 months. It may be that they do continue to breast feed for longer but this certainly was not reported in the present study, indeed two mothers had been advised by the health visitor not to begin weaning until the babies were 6 months old and they said that they found this difficult as in Bangladesh they would commence at 3 months. Perhaps lengthy breast feeding had been associated with late weaning which may not have been the case. The most common foods for early weaning were egg custard and rice. Some mothers used bananas and rusks softened down in milk.
Potty training

Mothers said that in Bangladesh the babies did not wear nappies. As it is a hot country the children do not need to wear many clothes so it is not important if they get wet. One mother said that because the children go to bed in this country they need to wear nappies. Attitudes were quite relaxed among all but one mother, who was going to start training at 6 months, most of the mothers favoured the second year when the babies had begun to understand. One mother said that with disposable nappies there is no hurry.

Sleeping and bedtime rituals

Sleeping and bed time did not seem to be a problem with the mothers; even though one child was reported as waking every two to three hours in the night, he was described as a happy baby. He would be settled by being sung to and given a dummy. Many of the mothers described their babies as being happy babies. Only one young mother found her baby difficult in the night. He was a very big baby and wanted feeding up to four times during the night. Mother was very young and looked extremely tired.

There did not appear to be any set bedtimes. Mothers often went to bed with the children. In order to settle babies off to sleep mothers said they would sing, clap, rock the babies or take them onto their laps. Some mothers said prayers to their babies. Several used dummies as comforters, but two mother said they did not like dummies. The general
attitude towards sleep and bedtimes was much more relaxed than that of the indigenous white British mothers, with remarks such as, 'the baby is contented if fed', and 'he does not cry very much as there is always someone in the family picking him up.' Five of the mothers actually said their babies were happy babies.

Temper tantrums
Only four mothers described their children as having temper tantrums, with explanations that they were either hungry, frustrated, or because of quarrels with siblings. These problems were handled by feeding, distracting or by taking the children out for walks.

Punishment and discipline
With the younger children no one suggested that smacking or shouting was appropriate, the reasoning was that the babies would not understand. Two families said that the father will not smack but mother will with the older children. One father said he reasoned with the children, and one family mentioned bribery. Only one father was said to use smacking as a punishment.

Habits
Many of the babies were too young to be considered as having habits. Thumb sucking was mentioned by five mothers and two of them did not like their children to do it.
Parental roles

Two of the husbands were away in Bangladesh but in general the work of child rearing, in the early stages particularly, was considered to be the woman's role. The comments were that mother looks after the children with the daughters or with the other women that are about, that would be grandmothers or mothers-in-law. Only one father was said to help with putting the baby to bed and changing nappies. This father was a priest (mullah) in the mosque. The daughters in one family said that fathers may help more in this country as there are not so many family members around, and one family said that father helps with visits to the doctor.

There is a high level of compliance with immunisation programmes in this community. In Bradford the pattern was that by 18 months of age the uptake for immunisation was 97 percent amongst the Asian population. Possibly because of the effects of infectious disease still common in the poorer areas of Bangladesh, immunisation is seen as being very important.

Leaving the children to go out

Those mothers who lived with their parents or in-laws said they were able to go out without the children but this would only be to shop or for some other practical purpose. Going out alone with the husband was not a sought after priority. It was more usual for the family to go out together to visit friends or relatives. Sometimes older children would watch the baby whilst the mother called on a neighbour. One mother said that all the women had small children or babies so there was no question of baby
sitting by other neighbours. People visited each other on Fridays which is the Muslims’ Holy Day and the day for family activities. The festival of Eid was also another occasion when friends and relatives were visited, but for women to go out for social reasons either alone or just with their husbands was not part of the culture, neither was it seen as being particularly desirable.

Table 11: Help with the children

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>B/A</td>
<td>Mother-In-Law</td>
<td></td>
</tr>
<tr>
<td>B/B</td>
<td>Daughters</td>
<td></td>
</tr>
<tr>
<td>B/C</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>B/D</td>
<td>Mother and Sister</td>
<td></td>
</tr>
<tr>
<td>B/E</td>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>B/F</td>
<td>Daughters</td>
<td></td>
</tr>
<tr>
<td>B/G</td>
<td>Daughters</td>
<td></td>
</tr>
<tr>
<td>B/H</td>
<td>Daughters</td>
<td></td>
</tr>
<tr>
<td>B/I</td>
<td>Daughters</td>
<td></td>
</tr>
<tr>
<td>B/J</td>
<td>Daughters</td>
<td></td>
</tr>
<tr>
<td>B/K</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

In this country help with the children was provided in the main by older members of the family. These were mostly young school-age children. In Bangladesh there would be many people in the extended family to help
especially with a newborn. Some of the women in the study did live with their mothers or in-laws and they helped with the children. The Bangladeshi interpreter said that when a woman had a baby in Bangladesh she was pampered by the other women. They would bring food and sweetmeats to help her regain her strength. Mother and baby would stay in the house for forty days after the birth of a child unless it was absolutely necessary to go out, such as for doctor’s visit.

**Uses of the Health Visitor**

Except in the case of two of the mothers the health visitor was generally considered to be helpful and turned to for help and advice. At the time of the interviews there was a health visitor specifically allocated to the Bangladeshi community. She was well liked and went beyond the remit of her job to help the mothers in this community. Baby care and family planning classes which she ran were well attended by young mothers, and some expectant mothers. The health visitor would see that transport was provided for those who found difficulty in getting to the classes.

Information on the whole was very prescriptive but this was partly due to the language difficulty and the reticence of the women to ask questions, in spite of the presence of two women who were able to interpret. Bottle feeding was discussed with special reference to cleaning and sterilising equipment, but there was no mention of breast feeding. The health visitor was a warm friendly person, well liked by the women, but there was obviously a cultural diffidence to challenge or query the information given
and opportunities for questioning through the interpreter were not given by the health visitor.

These mothers' perceptions of the health visitors' role will be analyzed in Chapter Ten along with those of mothers from the other two groups.
CHAPTER 10

MOTHERS’ PERCEPTIONS OF HEALTH VISITOR SUPPORT
A major concern of this thesis is the perception of the health visitors’ role by the mothers. In this chapter it is these responses that are analysed. The following comments were extracted from the interviews with all of the 35 mothers. These comments were made in response to the particular questions on how they perceived professional help given by health visitors: what sort of contact they had with their health visitor and how they used her. These collated responses have been analysed initially along the same lines as the health visitor data. Emergent concepts have been abstracted and clustered in the right hand column.

In a second stage of analysis, comparison is made between these concepts and the four major categories identified in discussion with health visitors about their roles. There follows discussion of other aspects of the mothers’ perceptions that raise different and often conflicting issues.
<table>
<thead>
<tr>
<th>Indigenous White Mothers comments on support given by health visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IWB/A</strong> Would rather not involve parents with issues to do with child development or illness. (Father a GP, mother a Nurse). Prefers to go to health visitor or own GP. Feels they are able to be more objective about the problems. Sought HV’s advice when having a bad time at night with one of the children, I was at my wits end. Health visitor advised to let him cry, and it did the trick. Other child was a poor eater. Health visitor advised not to make an issue of it, and to let him eat when he wanted to. I did get two books called: ‘My child won’t sleep’ and ‘So your child won’t eat’.. as I like to read other points of view, but my husband thinks it is unnecessary.</td>
</tr>
<tr>
<td><strong>IWB/B</strong> Used health visitor when one child was difficult with sleeping. She was fantastic. I welcomed the advice as I needed reassurance. The sleep clinic counselling was very helpful. My previous health visitor was hard to find.</td>
</tr>
<tr>
<td><strong>IWB/C</strong> Consulted health visitor about several issues, sleeping and eating, as the family are vegetarian. Health visitor put forward pro’s and con’s but I didn’t find it helpful. ‘You could do this or that’ it was too confusing. Gave advice which conflicted with the literature mother was reading. I did not find it helpful. I went to the clinic with one child whose weight had slipped from the 50th. to the 3rd. percentile. This health visitor was very helpful and organised a consultation with a dietician.</td>
</tr>
<tr>
<td><strong>IWB/D</strong> My previous health visitor was a member of the NCT and was very forceful about breast feeding. She kept the pressure on although the mother was losing a lot of weight and needing to feed the baby every two hours. Husband was cross and said he didn’t approve of the pressurising as he was concerned about his wife’s health. Wife had a different health visitor with the second child as they had moved into this area. Present health visitor is very helpful, gives straightforward advice and mother can ring anytime.</td>
</tr>
<tr>
<td><strong>IWB/E</strong> Has used the health visitor for advice on feeding problems and other general problems and does visit the clinic occasionally. Has had a long association with the hospital as the first child was born with a cleft lip and palate.</td>
</tr>
<tr>
<td><strong>IWB/F</strong> Health visitor is brilliant, can phone anytime for a chat, but mainly use mother for advice. Values mothers’ opinions and</td>
</tr>
</tbody>
</table>
advice greatly. Also has a sister who has three children and if there are any child rearing problems tend to ring mother or sister.

IWB/G Uses her for clinic visits. She is not very chummy, I can’t chat to her easily. I sort my problems out with mum or sister. Mum has a copy of Spock and Sister has Penelope Leach’s book. Spock is marvellous!

IWB/H Didn’t feel the health visitor gave her the support she needed. Child continued to lose weight so rang the hospital and consulted a paediatrician.

IWB/I Had a ‘Plunkett’ nurse in New Zealand with first baby. Found them very good. They were more organised and visited regularly. Has not used the health visitor with the second child who was born in this country. Has used Penelope Leach’s book, Baby and Child Care ‘like a bible’.

IWB/J Only saw health visitor once after the first child, and then at two years for a check. Doesn’t consult her with any problems. Generally feels confident to make own decisions or consults with friends. Feels mothers need someone to confirm and reinforce their own views and to be given confidence in their own beliefs. Felt that mothers views’ should be channelled rather than be dictated to. Also it could be seen that health visitors have a policing role which could make mothers feel uncomfortable.

IWB/K Doesn’t know who health visitor is. Goes for advice to an aunt or to other mothers in the NCT, they support each other. Doesn’t see the health visitors’ role as being concerned with the whole family. Feels that they could be seen as powerful and reporting on parents, and there is always the feeling that one is being observed for child abuse. She and her husband have discussed this and they do feel that parents are afraid of being accused of child abuse and this affects their attitude towards their children. There should be some positive input and advice initially in order for mothers to feel supported and relaxed enough to enjoy their child, especially the first baby.

IWB/L Health visitor helpful with sleep problems with second child, who is also attending a clinic for poor weight gain. Would have liked some straight-forward advice on how to manage the first baby. Hasn’t felt the need to consult the health visitor with any problems with the third child. Feels able to manage the children.

<table>
<thead>
<tr>
<th>Alternative sources of advice</th>
<th>Unapproachable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative sources of advice</td>
<td>Not supportive</td>
</tr>
<tr>
<td>Dependable</td>
<td></td>
</tr>
<tr>
<td>Alternative sources of advice</td>
<td>Not seen</td>
</tr>
<tr>
<td>Unacceptable approach</td>
<td></td>
</tr>
<tr>
<td>Should reassure</td>
<td></td>
</tr>
<tr>
<td>Policing role</td>
<td></td>
</tr>
<tr>
<td>Not seen</td>
<td></td>
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<tr>
<td>Other sources of help</td>
<td></td>
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<tr>
<td>Policing role</td>
<td></td>
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<tr>
<td>Negative</td>
<td></td>
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<tr>
<td>Practical Advice</td>
<td></td>
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<tr>
<td>Unnecessary</td>
<td></td>
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</tbody>
</table>
**COLLATED INTERVIEW DATA**

**EMERGENT CONCEPTS**

<table>
<thead>
<tr>
<th>IWB/M</th>
<th>Non-constructive</th>
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</table>

Attended a clinic once to see health visitor, found her understanding but not constructive. Was amazed when health visitor came to see her at her own request. Health visitor spent most of the visit talking to mother's husband about a patient they both knew. Mother was feeling desperate about her own breast feeding problems. Eventually health visitor offered options but they were the health visitor's own options, the implicit assumption being that the mother should continue breast feeding, which was proving very difficult for the mother who had returned to work and was also in a lot of pain. Mother said she desperately needed to be reassured that it was alright to give up breast feeding.

When this mother's marriage was breaking up at a later stage she felt ought to discuss with the health visitor the right things to do with the children in order to protect them. When she rang the clinic she discovered it no longer existed. It had moved without the mothers being informed. Subsequently did not see the health visitor throughout the breakup and was supported by friends.

**Bangladeshi mothers' comments on support given by health visitors**

<table>
<thead>
<tr>
<th>B/A</th>
<th>Other sources of support</th>
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</table>

If the health visitor was needed this mother would go to the clinic. Ideas about what to do for baby came from mother-in-law and family too.

<table>
<thead>
<tr>
<th>B/B</th>
<th>Other sources of support</th>
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</table>

This mother was very experienced and did not feel she needed the health visitor's help.

<table>
<thead>
<tr>
<th>B/C</th>
<th>Other sources of support</th>
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</table>

Health visitor helped a lot in the beginning. Used both her doctor and the health visitor for advice but felt that the health visitor knew more than the doctor. This mother also relied on her aunty and sister, who also had a baby, for advice.

<table>
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<tr>
<th>B/D</th>
<th>Other sources of support</th>
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This mother did not find her health visitor helpful.

<table>
<thead>
<tr>
<th>B/E</th>
<th>Other sources of support</th>
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The health visitor was helpful in giving advice about what to do according to this mother.

<table>
<thead>
<tr>
<th>B/F</th>
<th>Other sources of support</th>
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The health visitor was said to be their best friend, and helped them with all their problems. This mother had only been in England for two years and her husband was very old and frail. (They asked the researcher to look at lots of official papers for them as they were not sure how they should respond to them.)

<table>
<thead>
<tr>
<th></th>
<th>Advice on officialdom</th>
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**Non-constructive**

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<tr>
<th></th>
<th>Opinionated</th>
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<tr>
<td></td>
<td>Insensitive</td>
</tr>
<tr>
<td></td>
<td>Un-reassuring</td>
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<table>
<thead>
<tr>
<th></th>
<th>Unsupported</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Communication failure</td>
</tr>
<tr>
<td></td>
<td>Not seen</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Other sources of support</th>
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<th>Other sources of support</th>
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<thead>
<tr>
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<th>Practical advice</th>
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<th>Practical advice</th>
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<tr>
<th></th>
<th>Advice on officialdom</th>
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</table>

- 287 -
<table>
<thead>
<tr>
<th>B/G</th>
<th>The health visitor was seen by this family as someone who called and advised.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B/H</td>
<td>This mother no longer felt she needed to use the health visitor as her children were growing up. The youngest was six years old and was seen at school by the school doctor and nurse.</td>
</tr>
<tr>
<td>B/I</td>
<td>These parents found that the HV and Dr. gave conflicting advice and were in a dilemma about what to do about their baby's constipation. They had since been to the chemist who had given yet further conflicting advice.</td>
</tr>
<tr>
<td>B/J</td>
<td>Relied on the health visitor for advice.</td>
</tr>
<tr>
<td>B/K</td>
<td>Received advice from the health visitor about child rearing issues.</td>
</tr>
</tbody>
</table>

**Italian mothers comments on support given by health visitors**

<table>
<thead>
<tr>
<th>I/A</th>
<th>Health visitor is very good and gives straightforward advice, but she would rather go to her mum for advice and always consults her parents first.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I/B</td>
<td>N. sees her health visitor approximately every two weeks with her second child. This health visitor has been described as being very supportive by several of the mothers in both the Indigenous White group and the Italian group of parents. The mothers say she has a very relaxed approach, telling mothers to do what they are happy doing in relation to their queries and problems. However, she has advised N. to leave her youngest child to cry himself to sleep and not allow him to come downstairs after being put to bed. N. says she cannot do this as it would upset her too much, and although she is prepared to listen to advice she will make her own mind up about how to manage problems. N. had had a different health visitor for her first child and apparently this health visitor had become very cross with N saying that she was allowing the baby to put on too much weight.</td>
</tr>
<tr>
<td>I/C</td>
<td>This mother does not see her health visitor very often and has only consulted her once about a problem. She prefers to use her mother who gives her opinions and advice very freely.</td>
</tr>
</tbody>
</table>
| I/D | The health visitor was described as being very helpful when this mother's first child was born. Mother said she had club feet and needed lots of treatment. The health visitor would ask the

**EMERGENT CONCEPTS**

| Practical advice |
| Other sources of support |
| Conflicting advice |
| Practical advice |
| Other sources of support |
| Supportive |
| Unacceptable advice |
| Critical |
| Not seen |
| Other sources of support |
| Medical support |
| Empowering |
mother what her views were about a problem and then encourage her to do what she thought best. The mother said she would take other advice before making up her own mind. Now she does not use the health visitor but prefers to ask her friends or her mother whom she feels are more experienced.

I/E This mother found her health visitor helpful and consulted her more with the first two children than the second two.

I/F The health visitor has only visited this mother once which was two weeks after the baby was born. The mother said that she would not call her health visitor unless there was a major problem. She prefers to go to older people who are more experienced with children, such as her parents.

I/G The health visitor has never visited this eight-month-old baby boy at home, although the mother thinks that she is understanding as she has a child of her own and is quite young. When this mother had her first child she found the health visitor she had at that time very directive about how she should manage her baby. The health visitor had given very prescriptive advice about quantity and number of feeds the baby should have and how many meals a day. The mother said that she felt very guilty about not following this advice or that what she was doing was wrong and sometimes even lied to the health visitor. For general advice she talks to her mother and usually ends up doing what she suggests. If there was a medical problem she would consult her general practitioner. Generally she feels more relaxed with her second child and does not worry so much.

I/H Initially, says this mother, she had a very helpful health visitor who would give her clear advice and tell her exactly what to do, but the health visitor moved from the area and the family has not been visited since. The mother feels she is missing out as her friend's child has been given a very thorough two-year check by their health visitor. She thinks that there should be a uniform policy for these checks.

I/I This mother said that she had sought her health visitor's advice with her first child but because she had had such a bad experience with breast feeding her she had decided to manage the second child in her own way. She subsequently ignored the advice of both the health visitor and her mother and bottle fed her second child immediately. She also started to wean the baby at 6 weeks in spite of the health visitor telling her to wait until three months with the first child. The health visitor has not contacted her at all since she had her second baby and the mother thinks that this is because she already had a child and...
they assume she can manage. Mother says that the family feel they are being ignored.

I/J The health visitor upset this mother by telling her that her first baby was too fat and would not be able to walk. The baby walked at nine months of age. The mother has not consulted her with any problems since. The parents now have three children and mother says she looks after them by instinct. Her own mother does not ever look after the children or offer advice and the husband's parents are both dead.

I/K C has rung the health visitor for advice occasionally. She says she does not feel threatened by her in any way and perceives her as an equal. Although she might ask for advice from the health visitor and from friends she says she would make her own mind up ultimately. However she does use her mother a lot for advice and support.

If we look across all three groups of mothers we find considerable diversity in their perceptions of the consistency of health visitor support. The main positive and negative concepts which emerged from the mothers' comments of how they perceived the health visitors' approach are listed below.

<table>
<thead>
<tr>
<th>Emergent Positive Concepts</th>
<th>Emergent Negative Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>HV gave practical advice</td>
<td>Mother had alternative sources of support</td>
</tr>
<tr>
<td>HV was helpful</td>
<td>HV Not seen/ not needed</td>
</tr>
<tr>
<td>HV facilitated medical access</td>
<td>Mother felt missed out/ignored</td>
</tr>
<tr>
<td>HV was objective</td>
<td>HV gave unacceptable advice</td>
</tr>
<tr>
<td>HV was empowering</td>
<td>HV gave prescriptive advice</td>
</tr>
<tr>
<td>HV was reassuring</td>
<td>HV gave conflicting advice</td>
</tr>
<tr>
<td>HV was dependable</td>
<td>HV had 'policing' role</td>
</tr>
<tr>
<td>HV was supportive</td>
<td>HV gave not helpful</td>
</tr>
<tr>
<td>HV was available</td>
<td>HV non-reassuring</td>
</tr>
<tr>
<td>HV was facilitating</td>
<td>HV was a source of guilt</td>
</tr>
<tr>
<td>Counselling</td>
<td>HV non-supportive</td>
</tr>
<tr>
<td></td>
<td>HV non-constructive</td>
</tr>
<tr>
<td></td>
<td>HV was opinionated</td>
</tr>
<tr>
<td></td>
<td>HV was unapproachable</td>
</tr>
<tr>
<td></td>
<td>HV was pressurising</td>
</tr>
<tr>
<td></td>
<td>Communication failure</td>
</tr>
</tbody>
</table>
The following table (Table 12) gives an overall count of the views of mothers as to whether or not they found the health visitor generally supportive. In some cases there had been no contact at all.

Table 12: General Perceptions of Health Visitor Support

<table>
<thead>
<tr>
<th></th>
<th>Helpful</th>
<th>Unhelpful or not seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italian</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>IWB</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>All</td>
<td>18</td>
<td>17</td>
</tr>
</tbody>
</table>

The Therapeutic Role of the Health Visitor as Perceived by the Mothers

There was a little evidence in comments by some mothers to support the view that health visitors displayed a therapeutic role in their interactions with their clients. But this did not emerge strongly and uniformly.

She is not very chummy, I can't chat to her easily. I sort my problems out with my mum or sister (IWB/G).

I found her understanding, but not constructive (IWB/M).

Many mothers would have welcomed more support in the early months following childbirth. An exception was the sleep clinic counselling which was seen as being particularly helpful. Mothers problems were listened to and regimes of management were suggested by the health visitor running
this clinic. In essence this was a fairly prescriptive interaction, but welcomed. Two mothers said they could ring their health visitors for a chat whenever they felt the need. However they both went on to say that they would consult with family members and friends too before they made up their minds about which advice to follow. Although the health visitor was seen at times to be understanding, the lack of constructive advice was criticised. However, on the issues where there were clear professional guidelines, such as child abuse and smacking, there seemed no hesitation for health visitors to make very positive suggestions.

The therapeutic role may have been reinforced in the professional community by the introduction of the Edinburgh Post Natal Depression Scales, which encourage a listening function for the health visitor. (This has already been discussed in Chapter 6.) Even so, this service does not extend to the Bangladeshi women because of the language difficulty and the lack of link worker support. Two mothers specifically said that they could have done with more support following the birth of their first child, and one mother was desperate for counselling on how to manage her two small children, during the break-up of her marriage but could not locate her health visitor and so turned to friends for support. Many mothers seemed confused about health visitor policy in the area.
Objectivity - being impartial in relation to the mother's family - which the health visitors had claimed was one of the major strengths of their role, was only referred to by one of the mothers. Indeed, the majority of mothers seemed to rely on, and welcome family support and advice, particularly the mothers from the Italian families who generally saw their own parents as having more relevant experience than the health visitor.

Therapeutic functions, as we saw in the analysis of the health visitor interviews, can involve confronting or challenging another's behaviour (Heron, 1975). This can sometimes be helpful, but Heron says that in its degenerate form it can undermine confidence. Three mothers were criticised by their health visitors for 'allowing' their babies to put on too much weight. One of these mothers (I/G) said that she felt so guilty that she lied to the health visitor about how she was feeding the baby. Another Italian mother said:

The health visitor upset me by telling me the baby was too fat and would not be able to walk. He walked at nine months of age and I have not consulted her since (I/B).

This example of a degenerate form of the therapeutic intervention thus resulted in a breakdown of the relationship.
Other non-therapeutic interventions recounted were being pressurised by health visitors into breast feeding, being unhelpful, giving conflicting or confusing advice, and feeling ignored or left out by not being visited.

The health visitors themselves observed that some clients, particularly the young single mothers, still saw them as having a policing role. This feeling was not only confined to the young single parents but was also expressed by some of the indigenous white middle class mothers, one of whom is quoted below.

I don’t see the health visitor as being concerned with the whole family. They could be seen as powerful and reporting on parents, and there is always the feeling one is being observed for abuse (IBW/K).

The Health Visitor’s role as Educationalist and Expert in Child Rearing

The health visitor was seen as most helpful when giving straightforward practical advice. Some mothers accepted this advice without question, particularly the Bangladeshi mothers. Others would consider it together with advice from other sources, and then make up their minds whether or not to follow it. The Bangladeshi mothers and their families often relied on the health visitor for assistance in filling in official forms, and in this respect welcomed her as a friend who came to help with problems of dealing with
the British system. As we noted in Chapter 6, some of the health visitors saw this as an unacceptable use of their time.

Mothers who had had medical problems with their children had considerable attention from their health visitors and found their advice helpful. However there were very few mothers who accepted the health visitor as being the 'expert' on child rearing issues, especially among the Italian group. Although she may be consulted as an added resource, in many cases parents opinions were valued more. This was voiced most strongly by mothers in the Italian group.

I prefer to go to older people who are more experienced with children, like my parents (I/F).

I prefer to ask my friends or my mother who are more experienced (I/D).

No one mentioned health education as a direct function of the health visitor, but her role as facilitator and a resource was evident with the organisation for some mothers of sleep counselling, and consultations with a dietician (I/G, I/K, I/A, I/C).
The Empowering Role of the Health Visitor as Perceived by the Mothers

Empowerment is seen as an enabling concept, and as such, if mothers have benefitted from advice on problems which have meant they are able to manage their children as they wish, they could be said to be empowered. However this is dependent on whether the health visitor’s advice is consistent with the mothers’ beliefs. The following two examples illustrate how this approach can cease to be empowering.

I was having a bad time at night with one of the children. I was at my wits end. The health visitor advised to let him cry, and it did the trick (IWB/A).

The health visitor advised me to let my youngest child cry himself to sleep, and not allow him to come downstairs after being put to bed, but I can’t do this. It would upset me too much (I/B).

The second mother is not helped, an apparent contradiction of the definition of empowerment as a transactional relationship, with the mother defining her own problem, which must include a consideration of her feelings and beliefs. In all the mothers’ comments there was only one example of this occurring, this was from a mother whose child had medical problems.
The health visitor would ask me what my views were about a problem, and then encourage me to do what I thought best (I/D).

One of the mothers summed up this need.

Mothers need someone to confirm and reassure their own views and to be given confidence in their own beliefs. They should have their views channelled rather than be dictated to (IWB/J).

The problem appears to lie with those mothers who do not have the support of immediate family or lack confidence in their own mothering. These mothers may become so dependent on prescriptive advice that a variety of choice may be confusing. One IWB mother found this so on a feeding issue, but once again the choices put before her were the health visitor’s options. Little attempt was made to identify the mothers’ own needs.

For mothers to develop confidence enough to enable them to make their own decisions, preparation for parenthood needs to begin before ante-natal classes. Health visitors have said that by this time the mother-to-be is unable to explore the realism of motherhood, being pre-occupied with the forthcoming labour and delivery of the baby. They also feel that it is not the right time to discuss the negative aspects of motherhood.
Some mothers do have the confidence to seek out ways of managing their own situations which are acceptable to them. We have seen this occurring in the earlier chapter on empowerment, where the coping strategies parents develop with a sick child are explored. The indigenous white mothers in this study tended go to several sources for information for help: to the literature, their parents and other family members as well as the health visitor, before making their own decisions on an issue. They also sought out supporting organisations, such as the National Childbirth Trust. For those in this group who lack this support and confidence there is often guilt, conflict or confusion.

The following concluding chapter explores further the differences identified across the three groups alongside the theoretical framework of the previously identified three determinants of child rearing: economic survival, family cohesion and cultural transmission (Chapter 1). The central theoretical concept of empowerment is reexamined in relation to the actual function and role of health visitors as perceived by themselves and by the families they serve. The appropriateness of the empowerment model within the present remit of health visitor practice is critically reviewed.
CHAPTER 11

DISCUSSION AND CONCLUSIONS

The preceding investigations were centred on four groups of people in an urban community. This focus was on mothers from three different ethnic and cultural backgrounds who had young children and on the health visitors serving these mothers. Health visitors have a direct and statutory concern with child health care and family support and are thus seen as the ‘experts’ in issues relating to child-rearing. In this study their professional knowledge and attitudes were viewed alongside the perceptions of the mothers.

The investigation sought to:

- identify a range of attitudes and practices in child rearing among mothers both across and within cultural groups;

- determine the extent to which an enduring cultural heritage is reflected in the child rearing practices of mothers from the three cultural groups on which the study is centred;
ascertain if cross cultural links, or changes in cultural patterns have
been established where the mothers have been living side by side
for several years.

In relation to the health visitors the questions were:

How are these attitudes and practices perceived, and is the social
and cultural context acknowledged by the health care professionals
supporting and advising the carers?

How do mothers perceive the role of the health visitor, and does
this reflect the health visitors' view of their relationships with their
clients?

Does the professional approach appear to meet the needs of the
mothers and empower them in the fullest sense of the word?

The methodology designed for the purpose of addressing these issues and
to attempt to answer some of the questions is briefly outlined below to
remind the reader of the process followed.

Community nurse managers were approached in order to gain access to
the health visitors and to secure their co-operation. Having achieved this,
questionnaires were distributed to the health visitors serving the local
community on which the study was focused. The content of the
questionnaires was designed to establish a personal profile of the health visitors and their professional background. The health visitors were also asked for their views on how mothers with different cultural backgrounds prioritised their child rearing problems. There were further questions on the sources of literature and other information which the health visitors themselves found helpful to their practice.

Of importance to the study were the attitudes and beliefs which health visitors held about their client groups and, in an attempt to determine this, ten of the questionnaire respondents were interviewed in more depth. During these interviews their perceptions of their present and future role as a health visitor were explored together with their view of the relationship they had with their client groups, and the problems met in relation to child-rearing.

Four major models for defining practice emerged through a content analysis of these interviews. They described the health visitor’s role in relation to her practice as therapeutic, empowering, educational and as an expert adviser.

Thirty five mothers from the local community were also interviewed concerning their attitudes and related child care practices. The mothers were chosen from three different ethnic backgrounds with different cultural antecedents. They were: indigenous white British mothers, Bangladeshi mothers and mothers of Italian families. These are
representative of the diverse cultural and ethnic population of the city and may reflect the mixture of ethnic and cultural groups found in most urban communities in the UK today.

The questions put to the mothers were modelled on the main topics identified in the current literature on child-rearing, the reason being that if the so called ‘experts’ on child rearing saw these issues as pertinent to mothers, it would be useful to have the mothers’ own views on the subjects. How mothers perceived the role of the health visitor was also discussed in association with their own relationship to their personal health visitor. Categorising and condensing the information gained from the interviews with the mothers and the health visitors made it possible to extract data which may throw light on the differing perceptions of the mothers and the health care professionals. From the mothers’ data it is possible to redefine from their perspective who is seen as the ‘expert’ in child-rearing.

The literature review at the outset of the study identifies the broad determinants which affect child-rearing on a universal basis. We have also identified influences which have been apparent at a more local level in the UK this century. Both the universal and the particular are now revisited.

**Child Rearing Across and Within Cultural Groups**

It has been accepted in this study that we live in a very varied society, in which people bring to the care of their children a range of beliefs and
practices, influenced by their own history and the contexts within which they live and have lived. In transmitting the culture through child rearing, parents pass on attitudes, values, behaviours and skills which are perpetuated through each generation. The strength of an enduring cultural heritage has been demonstrated to be linked to the amount of support the mother receives from her own or her partner’s family, and is reflected in the confidence young mothers show in their child rearing. This was most apparent in the Italian families.

The mothers' of the Italian families were the most likely to have their own or their husband’s parents living close by, and to be supported by them. Although many of the mothers interviewed had lived in England for all, or much of their lives, their child rearing practices continued to follow closely those of their parents, reflecting Spencer’s view (1983) that parents and families occupy the most powerful position of influence for each generation. It was also evident that in the two mixed marriages where the fathers were Italian and the mothers from the indigenous white population, the Italian culture was most strongly represented and those cultural practices adopted.

There were distinctive differences between the Italian mothers and the indigenous white mothers in attitudes towards leaving the children to go out. The reluctance of the Italian mothers to leave their children with other people was more to do with concern for the child, whereas in the case of the Bangladeshi mothers, the reason for not going out without the
children was related to the role and position of women in Muslim culture. The close contact with parents and possible sharing of responsibilities may mean that respite from child care is not viewed with such urgency by the Italian mothers. It is also expected in both the Italian and the Bangladeshi culture, by hosts and guests, that the children will accompany the parents on social occasions.

Major Determinants of Child Rearing Practices

Three themes were identified from the literature review in the first chapter as being the major determinants of child-rearing across many cultures, these were:

- economic survival
- family cohesion
- transmission of culture

It is argued that the research substantiates this analysis. The emphasis may change with the socio-economic context of the families, but these factors are seen to be important and consistent determinants of practice.

Economic Survival

Economic survival and family cohesion are necessarily linked in a rural agrarian culture, thus making the hierarchical structure of the family and a
fostered interdependence all important (Stopes-Roe and Cochrane 1989). Many of the Bangladeshi mothers in this study come from an agrarian context. They are now in a situation where for the majority of the mothers the extended family has disappeared, and livelihood is no longer dependent on a rural culture and cohesive family structure. This has meant an acceptance by many of the young mothers of the health visitor as an authoritative figure, replacing the older, respected women in the family. Consequently many early child-rearing practices are being suggested and adopted which are congruent with the health visitor’s attitudes and beliefs. The health visitor is also looked to for guidance in other aspects of the socio-economical management of the family.

Weaning, feeding, discipline, and attitudes towards family planning were among issues being challenged with the Bangladeshi mothers by the health visitors. In spite of religious beliefs there was evidence of some acceptance of family planning advice and also with some mothers an adoption of recommended weaning and feeding practices. Levine (1988) saw this adaptive behaviour as being influenced by one such demographic and socio-economic change that the Bangladeshi families have experienced. Added to this high fertility is no longer a primary goal essential for the support of the family’s economy.

Identified too in the Stokes-Roe and Cochrane studies and borne out in this research was the fact that young Asian people are seeking to become more independent. This is most noticeable in the discussions with the
young Bangladeshi women in the study. Some of the fathers were also keen for their daughters to have a good education and aim for professional jobs. Several fathers voiced this opinion during the interviews with the mothers, specifically those with older daughters in the family. The changing situation of the family has meant that young girls now have access to education, which was not always possible in Bangladesh. Expectations of working also means that women will be able to contribute to the family finances in a more concrete way. It may also mean that Bangladeshi mothers who have had access to education will become more independent in other aspects of their child rearing.

In Chapter One of this thesis it was noted that economic survival can be equally as important in an urban Western setting as in an Eastern agrarian one. This is illustrated by some of the indigenous white middle class mothers where the goals of maintaining a professional career, and living in a style consistent with middle class values in Britain, have meant returning to work outside of the home after childbirth. As a consequence of this they require a more disciplined regime for their children, with emphasis on regulated bedtimes and concern for establishing sleep pattern routines. For these mothers night time waking is seen as a major problem, even with very young babies, whereas it is accepted as normal baby behaviour by the Bangladeshi mothers.

Child care arrangements also become essential for mothers returning to work, a practice which may not be entirely congruent with the mother’s
value system. It has been observed in some of the mothers in this study that this can result in engendering guilt and conflict. The situation is addressed by Harkness and Super (1982, see Chapter 1) who suggest that parents often have to accept practices to which their own value system has not fully adapted. For the indigenous white middle class mothers the problem has been compounded by the influence of ‘the experts’, not least among them child psychologists such as Bowlby and at times the socio-political stance of politicians. Both imply that a mother’s place is at home, looking after the children, and that the child’s best interests are served in this way. The decrease in nursery provision after the second world war, noted by Hughes (1980), reflected the socio-political climate and endorsed the current thinking in child psychology. Leach (1996) speaking at a conference recently was also reported as supporting this view.

Feminist ideology is thought to have increased the dilemma for some women. Freely (1995), mother of four children, writer and journalist, reviews feminist literature and charges feminism with reducing procreation to the status of a costly optional extra, and consequently leaving mothers in the lurch. She claims that in her twenties when she was lured into feminism she was admonished by women 15 years older who had no children, and now twenty years later she is lectured by ‘femstars’ who are 15 years younger and behave as if children do not exist. She suggests that feminism lays aside its obsession with sexual politics, stops ignoring what women actually do and starts helping them to do it.
Freely sees the difficulty which has arisen for feminism in the 1990’s as being threefold. Firstly the women who are close to the top of their career ladder have to render their family invisible in order to prove they can cope. They less than honest with their employers time in an attempt to hide family commitments rather than admit that there are times when they are needed at home. Secondly there is a vast army of women who are low paid casual workers who work a second shift at home. This has created for the so called ‘liberated women’ a different kind of poverty and made motherhood for some, a series of child care crises. The third area discussed concerns the right of women to redefine ‘success’. Freely complains that the feminist discussion has been largely concerned with logistics or the price paid in terms of lost opportunities and fatigue, so that mothers are made into martyrs. The joys, rewards and pleasure of motherhood have been neglected by the feminists.

The decision to stay at home and bring up the children or to go out to work with alternative child care arrangements should be an option, says Roberts (1995). The feminists role in procuring this option should be to lobby for the facilities which make the choice possible; amongst these are better nursery provision, creches in the workplace which function at realistic hours and addressing the poverty trap in which single mothers often find themselves.
Family Cohesion

A disparate picture is presented across the groups of mothers in relation to family cohesion. The majority of the Bangladeshi mothers in this study live in close community groups. The men are linked by the fellowship of the Muslim faith and the local mosque, and there exists a community cohesion which to some extent has replaced the extended family. In some instances there are other relatives in different parts of the country. Customs and practices are reinforced by this cohesion. However the close relationship of young mothers, with older more experienced women of the same family, is often missing for the young newly immigrant mothers.

The Italian families in the study are shown to maintain close family and community links. For the first generation Italian families economic survival may have necessitated this. At present where parents are living in the UK it tends to be in close proximity to their sons and daughters. They remain very influential in the upbringing of their grandchildren and provide a strong support network for the younger mothers. Their views are respected by the young Italian mothers, who see them as experienced in child care.

Perhaps the least cohesive family groups are those of the middle class indigenous white mothers. The health visitors have noted a lack of family support due in part to their social mobility. A further consideration here might be the acceptance of the Western ideology of bringing up children to be independent. There have been suggestions in the study of a
reluctance on the part of both grandparents and the young mothers to be too reliant on each other. Within this social group it is also likely that grandmothers may still be in some form of employment.

Cultural Transmission

Transmission of a culture can be both overt or imperceptibly organic in nature: overt as in the circumcision of a Jewish boy baby or shaving the head of a Muslim baby, or as Leach has indicated (1989), an accumulation of a complex and entrancing folklore passed on through the extended family. These practices may have developed for a variety of reasons, amongst these, as we have seen, are likely to be the socio-economic context of the culture, religious beliefs, the environment which may be hostile to a baby and the attitudes and values of the parents. All of the young mothers will look to their parents for guidance if they are present. However there are differences in how the advice is received.

The Italian mothers unequivocally accept their own mother's advice, seeing her as being more experienced and knowledgeable than the health visitor. There were pragmatic reasons for seeing the health visitor such as developmental checks and immunisations, but she was not depended upon for child rearing advice by these mothers, neither were they reliant on child rearing literature. Family ties are strong in the Italian culture, and the historical significance of this as described by Ginsborg (1990: 127) is discussed earlier in Chapter Seven. Cultural transmission is shown in the study to be most powerful where families are still in close contact.
For the young Bangladeshi mothers, we saw from the health visitor interviews that there was a much more realistic expectation of how babies behaved. It was expected that babies needed a considerable amount of comforting, and that their sleep patterns took time to establish. Therefore night waking was not seen as a problem. Having grown up in a culture where babies were cuddled and soothed for much of the day by members of an extended family, it is seen as the norm.

It would be wrong to suppose that the indigenous white mothers, because of the social mobility of many of them, were not the recipients of a culture. The accepted routines of child rearing, and the ‘battle’ to have children conforming as early as possible to social norms are all part of the white middle class culture. Early independence and the willingness to leave babies and children in the care of others to pursue a social and working life is also in accord with the culture of independence. The mothers questioned at the NCT meeting discussed earlier, obviously felt strongly about the loss of their own independence. We have also had examples of grandmothers in this study, who are not willing to forego their own independence to take on the child care of their grandchildren. Advice from parents was likely to be weighed against other sources. The health visitor was consulted for advice but it was not always accepted without question. There was also considerably more recourse to the literature on child rearing. So it would seem that a variety of people are perceived as the experts in child rearing by mothers from differing cultures.
The Experts in Child Rearing

In the Newsons' early study (1963) the indigenous white British mothers questioned from working class backgrounds, ignored the advice of the professionals, and the current trends dictated by psychologists and the medical profession, preferring to follow their own instincts. What needs to be remembered is that there was little social mobility in this group and the extended family was close at hand. The health visitors taking part in the present research found that many of the young single mothers, all indigenous white, were from local families and had the support of their own mothers. They were also perceived as being more confident in their child rearing and the problems they brought to the health visitors were more to do with socio-economic issues. A similar situation existed with the travelling families, who, like the Italian mothers, consulted the health visitors for immunisations and developmental checks but not about child rearing problems. It would appear that the mothers across these three groups saw their own mothers, or the more experienced women in the extended family, as the 'experts' in child rearing rather than the health care professional.

Few of the young Bangladeshi mothers had their own mothers nearby to whom they could refer. Instead they looked for advice to those whom they saw as the 'experts'. This was mainly the health visitor or the doctor and sometimes the local pharmacist. Their concerns however were usually to do with health and not mothering. There was a confidence about their mothering skills which seemed to be transmitted by the culture. For both
the Bangladeshi and Italian mothers the literature on child rearing played little or no part in the decisions and practice they followed.

The indigenous white middle class mothers seem the most vulnerable, being often unsure of their own skills and not always having the support of the close family. Often well-educated women, they seek guidance and support from many sources: the literature, friends, family and the health visitor. They are also the major supporters of organisations such as the National Childbirth Trust, an organisation which counts few if any mothers from ethnic minority groups in its membership. The local branch meeting which the researcher attended consisted entirely of indigenous white middle class mothers. There were no Italian mothers nor were there mothers from any other ethnic minority. The main speaker for the evening was a health visitor who specialised in sleep counselling, a topic of major concern for many mothers in this group.

The plethora of information gathered by these mothers, who are often lacking in confidence, can result in confusion and feelings of failure if their babies do not fit into a particular mould. They do not necessarily see the health visitor as the expert she envisages herself to be but consider her advice alongside that of others. Writers such as Leach (1988), Stoppard (1995) and Kitzinger (1994) are still very influential. These well-known authors have also been joined by many more articulate confident women who have written about their personal experiences of child rearing. Having found an approach which works for them they want to tell others
about it. Essentially these are their experiences, in the context of their lives, and will not necessarily work for other mothers and their babies embedded in a different context.

We return again to the cultural ‘niche’ described by Harkness and Super (1982) in Chapter One and the critical importance of the individual characteristics of babies which can make adaptation difficult. This is especially so where cultural expectations are rigid and certain kinds of behaviour on the child’s part may create upset or difficulty. As Thomas and Chess (1982) have pointed out, the parents from the native born middle class in the New York Longitudinal Study (NYLS), made more demands on their children for the early establishment of regular sleep and feeding schedules than did the working class Puerto Rican parents. The children of the NYLS parents were also pushed to achieve early self feeding, self dressing and were expected to adapt quickly to new situations and new people, demands say Thomas and Chess which are especially stressful for children with difficult temperaments. Within the context of the lives of mothers in this study and indeed all mothers, situations they are confronted with in child rearing will present differently. A problem for one mother might not be seen as such to another, and vice versa. The health care professional’s task is complex. Empowerment cannot be a simple formula applicable to all mothers in all settings. If we are to accept the model of empowerment as a concept which informs the theoretical basis of health care practice a more critical appraisal is necessary.
Empowering Mothers

As mothers have differed in their perception of the ‘expert’ in child rearing so will the process of empowerment, as we were reminded by Rappaport (1984), be variable from setting to setting. Most professional help in the past has been focused on averting crisis, health surveillance and identifying developmental delay. Rather less focus has been on assisting parents to develop their parenting skills. Support without empowering, says Barker (1990), simply leads to ever greater dependence and reliance on the professional services. The Child Development programme pioneered by the Early Childhood Development Unit at Bristol University, suggests that the health visitor should go into homes without preconceived aims and objects. Her task, they say is to discover the parents aims and objectives and help them to achieve these. Effectively, says Barker, (1987) she endeavours to develop the parent’s own skills, to support the parents when necessary, but to leave adequate space for them to decide on their own priorities. There was evidence in this study that mothers were given choices but they were the health visitor’s choices and not their own. This produced feelings of frustration and powerlessness, as one IWB mother describes below;

I had breast feeding problems with the second baby, having fed the first successfully for nine months. My nipples were sore and cracked, it was agony. We were having bad nights, and I had returned to work after maternity leave. I desperately wanted to be
reassured it would be alright to give up breast feeding, but the health visitor offered options with the implicit assumption that I should continue to breast feed (IWB/M).

The democratic aspect of empowerment, described by Gibson (1991) earlier in the study, points to a redistribution of power. In addition to giving mothers the opportunity to voice their own views it must also include wider perspectives such as the advancement of social justice. This will entail health care professionals becoming more political, for a subordinate status is covertly assigned to the clients when the health visitor has to carry out such tasks as approaching other services on behalf of them. In many instances in this study, these situations came about in interactions with the Bangladeshi mothers because of a language problem which needs to be addressed more vigorously.

Empowerment can become an idealistic theory detached from the realistic problems of individuals and the realities of professional and political power. For those mothers whose major concerns are related to their low socio-economic status, and inadequate facilities to enable them to get out of the poverty trap a voice is needed at national level. Who better to do this than the organisation with the most direct contact with mothers, and with first hand knowledge of the problems which confront them? However there is a difficulty for health care professionals who may be subject to professional constraints on their actions from management and political agencies.
Some mothers in the study stressed that at times they wanted straightforward help. How should this be addressed and why is it such an apparent problem? The health visitors as an occupational group claim specialist knowledge, a claim reinforced by health visitors in this research. Robinson (1992) reminds us that to lay claim to a specialist knowledge makes it unavailable to the client and amenable for evaluation only to the particular group possessing it. This she says excludes from others the power to describe, define and control an area of life. Some of the indigenous white mothers appeared to be trying to gain control by searching for information from various other sources in order to make informed decisions. Sometimes this resulted in confusion.

The health visitors in this study said they were able to inform mothers of research to support their advice. This sounds very plausible, but is also attacked by Robinson (1992) who feels that power, i.e. knowledge, justified in scientific terms, protects the professional from political debate and non-professional examination. Life’s issues, she contends, are transformed into technical questions susceptible only to technical expertise, and when scientific issues move into the public health area democratic choice can cease to exist. On the other hand health visitors are faced with the difficult decision of offering what they see as their own ‘expert’ knowledge and accepting a democratic approach to a problem which may be at variance with their beliefs.
Breast feeding was presented by some health visitors as almost a ‘no choice’ option, examples have been cited in the study. Smacking children is also being pushed towards a law-enforced prohibition strongly supported by the Health Visitors Association and by Leach (1991), although Leach claims in her book on child rearing (Leach 1989), that she is not laying down rules or telling mothers what to do. There was also a feeling among the mothers that weaning before three or four months of age was unacceptable. There were several instances of criticism with regard to weaning reported by mothers in the study, criticisms which were upsetting to the mother and resulted in a breakdown of relationships with the health visitors concerned. The following three comments are all by Italian mothers:

The health visitor was very prescriptive about the quantity and number of feeds the baby should have, and how many meals a day. I felt guilty about not following this advice and sometimes lied to the health visitor (I/G).

I had such a bad time with breast feeding my first child that I decided to manage my second child in my own way and bottle fed her from the beginning. I ignored the advice of the health visitor and started to wean the baby at 6 weeks in spite of the health visitor telling me to wait until she was three months (I/I).
The health visitor was very cross with me and told me I was letting the baby put on too much weight (I/J).

Most mothers will comply only too readily with research findings when the safety of their child is an issue. Witness the stampede to change cot mattresses recently following the research by Bolton et al (1993), in which certain bedding materials were implicated in cot deaths. And also in response to research into cot deaths, the willingness of mothers to follow guidelines of putting babies to sleep on their backs. Mothers received much of the above information through the media and were generally accused by the professionals of panicking. The availability of information is empowering and mandatory in a partnership between health care professionals and their clients. Research findings should be part of the options which can inform choice, the mother’s choice.

The mothers who expressed the need for straightforward advice in the study tended to be the most vulnerable. For the most part these were the indigenous white mothers who doubted their own skills and ability in child rearing. Education for parenthood encompassing a wide spectrum of issues, psychological, emotional and practical which are implicated in parenting is perhaps the way forward. To leave this education until pregnancy is established is too late, as the health visitors observed. Discussion needs to take place among young people on how they envisage their lives may be affected and changed with the arrival of a child to care for. A recent BBC programme (Panorama, BBC 1 13/11/95)
explored with young couples how relationships can suffer between partners when they are unprepared for the changes a child will bring about to their lives, a situation voiced by many of the mothers during this research.

Policy Implications

Although parental choice and consumer satisfaction are verbally rated high on the agenda in the present business-orientated health care provision, it is not usual for parents to be consulted on the type of health care they would like to have available in the community. It was not apparent that any mothers were consulted in the local Health Visiting Review (1990) which set out to ‘Identify Client and Community Needs’. These were identified by the health visitors on behalf of their clients. In a recent letter to the Times newspaper Sir Duncan Nichol, Professor of Health Services Management, together with several other professionals in Health Service Management, made a statement in relation to the current Health Service situation in the UK, which included the following.

This debate must involve the public as patients, carers and taxpayers. No longer can the consumer be viewed simply as a token partner in health-care. Patients must be given the opportunity to become actively involved through the setting up of a patients standards board, and a consumer resource centre should be established for the provision of information to patients (The Times, 9 September 1995).
Partnership in health care needs to be a much more positive and active concept within community health care. Empowerment means more than parent held records. Parents should be true partners in decisions about their child's health and upbringing. Empowerment means choice for parents. A requisite for this is having the knowledge, information and resources for choice to be an option, enabling informed decisions to be taken by the mothers. For those mothers who lack the confidence which close family support gives, education for motherhood is strongly indicated well in advance of the first pregnancy.

An important issue which arose for the health visitors was the recognition that postnatal depression was a very real problem for ten to fifteen percent of new mothers. The use of the Edinburgh Postnatal Depression Scales as a diagnostic tool for the health visitor is now widely in use in many health authorities. There is no evidence to show that it has been standardized for those mothers who are not literate in the English language. As it is essentially a self report scale it is therefore either being used inappropriately, or some mothers are being excluded from this screening process. It is a powerful vehicle for the health visitor to exercise her therapeutic role of listening and supporting and for some mothers this service was not available. Therefore in this study neither the therapeutic role nor the empowering role of the health visitor were exercised equally across the groups of mothers.
For the health care professional, empowerment of mothers is a more demanding process requiring the acceptance of mothers as partners in their child's care and development, rather than consumers of a service. It also requires on the part of the professional patience while mothers explore their choices, and an awareness of the importance of the differing contexts of peoples lives. In communities which are a mixture of different ethnic and cultural groups the task for the health visitor is more complex. If empowerment is thought to be the most satisfactory way of supporting mothers rearing children, a strategy is needed which will enable mothers to identify their own needs and the best way for them to be in control of them. If the concept is to be meaningful in the discourse of health care professionals the political implications cannot be ignored. Skelton (1994) cynically claims that existing powerful groups whether governments or professionals are not going to hand over resources or responsibility to the less powerful, unless they can see a tactical advantage in so doing.

Evidence-based care with its emphasis on testability (Roberts 1996) will favour the medical model and undermine health visiting practice. Health visitors acknowledge that aspects of their practice is unquantifiable (see chapter 6). Roberts has argued that health care providers should be required to back up assertions of the effectiveness of their care. If, he says, service providers cannot restructure their service into a testable form it goes unchallenged and becomes established simply by custom and practice. He sees aspects of health visiting as having come about in this way and being expensive and no longer affordable.
Walter Barker (1991) sees ‘community mothers’ as an essential part of the way forward. These women will be recruited, trained and monitored by health visitors and does not, says Barker, negate our belief that health visitors are a unique and essential feature of our health service. His suggestions have been both welcomed and criticised by health visitors, one positive response was:

are we afraid that by empowering the public we disempower ourselves? (Ashdown, S in Barker, 1991)

This study was centred in an urban community of a moderate sized town. The cultural and ethnic mix of the inhabitants is probably characteristic of many urban communities in the UK outside of the larger cities. The research findings may then - with caution - be generalised to reflect child-rearing patterns and the perceived role of the health visitor as experienced by mothers in many similar settings. The experts who ‘legislate for mankind’ will be those whom the mothers accept as the ‘experts’ in child-rearing. These will be different people for different mothers. They will essentially be those in whom the mothers have confidence.

Further research
In summary, it is hoped this insight into the different attitudes and beliefs which mothers have towards child rearing and their perception of the support they receive, may be beneficial to those health care professionals involved with mothers and their children. This was a small scale study in
which fifty percent of the mothers have claimed that they did not receive the support they would have liked. It would appear that mothers have not been consulted significantly to gain their perspective of a desirable community policy. There have been other studies of a similar scale (Mayall and Foster 1989, While 1986 and 1989 and Cowley 1991) but a way forward might be a broader survey of mothers attitudes and views on the type of community health service which would be most helpful and acceptable to them. It may also require the health service concept of empowerment to move closer to Freire’s original interpretation, including community participation and community development. This may or may not involve the health visitor in the role she sees herself fulfilling at present.
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BIBLIOGRAPHY


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APPENDIX I
HEALTH VISITOR QUESTIONNAIRE

It would be helpful to have the following personal information. This will of course be anonymous so no name is required.

PERSONAL

Age...............  
Nationality..............  
Country of birth.............  
Number of own children (if any).............  

Professional qualifications Dates achieved

FORMAT OF HEALTH VISITOR TRAINING

Please give a brief description of your training, to include:

Length of course

Institution

Length of time on field work

Experience with children

Estimate proportion of course devoted to child development (please tick).


Any other information

PRESENT POST
Please indicate your average case load of 0 - 2 year olds.

**ADVISING PARENTS**

What are the most common problems parents wish to discuss in relation to the 0 - 1 year old infant? Please rank the following, 1 being the most common comment.

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<thead>
<tr>
<th>Country of origin</th>
<th>Bangladesh</th>
<th>Italy</th>
<th>England</th>
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<td>Feeding</td>
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<tr>
<td>Sleeping</td>
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<td>Elimination</td>
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<td>General Health</td>
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<tr>
<td>Child Development</td>
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<tr>
<td>Other Concerns</td>
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What are the most common problems parents wish to discuss in relation to the 1 - 2 year old infant? Please rank the following, 1 being the most common comment.

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<td>Sleeping</td>
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<td>General Health</td>
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<td>Other Concerns</td>
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- 357 -
When giving advice to parents or discussing problems with them, what resources do you draw on as a basis for giving information/advice? Please rank the following, 1 being the most useful.

- Personal experience with your own children
- Experience of other clients/parents
- Information from medical colleagues
- Courses attended
- Books, texts, articles

Other sources.................................................................

Please list any authors, books or other texts you have found particularly useful sources of information on child care and development.

Please list any books or other literature you would recommend to parents for guidance on child rearing.

Thank you very much for your time and effort in completing this questionnaire
APPENDIX II

THE MOTHERS' INTERVIEW SCHEDULE
Information for parents

I am a nurse tutor at the Hospitals for Sick Children, Great Ormond Street, and am engaged in a study of the child rearing practices of healthy children. This will be helpful for nurses in children’s hospitals who need to understand the backgrounds from which children come in order to meet their needs more effectively.

Any information given will remain anonymous. Thank you for cooperating in this interview.

Parents

Age

Nationality

Country of birth

How long in this country

No. of children

Occupations

Maternal grandparents

Nationality

Country of birth

How long in this country

Paternal grandparents

Nationality

Country of birth

How long in this country
<table>
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<tr>
<th>Infant</th>
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Temper tantrums

Management

Initiating factors

Punishment/discipline

Toileting/training

Commencement

Attitudes towards training

Habits

What is considered as a habit

Views about these

Parental roles

Involvement of both parents (other relatives?)
Leaving the children to go out

Possible? Desirable?

Attitudes to this

Who is the child left with

Help with the children

Useful Literature

Use of Health Visitor
APPENDIX III

HEALTH VISITOR INTERVIEW SCHEDULE AND THREE EXAMPLES
Personal Information

How long have you been a health visitor?

What made you choose this branch of your profession?

Do you enjoy the work?

Health Visitor Role

What do you think feel are the most important aspects of health visiting?

What do you personally find most satisfying about your job?

What are the frustrations?

The Health Visitors Perception of her Client Group.

How would you describe your own client group in terms of their social and cultural traditions?

How would you say they differed from your own social and cultural background?

Do you find the situations you meet with various clients require different approaches? How might they differ?

Do you ever encounter what you would you consider 'sensitive issues', what would these be?

How would you set about establishing trust when it seems important to discuss these issues?

How do you decide what approach to use in different situations?

Health Visitors as Professionals

What do you feel is the health visitors specialist knowledge?

How is it gained and maintained?

How would you see this differing from parents and other family members who offer advice to young mothers?

Why do you think some mothers prefer to accept the advice of mothers or friends rather than professional advice?
How would you justify the interventionist approach of the health visitor?

Do you feel that a client has the right to accept or reject a health visiting service?

Why do you think some parents see your role as a policing role? Does it concern you?

What about the concept of prioritizing your work load? What criteria would you use for this?

One of the stated principles of the CETHV is "To stimulate an awareness of health needs". How do you think this can be achieved?

How do you think that the socio-cultural background of clients might influence their receptiveness to this?

The CETHV talked about "promoting a responsibility for health in clients." do you there is any moral purpose underpinning this notion?

Approaches to Child Rearing Practices in Client Groups:
Vignettes from parent interviews.

Most mothers seem to accept that breast feeding is best for their babies, but many still choose not to or do not continue for long. Would this be true of your client group? What are your feelings about breast feeding?

What do you feel about early potty training? How would you respond be to a young mother who was proposing to start potty training her baby at six months of age?

What are your feelings about mothers taking crying babies or infants that will not settle into their own beds at night?

How would you advise a young mother with three children, two of whom were at primary school, who said that although she put them to bed each night by 7.30pm. they all ended up coming downstairs every night and falling asleep on the settee. Her husband did not object to this and felt it was unkind to expect them to be upstairs alone. She felt she had no time to herself.

A young mother said she had been advised by an aunt with whom she lived to ignore baby’s cry, and let him cry himself to sleep. This distressed her but she felt the aunt knew best.

What do you feel about leaving babies to cry themselves to sleep at night?

Does bedtime crying seemed to worry young mothers in your client group very much? If so what would be the approach to this problem?

Have you met any cultural practices in child rearing which have concerned you?
What sort of queries and problems on weaning do you encounter?

Do you meet mothers who follow specialist diets, such as vegetarian, vegan, wholefood health diets, and does this present any problems?

If a mother volunteered that she disciplined her 2.5 year old with a good hard smack that really hurt, and her husband’s family did not approve or believe in physical punishment, how would you respond? What are your own views on smacking?

Some of the young mothers seemed to have problems adapting to the change in their lifestyle which a baby brings. Why do you think this is so?

One young mother was very frustrated as she had given up a prestigious job when the baby was born and her husband who worked long hours never wanted to go out in the evenings, even if she arranged a baby sitter, she said their relationship had become very strained. Are you able to help couples having these sort of problems?

Is the current high level of marital breakdown a factor in your work? Do you feel single parents have specific needs?

Health Visitors view of her Role both National and Local

What do you see as problems in the health visiting service as it is defined at present?

How would you like to see the role of the health visitor develop in the future?
MS How long have you been a health visitor?

HVI Thirteen years.

MS What made you move into this branch of your profession?

HVI Selfish reasons really. I finished my General Training and then got married and had the opportunity to work in a small District hospital in the children’s ward. Whilst I was there was an enormous amount of contact with the health visitors. During that time I realised that health visiting would be a much more practical job if I had children. Then when I had children I was able to do a job share, and have managed to clock-up 13 years of health visiting.

MS Do you find it a satisfying job, having moved into it?

HVI Yes, yes I do.

MS You do? What are the most enjoyable bits?

HVI Its very nice being your own boss without those sorts of restraints. I feel it has improved since we moved into Doctors’ surgeries and they can see what we are doing and you can communicate more with them, and we are much more appreciated.

MS Do you feel then that in days gone by your role wasn’t fully understood?

HVI Definitely yes. It is the sort of job you need to spend time in as you don’t get results immediately and it can take up to a year to build up relationships within a case load, but it takes longer than that to get to know the doctors and build up their trust.

MS What about frustrations within the job. Do you find there are any?

HVI Lots and lots.

MS Tell me about the major ones which concern you.

HVI If you let it the job could be really depressing. For example if you try to set up a group, for instance a post natal group, you will always get the converted. You never actually get the ones that need to come, that can be said about any aspect of our job really, and I don’t know that we are achieving what we aim to do. That is trying to change peoples attitudes and increase peoples understanding of parenting. I don’t feel that we achieve that at the end of the day.

MS Do you feel that you achieve it with one section of society and not another?

HVI Well yes. When we run courses the converted come and even if others come from a different social group they don’t really fit in, so they stop coming

MS How do you feel you might reach the others if this approach is not working?
I don’t know because our job has become more and more desk bound that we do less home visiting than we have ever done before, and nothing can replace home visits.

MS
Is that policy, or is it because you just don’t have time?

HVI
It is partly time and partly case load size, and partly the way we now work. We don’t keep popping round to peoples houses any more. If we visit now it is for a very specific reason. Otherwise it is not considered to be ‘cost effective’.

MS
What about your client group. How would you describe them socially and culturally?

HVI
A very mixed group. I cover an area of the town which has a large amount of council housing. Consequently I suppose they are a little bit further down the social scale. I also have one small pocket of middle class professional couples, so quite a cross section. I also have lots of unmarried young mums who are on benefits, and who are not living with their partners. I also have a large group of elderly clients and as a knock on effect of that we have in this practice many of the old extended families in St. Albans. So we tend to keep families quite far-reaching.

MS
Do you see some really big differences then across the cultural groups?

HVI
Yes we do.

MS
What about the young unmarried group. Do you see them as having specific problems or are they confident with their babies?

HVI
I think they are quite confident and there is often a good support network of mothers with extended family nearby, which quite a lot of them have got. They certainly don’t have the problems that the middle class families have who have moved here for job reasons. They have no extended families and are therefor much more isolated. Though of course they have other problems. The girls on benefit seem to fall into the same categories. They get themselves lumbered, get themselves rehoused, and this is what they seem to aim for, getting their house and their own baby. With or without a partner. Some of them don’t see that as necessary.

MS
What would you see as their main problems, that they would either express to you or that you would identify as a problem?

HVI
They would see their problem as housing. I would see a longer term problem, that of children being brought up with only one parent. Children spending an enormous amount of time being influenced by different things from those of children with two parents. There is a lot of TV and not very much outdoor activities and the knock on effect of that...fairly anti-social behaviour. A lot of children are in front of the television when you get there and still there when
you leave. It depends what sort of support these girls are getting. If they are getting support from their mother it is different, but if they are stuck in a flat with no garden it is not very easy for them.

MS What about other clients. Have you any Bangladeshi families?

HVI I have a few. They are mainly second generation families and they are fairly well established. All of mine live in Dellfields because that’s where they all want to live. They are all together there. None of my client group have any specific problems. All of the women are learning English.

MS Do you ever have to go into to any of those families because of what you would see as a sensitive issue, or with a hidden agenda?

HVI No not really. There is the issue of contraception. I have gone along and taken women to the family planning clinics, but they have wanted to go. This used to be a sensitive issue but is not now.

MS What about your other families in relation to sensitive issues?

HVI I can’t think of anything.

MS What about child abuse? Would this be seen as a problem or something to go warily with.

HVI No. I would be open and up front. Parents hold their own records and we share information. They would know why I was visiting if this was on the agenda.

MS Can we talk about your specialist knowledge as a health visitor. What do you feel is special about your knowledge as distinct from other branches of the profession?

HVI I think child development, and health needs across then age spectrum. We do have a large elderly population.

MS Where do you think you have gained your specialist knowledge?

HVI I think a nursing background helps, and then experience with other clients and courses.

MS Do you feel that the advice and support you are able to offer is more helpful or valuable than that from other family members or friends?

HVI Yes, because we can be more detached from the problems. We are not emotionally involved and thus can have a more rational approach. In the lower social classes the mother’s influence can be very strong, whereas the educated women will listen to several peoples advice and make her own decision. The middle class mothers will have a list of questions written down for you when you visit, and their problems in
perspective are quite minor issues. Whereas a mother with five children from a lower social class group laughed when I went through the post-natal depression scale with her. She said it can’t be any worse than it has already been, can it?

HVI Mind you the middle class mums have their problems. They are often isolated and it is a big adjustment to make from going out to work as a professional woman to being at home with a baby.

MS Do you find they have unrealistic expectations of motherhood?

HVI They have unrealistic expectations of both themselves and their children. For themselves they want to get back to work and feel guilty. They are not prepared for the mess children make and the hard work involved.

HVI One of my major concerns is the mushrooming of bright shiny private day nurseries. The mothers are impressed by them. They receive children from 7am. to 7pm. and I feel it is nothing more than institutionalized care for these children. There is no opportunity for the children to become emotionally attached as there are so many staff changes. The mothers see it as an ideal opportunity to go whizzing back to work in London.

When I take my antenatal and postnatal classes I make sure the subject is discussed and I make no bones about my view of either a nanny or good childminder being preferable to a day nursery. I know for a fact that these children at the day nursery never get taken outside because of the shortage of staff.

MS Do you think anything can be done about the lack of insight into real world of motherhood for these middle class women.

HVI Well I think it has definitely got to be part of general education. Parenting skills and a realistic picture of what motherhood entails. Especially important where the extended family is not around.

MS In terms of general child rearing practices do you have any strong views, about such issues as taking children into bed at night with the parents and discipline.

HVI No not really. Many of these things are cultural and if the family accept it that is up to them. The official line on smacking is laid down for the health visitor and I would have to suggest alternative methods of discipline, but again one has to be realistic about the odd smack.

MS How would you like to see health visiting develop in the future?

HVI I think the practice attachment is a good thing, and I would not like to see home visits disappear as these are the bread and butter of
Management seems to be in a mess it is one directive after another with no grass roots support. This definitely needs sorting out. There is also a slight worry that we become too medically orientated working so closely with the GPs, because the GPs are purchasing 'us' we may find they develop their own agenda for us which would be different from the philosophy of health visiting as an holistic approach to community health. It will need to be seen as cost effective and may mean chasing immunizations and child surveillance checks.
How long have you been a health visitor?

14 years.

What made you choose this branch of your profession?

Well I had been in hospital for 16 years and I felt I wanted to know what happened to children beyond 10 days. That was my initial reason for going into health visiting.

Do you find it satisfying?

Oh yes. I like working on the community in preference to being in hospital. I would never go back into hospital. I like being my own boss and managing my own work. I also like the preventive aspect of it. I am very much involved with the breast feeding initiative in this area, and a lot of my work is involved with breast feeding, and because I am allowed to organise my work I am able to pursue this.

Are you given total freedom to organise your work in the way you want to?

Yes, my case load is organised for 15 hours a week on health visiting and 1 hour a week for breast feeding very specifically, which I accumulate and use for either in-service training with other health visitors and I run a breast feeding clinic.

So there is quite a bit of autonomy really? Are there any frustrations in the job?

I would like to do more breast feeding but as far as health visiting goes, non at all.

In your health visiting role how would you describe you client group in terms of their social and cultural backgrounds?

Middle class white with a few exceptions. I have one Bangladeshi family and several second generation Italian families.

Do you find any differences across the three groups?

Oh yes. The one Bangladeshi family I have got are plonked right in the middle of a new private housing estate, very much a white middle class community belt and they are very isolated. A poor family with three young children one with bad eczema. They go to the local school but the children haven’t got very much English. Dreadful teeth problems. They don’t go to the dentist regularly.
Why do you think they are so isolated?

They are way out of their depths there. They haven’t got the language. The people around them don’t speak to them. Mother doesn’t speak any English. The children haven’t got any toys to play with and it is very difficult to do any work with them. I feel sorry for them because they would be much better in a community where people could communicate with them. They are housed up there by the council. That is unfortunate for them.

Do you see their problems as being very different from your other clients?

Oh yes I think so because they are not able to ask for the right kind of help, and the communication problem has meant that they haven’t had the dental care they need.

What about your Italian families?

They are fine. They are culturally different. Compared to other English around them they have a different outlook on children, perhaps they are more important to them. They give that impression. They come up to the clinic a lot with little problems they want to iron out. They do seem to be more child orientated than the local population.

Does this come out in any way in their child-rearing?

I think the children are babied more. I think the indigenous population are more concerned about making their children grow up. Certainly with breast feeding the Italians turn a blind eye but if you are breast feeding beyond 6 months in the indigenous population you are considered abnormal.

Does it seem to you that the Italian women breast feed for longer?

Not necessarily because they are influenced by the population they are in, but I think they are more tolerant of it.

What about sensitive issues across the groups. Would there be things that you would consider sensitive issues?

I don’t think I have been aware of any particular sensitive issues. Could you give me an example?

What if you had been alerted to say child abuse in a particular family? Or would there be anything that you went into a family feeling a little bit tentative about bringing up?

I don’t think I would deal with it any differently with any family. I suppose when I go to the Bangladeshi family the place smells of
curry and I don’t know whether the people living around there would pick upon that and object to it, but nobody has ever come rushing to say that they don’t like these people living next to us. It is very obvious that they don’t care for their garden and the curtains aren’t very attractive so I would imagine they are not very popular although they are very nice people. But I don’t suppose they have been given the chance to get to know the local population. They are very poor in their own right.

MS I would like to ask you a bit about the health visitor as a professional and what you feel is your specialist knowledge.

HVH I would say identifying health needs. I think most health visitors would say the same. Identifying problems in any family and trying to resolve them.

MS Where do you think this specialist knowledge comes from?

HVH I suppose mostly experience, and we are always going on courses to keep up to date. We also get a lot of ‘expert’ knowledge from our health visitor journal, which has a lot of update knowledge in it. Obviously we are updated on all relevant issues such as child protection. I think basically though identifying health needs. I am very interested in public health. I do a child health clinic and I think that may be threatened if we become employed by GP’S, they are not likely to want us working with other client groups. That is a worry. In this area we are lucky in that as yet we do not have any restrictions. We can at the moment deal with local needs in our client group and then we can get together and have a joint campaign on something like ‘how to eat healthily’. We might invite schools to come in, or other groups to have their blood pressure taken. That’s public health.

MS What do you feel then about the home visits?

HVH I love them, but I do very few. I think it is essential to make a relationship with the client you are working with so I very much believe in doing an ante natal visit before the baby is due. It makes it so much easier after the baby is born. It helps to get to know how somebody thinks. It also helps in identifying post-natal depression.

MS Do you feel that your mothers appreciate home visits?

HVH Oh yes. My clients expect it. They have their visit ready for you. It gives them more chance to relax and talk to you than if they come up to the clinic.

MS Do you feel that they use you for help and advice in a different way from what they would use their family or friends?
I think if you explain your role clearly then they do. I always make an appointment as I haven’t got time to waste knocking on doors if people aren’t going to be there. I also have specific remit in my mind about what we are going to discuss, so the client is quite clear about why I am going. We keep it to a minimum.

So you go in with an agenda?

That’s right, and I tick them off in my mind. Specific issues I will discuss certain issues.

Do they ever bring up different things?

Oh yes, absolutely, but I always make sure I cover the things I have gone to deal with.

Do you think that your input would be more acceptable than the mother’s family or friends?

Not necessarily unfortunately, they are willing to listen to their own mothers before anyone. It comes up time and time again especially on feeding where the grandmother would advocate what she was doing 20 years ago. The willing participant will listen to what you have to say and not necessarily follow it through. You can only advise on the latest research.

Do you find you are always welcome?

Yes. I haven’t not been invited into a house for a long time.

This is an interventionist approach would you say?

Yes you are trying to get in and talk about safety before the child the child is in danger and weaning before they begin.

But do you think we still have the right to go into homes and give our advice. It started a long time ago when public health was a major concern in child mortality.

I think it could be seen as interventionist, you have to make them feel that it is their own idea. I did a first visit the other day and went up to see the baby and their was a cat on the bed and no cat net. I said quite strongly that that was a very dangerous practice and I don’t have any qualms in doing that. How you say it is going to make a difference on whether you get back into that house.

You still are one of the few people who are allowed to enter homes.

I think that people do expect us to go in. The complaint is more that I don’t know who my health visitor is.
MS Do you think people have the right to reject you?

H VH Oh yes. There are three health visitors here, sometimes if we are not happy dealing within a client we swap them round.

MS Do you think that some parents see you as having a policing role?

H VH Yes, and that is the importance of the ante-natal visit. Where you can actually explain your role. I am suspicious of a family at the moment where I think that something might be going on and I think the mother is suspicious that something is going on as well, but she doesn’t know that I am suspicious of her.

MS So you are going in with a slightly hidden agenda because you have this feeling something isn’t right but neither of you are discussing it openly.

H VH She knows I am concerned about the family, but she has never asked me why I have gone there, and I haven’t had to explain that I’m have had an anonymous phone call, (laughs).

MS So she may be fully aware the reason for your visits? Do you think your different client groups see you in a different way?

H VH Oh yes, the Bangladeshi families see you very much as someone who helps. Every time you go there they want you to read something or write something for them. You are very much seen as someone who will do something for them. Very welcoming. I do try and keep it on a very professional level, although I do bend over backwards with a PR job on the first few visits. It does make it difficult though if people then disclose things which you have got to go and report.

MS Some time ago the Council for the Education and Training of Health Visitors, (CETHV), talked about promoting a responsibility for health in clients. Is this principle followed and do you think there is any moral purpose underpinning this? and do you find any difficulty in these directives?

H VH If you agree with what they are trying to promote then that is not a problem.

MS What about such issues as smoking where the government still allows cigarette advertising and you have to push the health risks involve?

H VH Well for me that isn’t a dilemma. I don’t think they should be advertising. I think we do have a political role. I think we also have to be the champions of women’s rights as well.

MS Just a few questions about child rearing. You are obviously quite committed to breast feeding so what do you feel about mums who decide not to?
Well I always make that quite clear to them as I am also a local counsellor for the NCT. and they all know me in that role, so it can be difficult for some of the mothers who feel they can't talk to me about bottle feeding. So I have to make it quite clear on my ante-natal visit.

MS 
So it would be their choice?

H VH 
Absolutely, I am in my role as a breast feeding counsellor to help those mothers who want to breast feed and are having difficulties.

MS 
What are your views on mothers taking children into bed with them if they won't sleep.

H VH 
Fine. The only time that we say to mothers that they shouldn’t take their child into bed with them is if they have been drinking, that can be worry. The only time babies have died in this situation is when the parent was drunk. Sometimes I do draw attention to the baby getting too hot and the link with cot deaths. Most of the families do use duvets.

MS 
So it would really be for the safety aspects you would advise against it.

H VH 
Yes. I think the mother should get as much sleep as she can.

MS 
Do you find that Italian families tend to keep their children up later?

H VH 
Yes, but that is their choice. I only expect them to ask for my help if they want to change.

MS 
Do you find that young parents today have unrealistic expectations of motherhood?

H VH 
In spite of going to parentcraft and ante natal classes. It is a bit late, though to talk about the realities of it when they are already pregnant. I don’t think they are going into it with the wrong ideas as they are often terribly well informed. I think it is about practical things like not getting enough sleep, not realising what it is like to get up two or three times in the night and then demands a small baby can put on you. Pictures and leaflets on child-rearing all make it look so easy, you don’t see the baby screaming for hours on end.

MS 
Do you feel that perhaps womens’ roles have changed over the years they are less prepared.

H VH 
They are all keen to get back to work for one reason or another. I think they are also pressured into feeling that they have got to be a perfect wife, mother and housewife and still do a job.
You don’t think any of the mothers feel it isn’t totally there responsibility?

They can have unrealistic expectations of their partners. Many men don’t want to be very much involved in child-rearing especially when they are small babies. Either that or they are on their own and they don’t want anything to do with their partners.

What about smacking, what are your personal feelings about it?

I don’t approve of smacking myself it doesn’t give the child the right message. I can understand why people do smack their children. It depends what the smacking is about really. If the child runs into the road then I think that is the parents fault for not having reins on. The child probably doesn’t need a smack anyway because it has had the fright of it’s life. I can’t really see any incidence where it is justified, people who smack and are unable to cope.

You wouldn’t see any justification for smacking then?

I suppose if a child has broken up all your lipstick or something it would be very difficult not to give a smack. I don’t think it can ever be justified.

How would you like to see the health visitors role develop in the future?

Well I wouldn’t like to see any more reduction in home visiting. For me it works very well and I don’t really want to see any changes. Too much of our time is taken up on clerical duties and computer entries. I do think the visits I do now are more effective than when I first started and did them in a random way.

And you definitely feel that mothers value the home visit?

Well I hope they do. Quite often they will ask you to go round. I wouldn’t like to see less home visits.
Can you tell me how long you have been a health visitor?

About twenty years, with some breaks when the children were born.

What made you choose this branch of your profession?

It is varied and interesting work, and it fitted in with the family.

Do you enjoy your work?

Yes, at times it can be very satisfying.

How would you describe your present client group in terms of their social and cultural traditions?

Well I have recently changed my responsibilities. For a number of years I have looked after the travelling families, but now I have taken over from HVX and my main client group are the Bangladeshi families.

Tell me about the travelling families first.

Well they are usually very responsible about immunisation and developmental checks. For some time now they have held their own records, which is a great help when they are travelling around, and even if they can’t read they still produce them and ask you to check what the children are due for. Some of the families are on permanent sites and others turn up at frequent intervals, so you do get to know them.

And now your case load is mainly Bangladeshi families?

Yes, approximately 170 families. I also have a mixture of English, Pakistani, West Indian, Italian and Moroccan families. I have had this case load for two months. I have worked before with Indian and Pakistani families but not with Bangladeshi families, and I am finding it very different.

Can you say what’s different?

Yes. I find that there is a difference in their attitude towards health professionals to start with. They are very much more demanding of what they think I should be doing. Which is unusual with Asian families, who I have found generally not to be so demanding. These are just first impressions, as I haven’t really had time to get to know them well. There is also the problem of the women having to stay at home more, whereas with other Asian groups, you do not get this so much. Larger families too, which is not so common with Indian families.
Is this more traditional with Muslim families?

Yes, they will have 10 children quite happily.

Do you think the demanding may be something to do with the fact that they are the most recent immigrant group in the area, and have been identified as having problems, and perhaps there has been a lot of input into these families?

Yes I do think they have been given a lot of attention and a lot of different people trying to get in touch with them and make changes. When you look at the number of people going into each family from education, housing, social services and health. There is an awful lot of input.

What sort of problems do they approach you with?

They approach me with financial problems, social security problems, problems with children at school, that is older children, problems that they might be having with a disabled child. Those are the sort of things that they come up with. With the younger children and babies, its not eating, that is a major thing.

Are they concerned about that or are you?

Yes, it tends to be something that they raise at clinic. Skin problems are another concern. They are the things that strike me, but a lot of the contact that they want to make with me is about social security and financial benefits, and housing.

Do you consider this a part of your job?

I do consider it part of my job. Some of the other agencies do have link workers so I am able to siphon a lot of that off, as there is much more appropriate use of my time than sitting in their houses filling in forms. I am certainly prepared to discuss benefits but sitting filling in forms is using up a lot of expensive time.

What sort of issues would you be keen to tackle in their situation?

Well I would like to get the ante natal classes off the ground a bit more as there is a lot more preventive work could be done in the ante-natal period. Then the previous health visitor started the 'Dellfield Project'.

Would you like to tell me about that?

It is a project particularly aimed at the Bangladeshi families and the anaemia which has been noted in the toddlers, and that needs a lot more input into it and again would be highly preventive.

Has it been identified in a real way, by blood testing, or is it something that people feel is a possibility?
I think it started by observation of children, and then there were three of four toddlers that I can think of at the moment, that were referred to the paediatric clinic and when a routine blood was taken they were shown to be extremely anaemic. We don’t know the extent of the problem yet but we have been alerted to it.

But do you think this could be so with children from other cultures too, because I can think of lots of children from indigenous White families who are pale and thin.

Well from the research I have read, and a recent conference I attended which discussed follow on milks and how all children need them, it seems that there are particular groups more at risk, and the Bangladeshi community might come under one of those groups, because of feeding patterns, and non-availability of Halal baby foods. Also prolonged bottle feeding. I wish we could have a proper screening programme here and then we would know what we are doing. At the moment we feel we are working in the dark.

But there are two Halal butchers quite near to this estate.

Yes, but going back to the adults they don’t think that giving meat to the babies is an appropriate thing to do, and they just give egg custard and semolina forever, with the odd bit of vegetable here and there but not meat, and a bottle of milk is seen as the most important thing to give to the child.

What about the men in the families. In the group I interviewed several of the men had been in this country a long time, and spoke English quite well. Isn’t it possible to get the importance of the need for iron in the diet over through them?

Certainly you can try and communicate those ideas but whether as a cultural group they take them on is another matter.

Apart from this health problem do you encounter what you would consider to be sensitive issues with these clients?

Contraception.

Contraception is a sensitive issue? In what way?

Certainly talking about it with some families would be quite difficult, and because of the religious feelings about contraception it is a very difficult thing to do, and I probably haven’t looked it yet properly as I don’t know the families very well, but that is certainly my first impression.

Is it because the women are not receptive to it or what?

I think the women are receptive to it but the men aren’t. I think the
women would quite like to have a rest between pregnancies, but the
men see it as a threat to their religious beliefs.

MS So do you ever get the women approaching you independently?

HVD I have in the past, and they have said that their husband doesn’t
want contraception but they do, and that is difficult, but not yet
with my new client group.

MS How have you dealt with that situation?

HVD Well, I have looked at the woman with a problem and tried to get her
help with what she feels she needs and referred her to a family
planning clinic or a doctor for advice. That is very tricky because
it makes it seem as if I am colluding with her against her husband,
but on the other hand she is my client and I feel I must treat her as
an individual.

MS Would you ever see the man and wife together in this situation?

HVD Oh yes, yes. In fact a man who has lived here for a number of years
brought his wife to the clinic last week. She had just arrived in
England and has three children already. He wanted to discuss
contraception. He said he wanted lots of children but he wanted his
wife to have a gap, but in lots of cases the man would not want to
talk about contraception or indeed have anything to do with it.

MS Do you think that there is a need for health education classes for
the men or with the men included?

HVD You would need a man to be leading them, and you would need someone
with a lot of understanding of the cultural background. At the local
surgery which has a mainly Asian client group, the practice nurse has
started a group for diabetic men. She had a lot of difficulty
getting them to attend but once they were there they were quite
receptive.

MS When you go into the families are there any particular differences
you have noticed in relation to child rearing?

HVD Well there does seem to be differences in patterns of discipline.
The health visitor who had this client group before me has had to
take cases to child protection, where dad has been reprimanding the
child and gone over the top, and the family has been warned that this
is not acceptable in this country. They can’t beat their child when
its been naughty, and it has been a case of explaining the whole
system to them but the cases have not been taken forward and the
child put on the register. It has been more of working with the
family to show different ways of disciplining children.

MS And would they object to this?
Oh yes, because if there child has been naughty they see it as their job as parents to discipline the child. They would not see that anyone outside of the family should have anything to say on the matter.

If you had to go into a family where you had been alerted to this sort of problem, would you go in with a hidden agenda or would you tackle the issue in the open?

I think nowadays you have to go in a very open way. You may have been talking to the families before the crisis. I have had an Asian woman who used to come and see me because she was being badly beaten by her husband but she did not want me either to visit her home or be helped by the women’s refuge worker. She would only come and see me in the clinic to relieve her feelings. She is still living with her husband and would not want the situation to be discussed with any members of her family.

It does seem to be a very close cultural group. What are the main differences between this group and other clients that you have?

It does seem to be a very secure family unit for children to be brought up in as there are so many people around. Of course it can be bad, but where there aren’t any pressures. It means that children have a lot of adults to relate to, lots of aunties and uncles and other children to play with. A very closely knit family set up. I am just trying to think of other cultural groups that I have worked with. Not much to do with Italian families, the Moroccan families have a very similar close knit community and family life.

What about other child rearing problems. Sleeping?

No, no problems.

Night time waking?

No. Never raised as a problem. It seems as if the families just accept that young children are going to be wakeful and demanding and be in bed with their parents and that’s accepted and that’s fine. Neither are temper tantrums an issue. You don’t observe many Asian children lying down and thumping the floor. I think that up to a certain age everything is done for them.

There is no frustration then in the early years?

No, but then there is a sudden cut off point, which must be very tough for that child. I think in those early years when English parents stand up to their children the Asian families tend to give way.

Do you think English parents start to do this too soon?
Yes, we do. People talk so much about behaviour problems in the under fives and they are really unrealistic expectations of the child. They also expect babies to be sleeping through the night at three months of age and if they are not then that is seen as a problem. They are not realising that children ‘will’ wake up in the night, whatever age it is. We expect children to be in their bedrooms for long periods on their own whereas Asian children are never on their own and not expected to be.

This I suppose can create many of the problems which the indigenous white population bring to you?

Yes, but then they are often on their own with no family support, and the Asian women would not be expecting to do so much in a day.

Do you find in the indigenous white population that there are unrealistic expectations of motherhood and of the infants behaviour?

Oh yes we do have this dilemma, and we do try and deal with it at some of the ante-natal classes. We try and get the mothers then to face the realities of having a child. But often they don’t want to look at it then, they are more concerned with the delivery, but then 6 months later they are saying "I wished somebody had told me what it was really like."

Can this problem be got over?

Well I think that young boys and girls these days don’t see children around in their families, so they haven’t got contact with babyhood to know what it is really like. Its just another thing that we do and have these days. We have a house and a mortgage and a car and then a baby.

Do you ever see couples together to discuss any problems they may have?

I don’t actually see couples much outside of ante-natal classes. I know one health visitor does quite a few evening visits. I know that there can be quite a reaction from the fathers. They can often be shocked and low after they have got the baby, with all the concerns and worries they may have. It isn’t just the mother who has them all. I have one English father among my clients at present who I am quite sure is post-natally depressed. He is showing all the symptoms, anxiety and waking up at night, and we are not really addressing this problem, and of course we are encouraged to do less home visits and to try and see more people in the clinics where we are not going to pick that up at all.

One thing I did want to ask you was about your specialist knowledge that you have of families. Where do you think you get this specialist knowledge from?
Firstly I think our training helps because we are asked to look at social groups and families their psychology, and how they function. So it starts you looking wider than looking at somebody with an illness doesn’t it? I suppose it builds up and during your training you are under supervision the whole time so that you can talk about things with the person who is helping you.

And in relation to child rearing, how do you think that your knowledge might differ from that of the other people mothers tend to consult with their child rearing problems?

I suppose because we have quite a lot of research at our finger tips, and we are updated the whole time with things that are going on, that’s a good base isn’t it?

Yes.

We are often confronted with..."My mother says this, a parenting magazine says that and I have been to a post-natal group and heard this, what do you think?" Well, there often isn’t a cut and dried answer but the health visitor can sit back and say, "Well all of those things may have an element of truth but what do you think is right for your child?" The health visitor can help the mother to look at things more objectively.

Would you get the same sort of questions or approach from your Asian families?

No. They trust you immediately. There is a tremendous amount of trust and instant respect which one is not really used to from the indigenous population. You have to prove yourself with them, they talk about what you have said and weigh up your worth, whereas the Asian families accept you immediately. There is sometimes a conflict between the advice of mothers or mothers-in-law with the indigenous population. I suppose that is what health visitors can do with mothers, because everywhere they turn someone is telling them something different, and the health visitor can help them to realise that they have got to find the right way and no one can actually tell them that. We can tell them what is available and what the research says and they must find their own way.

What about the common problems, like sleeping, or not, and night time crying. Do you give options here?

Yes, when I do have sleep groups, I present it to them that all different cultures do different things and it is going to be up to them to do what is right for them. Some will have fairly fixed ideas about when their child should be sleeping and others will accept that what the child does is ‘childish’ behaviour and be quite happy with it.
MS What about discipline?

HVD My usual theme is that children like to know where they are, and like to know what is what, but how firm they are with their children is largely up to them.

MS What about smacking?

HVD Yes, we have our ‘No Smacking’ guide now, I could do with a course on that. Parents often ask, "Do you think I should smack?" Again it is trying to present them with what the options are, but it's a difficult one. If they smack, what the child thinks of the smack, how does it affect them and what other different ways are there to approach the discipline problem, but the people that ask about it are the people that are going to think about it. Other mothers will give a swift slap around the legs but never question whether it is right or wrong. It is more difficult to approach these mothers and to get them to think about it.

MS What if you saw that happening, a child being slapped?

HVD I would have to say something before I left. I would not feel satisfied unless I had said something to the effect that perhaps that wasn’t the best way of approaching that problem.

MS Taking health visiting as it is at present, do you think it has problems?

HVD Yes I think it does have problems, because I don’t think that all the emphasis on market forces and measuring out funds, health visiting will be seen as not having many measurable outcomes. It is a long term approach. I think that it is important that families get help early on to try and prevent breakdown of family life. It does look bleak at the moment. We are always being asked to justify exactly what we are doing and account for how we spend every minute of the day. It is difficult to do that. You can’t always quantify it. Often the work that a colleague has done for the last ten years with some families may benefit what you are doing at the moment, and that can’t be measured.

MS What would you like to see happening in health visiting in the future?

HVD A lot of the things we have done in the past has been left to our own judgement, and I would like that to continue. I would like the Trust to realise that the public health part of our job is important, as that is another thing that is at risk. The work that we do with GP patients directly can be charged for, but the other work that we all do as part of our job is public health work, and is more difficult to measure financially but is equally important.
APPENDIX IV

QUESTIONNAIRE FOR MOTHERS IN THE NATIONAL CHILDBIRTH TRUST
The following statements have been taken from Western literature on Motherhood. I would be very interested to receive your responses to these statements in the light of your own experiences. It would be a useful contribution to the work I am currently doing on child rearing practices across three cultures. Any further comments would be welcomed should you care to make them. Thank you for your cooperation.

Maureen Swanwick.

1. The home has become a more private place with smaller families and relatives living at some distance away. For many women this means that the day to day care of young children is an isolating and lonely experience.
   Agree  Disagree
   Comment:

2. Many mothers look for other sources of parenting support other than that offered by the professionals.
   Agree  Disagree
   Comment:

3. Professional sources of parenting support are not always reassuring and can make mothers feel guilty.
   Agree  Disagree
   Comment:

4. The most important support system for mothers with child rearing is provided by; Tick where in agreement.

   Father
   Parents
   Friends
   Professionals
   Others, state whom
5. On becoming a mother many women experience feelings of loss. The most commonly expressed losses are:
Loss of status
Loss of independence
Loss of privacy
Loss of social networks
Loss of an idealized concept of motherhood

Comments:

6. Mothers may experience more feelings of inadequacy in parenting than the father because she sees the onus of the responsibility on her.
Agree    Disagree

Comment:

7. However much husbands help with the children it remains help in what is ultimately the woman’s responsibility.

Agree    Disagree

Comment:

8. The individuality of the child plays a large part in the developing relationship between mother and infant. It is an aspect of child care in which previous experience does not necessarily transfer from one child to the next, and can be unhelpful if expectations are inappropriate.

Agree    Disagree

Comment:

Thank you for your time and thought,

Maureen Swanwick
APPENDIX V

EDINBURGH POST NATAL DEPRESSION SCALES
Appendix

Edinburgh Postnatal Depression Scale (EPDS)

The Edinburgh Postnatal Depression Scale (EPDS) has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression; a distressing disorder more prolonged than the 'blues' (which occur in the first week after delivery) but less severe than puerperal psychoses.

Previous studies have shown that postnatal depression affects at least 10% of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long-term effects on the family.

The EPDS was developed at health centres in Livingston and Edinburgh. It consists of ten short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than 5 minutes.

The validation study showed that mothers who scored above a threshold 12/13 were likely to be suffering from a depressive illness of varying severity. Nevertheless the EPDS score should not override clinical judgement. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week, and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Instructions for users

1. The mother is asked to underline the response which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6–8 weeks to screen postnatal women.

The child health clinic, postnatal check-up or a home visit may provide suitable opportunities for its completion.

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

J. L. Cox, J. M. Holden, R. Sagovsky

Department of Psychiatry, University of Edinburgh

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

---

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

9. I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

---

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptom.

Items marked with an asterisk are reverse scored (i.e. 3, 2, 1 and 0). The total score is calculated by adding together the scores for each of the ten items.

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