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Finding a Balance: Employed Mothers' Personal and Family Health Decision Making

by

Kaysi Eastlick Kushner 

A thesis submitted to the ***Faculty of Graduate Studies and Research*** in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

Faculty of Nursing

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DEDICATION

This dissertation is dedicated to my family: Stephen, my partner and Elie, Rivka, Dani, and Yonit, our children. They supported me through my journey as a graduate student and kept me grounded in the daily life of employed mothering. I also dedicate this dissertation to my parents, Kenn and Lu Eastlick, who raised me to believe in my ability to achieve my goals and to my in-laws, Syd and Dorothy Tapper, who believed in me. Finally, I dedicate this research to Sharon Thurston, Colleen Novotny, Liz McCord, and Tammy Horne who share a passion for women's issues and a commitment to the work of the Edmonton Women's Health Network. These women's unfailing friendship, humor, and encouragement of my critical feminist views sustained me, supported my focus on the everyday concerns of women, and reminded me that there are as many women's voices as there are women.

Abstract

This critical feminist grounded theory study examined how employed mothers make health decisions for themselves and their families. The study integrated women's meanings of health, health work, and social institutional influences in their decision making. Twenty women, who parented a child under 18 years and were employed as support staff at a large Canadian institution, participated over two years in individual and focus group interviews. Interviews were audiotaped, transcribed, and analyzed using constant comparative methods.

Women's health decisions and health work reflected their inclusive view of individual and family health as the capacity for everyday living. The social institutions of motherhood; the family; the health, education, and social systems; and the workplace shaped the expectations, demands, resources, and constraints women considered in decision making about health and caring work.

"Finding a balance" emerged as a continuous, recursive decision process that included the phases of keeping track, cueing in, figuring out, balancing solutions, and assessing results. To achieve balance, women used multiple strategies to meet priority expectations and demands within available resources and situational constraints. Resources for achieving balance included flexible self-expectations; flexible family and workplace demands, and support from family, workplace, and social systems. Constraints included time pressures; inflexible self, family, and workplace expectations; and difficulty accessing workplace, health, and social resources. Decision styles developed with experience and supported health routines that relieved women from otherwise continuous demands. The styles changed over time in response to family development

and women's increased awareness of potential inadequacies in routines. Women often focused on family over self-care and, as a result, made compromised decisions that did not acknowledge their own needs. Women's dissatisfaction with unbalanced solutions increased their stress and guilt and reinforced limited alternatives and routine self-neglect. To find balance, women processed contextually-focused, relational aspects of decision making concurrently with analytically-focused, rational aspects. The process of finding a balance challenges the individualist rational choice theories that dominate current decision making research. This study reveals a model of competent decision making and reinforces the need to implement health, social, and workplace policy and programs that are responsive to women's everyday contexts.

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I wish to acknowledge the encouragement and support of **Margaret Harrison** throughout these past years. Her extensive knowledge of women's and family health, health promotion, and research methods constantly encouraged me to extend my knowledge and abilities. She skilfully used her wisdom, critical thinking, patience, and humor to guide my development as a researcher and scholar. I am grateful to **Vangie Bergum** for her thoughtful and thought-provoking comments about women's experiences as mothers, to **Ray Morrow** for challenging me to extend my understanding of critical and feminist theory and methodology, and to **Deanna Williamson** for her support and expertise in family health promotion policy. I thank **Anne Neufeld** for chairing the oral defense, for her expertise in women's and family caregiving issues, and for her support through the years. I am grateful to **Dr. Marcia Killien**, the external reader of the dissertation, for her expertise and scholarship in employed women's health. Finally, I wish to thank the **women** who participated with me in the research. They generously gave their time and energy to share their experiences, answer my questions, and respond to my developing representations of their experiences.

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CHAPTER 1

INTRODUCTION AND RESEARCH PROBLEM

In North American society, women's daily life and health experiences are different from men's, framed as they are within a social context that continues to orient women toward nurturing and caregiving of others over caring for themselves. Women's caregiving work often is provided from positions of unequal power or control over decision making compared to men's family, workplace, and social positions (Tronto, 1992; Wuest, 1995b). In recent decades, women increasingly have combined paid labor force participation with their traditional caregiving and family responsibilities, shifting the dynamics of women's multiple responsibilities for paid and unpaid work.

In Canada since the 1960's, the participation of women in the labor force has changed dramatically. Between 1976 and 1997, the proportion of dual-income two-parent families with at least one child less than 16 years increased from 48% to 78% (Statistics Canada, 2000). In fact, the dual-income family now predominates, surpassing the "traditional" family consisting of a working father and a stay-at-home mother (The Vanier Institute of the Family, 1998). Currently, 69% of partnered and 55% of lone mothers of preschool children and 79% and 75% respectively of mothers of school age children are employed either full or part time (The Vanier Institute of the Family, 2000). The patterns of employment for Alberta mothers are slightly higher for partnered women and substantially higher for lone mothers: 68% of partnered and 73% of lone mothers of preschool children and 82% and 84% respectively of mothers of school age children are employed. Employed mothers daily engage in more hours of unpaid family work and in slightly more total hours of paid and unpaid work compared to their male partners who spend longer hours in paid work (Statistics Canada, 2000; The Vanier Institute of the Family, 2000). For employed mothers the reality of the "double day" (Alvi, 1994, Hochschild, 1989; The Vanier Institute of the Family, 2000) continues with concomitant responsibilities in the labor force and in the family.

The family and paid work[1] experiences of employed mothers,[2] whether in a dual-income family or as a sole support parent are an issue of general concern to Canadians. There is extensive discussion in the popular press including newspapers and magazines and in publications in the women's or family section of most book stores. A substantial research and literature base related to work-family issues also exists in disciplines such as nursing, sociology, psychology, education, women's studies, family studies, and medicine.

A work-family-health connection has been established in current health and social science literature that merits further focus for nursing and other disciplines engaged in

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1

The word "work" has multiple meanings, including reference to purposeful activity or effort, achievement, employment, profession or trade, the location where such activity occurs, and the style, quality, or product of such activity (Messias, Hilfi & Aroha, 1997). I use work to refer inclusively to both paid work (employment) and unpaid work (family work including child rearing, caregiving, and house work; health work; and volunteer work). This inclusive usage is consistent with feminist theorists such as Oakley (1985), Smith (1987), Hochschild (1989, 1997), DeVault (1991), and Garey (1999). The women who participated in this study endorsed my inclusive view of work. Mirchandani (1998), however, provided a thought-provoking discussion of potential difficulties associated with an expanded concept of work, including some women's choice to protect their boundary between paid and family work to limit intrusions of one into the other or concern that workplace acknowledgement of emotion work would lead to greater regulation of these activities. The use of an inclusive conceptualization of work is, therefore, both a political act and a personal choice that merits sensitivity among those who challenge a traditional public/male view of work.

2

I use the terms "employed mothers" and "at home mothers" to identify women's participation in the paid workforce. My intention is to reflect women's orientation to their work without defining one as the absence of the other (eg. employed and nonemployed). Although, I distinguish employment as full or part time, I do not make this distinction in reference to mothering or family work. My usage is consistent with feminist scholars such as Garey (1999) who challenges the common term "working mother" as a gender-based and asymmetrical conceptual category. There is no comparable category of "working father" in common use. Either term implicitly denies the work involved in unpaid family and community activities such as caregiving, parenting, housework, or volunteering.

health promotion. A variety of issues and concerns faced by families, particularly women, who engage in the dual experiences of paid and family work have been documented. These experiences are influenced by personal, interpersonal, and social factors. Socio-economic status and socio-environmental conditions are recognized as important contextual factors. The relationship between health and multiple responsibilities in the workplace and in the family has been studied extensively. Health-related effects have been addressed not only for the individual working women, but also for their families, and for the greater community and society.

Scholars increasingly recognize that contextual as well as personal factors influence whether multiple responsibilities enhance and/or compromise health and well-being. The documentation of influencing factors has contributed to some understanding of their relative effects on health and well-being. But, the complex relationships between these factors and the processes involved in making decisions and meeting demands in daily life remain poorly understood. Such understandings are necessary to researchers and practitioners who focus on the application of knowledge in practice.

The Researcher's "Voice"

My, the researcher's, voice is integral to the construction of this study and to my work as a researcher, theorist, and practitioner. My voice embraces a metatheoretical orientation to science which I describe as critical, postpositivist, praxis-oriented, and critical realist. This orientation is informed by my standpoints as a feminist, community health nurse practitioner, nurse educator, social activist, and (aspiring) nurse scholar. Nursing and health promotion perspectives on theory and practice ground my approach to research. My voice is also informed by my personal experience as an employed partnered mother of four children engaged for the past fourteen years in the everyday management of family and employment responsibilities. Further, my own socio-cultural background as a Euro-Canadian, middle-class, well-educated, professional woman necessarily influences my view of the world.

I have described my voice and experience to acknowledge their potential influence on my work as a researcher and so declare my recognition of a "conscious

partiality" (Hedin & Duffy, 1991, p. 227) which is integral to this research. This acknowledgement of the values and assumptions that inform my perspectives serves as a means of making public rather than denying the potential bias considered inherent in all inquiry. This said, however, I have focused this research on a faithful and "true" reflection of the experience of the women with whom I participated in this research. It is their experiences, not mine, that have been represented.

Research Problem

In the health and social sciences, numerous questions remain about the ways in which women's lives and health are influenced by personal, interpersonal, social, cultural, economic, and political environments. Additional questions remain about the processes engaged by women and their families to make decisions and meet demands in daily life. Answers to these questions are of interest not only to researchers and scholars, but also to employers, service providers, policy makers, and perhaps most importantly, to the substantial proportion of women who daily experience the multiple responsibilities of paid and family work.

To date, most research in the work-family field has been descriptive and/or correlational, focusing on description of women's experiences, identification of factors influencing women's experiences, and interpretation of relationships between factors. Women's experiences of motherhood have been described using qualitative approaches such as phenomenology and grounded theory (e.g. Barclay, Everitt, Rogan, Schmied & Wyllie, 1997; Bergum, 1989, 1997; McMahon, 1995; Rogan, Schmied, Barclay, Everitt & Wyllie, 1997). Qualitative, particularly ethnographic, approaches have been used to describe what women do in mothering work (Block, 1990; Oakley, 1979, 1986; Sullivan, 1997), in family and household work (e.g.. DeVault, 1991; Oakley, 1985), and in family and paid work (e.g.. Garey, 1999; Hochschild, 1989, 1997). Quantitative descriptive approaches also have been used to study what women do in their mothering and family work (e.g.. Barnard 1978; Barnard & Kelly, 1990; Barnard, Hammond, Booth, Mitchell & Spieker, 1989; Barnett & Shen, 1997; Brayfield, 1992; Hiller & Philliber, 1986).

There has been limited focus on how women make decisions, particularly health

related decisions, as they deal with their multiple responsibilities in paid and family work, despite extensive research about these responsibilities. The relationships between what women do in their work and personal and family health or lifestyle practices, health status, and well-being have been researched qualitatively (e.g.. Meleis, Norbeck, Laffrey, Solomon & Miller, 1989; Stevens & Meleis, 1991) and quantitatively (e.g.. Glass & Fujimoto, 1994; Kandal, Davies & Raveis, 1985; Wickrama, Lorenz, Conger, Matthews & Elder, 1997; Woods, 1985a; Woods, Lentz & Mitchell, 1993). As well, the relationships between what women do in their work and personal satisfaction, family functioning, and family relations have been studied using descriptive qualitative approaches (e.g.. Hochschild, 1989, 1997) and descriptive, correlational, and comparative quantitative approaches (e.g.. Greenberger, Goldberg, Hamill, O'Neil & Payne, 1989; Greenstein, 1995; Vannoy & Philliber, 1992; Wortman, Biernat & Lang, 1991). Some studies have addressed the question of how families, particularly women, deal with the dual experiences of family and paid work (e.g.. Hochschild, 1989, 1997; Wuest, 1995a, 1997a, 1997b, 1998).

The need for theorizing about women's experiences from their own perspectives has been recognized by many researchers in the health and social sciences. Women's perspectives on selected aspects of their experiences have been described in a limited number of studies. The studies address the experience of mothering (Bergum, 1989, 1997; McMahon, 1995) and the ways women define their roles in the family and workplace (DeVault, 1991; Garey, 1999; Hochschild, 1989, 1997; Oakley, 1979, 1986). Women's decision making about selected aspects of personal and family health practices (Morse & Bottorff, 1988; Semchuk & Eakin, 1989; Wuest, 1995a, 1997a, 1997b, 1998), social support (Harrison, Neufeld & Kushner, 1995) and childcare (Dowswell & Hewison, 1995; Thompson, 1993) have also been described.

Feminist critique of extant theory and research methodologies (e.g.. Cook & Fonow, 1986; Duffy, 1985; Harding, 1986, 1987; Mies, 1991; Reinharz, 1992; Stanley & Wise, 1990) has stimulated continuing discussion about not only the knowledge and theory needed to represent women's experiences, but also the means used to generate

such knowledge and theory and the use to which it is put. A feminist perspective promotes a focus on issues of particular import to women, the examination of women's experiences as they define them, and the subsequent development of strategies to improve women's situations (Campbell & Bunting, 1991; Currie, 1988; Harding, 1987; Seibold, Richards & Simon, 1994; Webb, 1993).

Feminist scholars have been credited with raising awareness that women's perspectives on their experiences must be represented, and that assumptions about conceptualizations such as "women's work" and women's roles must be challenged in order to broaden inquiry and theorizing about women's experiences (Oakley, 1986, 1993; Woods, 1987). Also, Thorne (1992) contends that feminists have emphasized "the social organization of sexuality, intimacy, reproduction, motherhood, fatherhood, childhood, sexual divisions of labor, and the division of gender itself" (p. 11). Beliefs that family arrangements are biological have been challenged. Rather, feminists support recognition of family arrangements as socially and historically constructed, widely varying and fluid in form, and the result not of moral decline or denial of nature but of economic, demographic, and social change (Thorne, 1992). There is a growing body of identified critical and feminist literature addressing the issues relevant to the experiences of women engaged in paid and family work.

Collins (1994), however, contended that much of feminist theorizing generally, and theorizing about motherhood specifically, has routinely minimized the significance of race and class, thereby reflecting mainstream, Western social thought overall. She supports the need for diverse perspectives, recognizing that

> Varying placement in systems of privilege, whether race, class, sexuality, or age, generates divergent experiences with motherhood; therefore, examination of motherhood and mother-as-subject from multiple perspectives should uncover rich textures of difference. Shifting the center to accommodate this diversity promises to recontextualize motherhood and point us toward feminist theorizing that embraces differences as an essential part of commonality (Collins, 1994, p. 62).

The influence of social class on women's experiences has not been consciously studied in most women's health research. The sampling of middle class and professional women in most research reflects convenience in access to study participants, more than any deliberate class bias. Nonetheless, the experiences of women employed in working class, nonprofessional or support staff, capacities who may be less advantaged economically and socially have not been studied in-depth.

Regardless of their workforce position, employed women continue to fulfill most of the family responsibilities in addition to their paid work responsibilities. Family work including household and caregiving work remains a conventional expectation of women's roles within the family (Oakley, 1985, 1993; Wuest, 1995a, 1997a, 1997b, 1998). Women assume primary responsibility for health care as decision makers and as caregivers, for themselves as well as for immediate and extended family members (Oakley, 1993; Heller, 1986).

Employed women's dual decisions about paid and family work influence the health and quality of their life, as well as their family and the community life (Martin, Courage, Godbey, Seymour & Tate, 1993; Woods, 1987; Wuest, 1993). The "importance of the numberless, daily, routine, preventive, monitoring, and promotional tasks which serve to maintain and build the health of the family, and by extension the health of the society at large" (Heller, 1986, p. 65) were documented in one Canadian study of the tasks and responsibilities of women in maintaining their own health and that of their families. Such knowledge needs to be integrated with an examination of how women make decisions about their everyday health tasks. This integration is a necessary step toward development of health promotion practice frameworks that reflect the everyday experiences of employed mothers and their families.

Killien (1999) advocated the use of a framework that would support identification of specific risks and protective factors for women's health across the developmental stages of women's and family lives and contribute to the development of health promotion interventions. In her recent review of women's work and health research, Killien recommended that nursing science engage a complex and holistic framework for

research and theory development in this field to facilitate intervention development. Killien contended that nurse scientists focused on health promotion practice present a unique perspective in women's work and health research.

Conclusion

Understanding how women make health decisions and the personal, family, and social influences on decision making is a necessary component of developing women's health theory for health promotion practice. I contend that there is a need for generating knowledge from women's perspectives that critically reflects the complex diversity of personal, interpersonal, social, cultural, economic, and political influences on women's experiences of family and paid work. In addition, I concur with Killien's conclusions and recommendations.

The purpose of this study was to examine employed mothers' personal and family health decision making processes as they dealt with their dual experiences of paid and family work. A substantive theory of how employed mothers make health decisions for themselves and for their families was generated from the data.

The goal of this study was to extend nursing knowledge about employed mothers' health decision making within their existing social context. Generating knowledge about how women make health decisions that guide their health actions is necessary in order to develop understanding of factors and conditions that influence health action. This knowledge is prerequisite to developing effective interventions that promote the health of the women themselves and of the families and communities who depend on women's caregiving activities. Further, such knowledge can prove useful to employed mothers, themselves, in terms of gaining insight into and understanding of their circumstances, as well as developing individual and/or collective strategies aimed at improving their lives, particularly their health and well-being. By extension, improvement in women's lives should contribute to improvement in the lives of those children and adults for whom the women care.

Chapter Overview

In the following chapters of this dissertation, I present the knowledge that guided

the research questions, the research design used to answer the questions, the findings of the research, and the major implications of the research for theory, policy, and practice in nursing and health promotion. Current knowledge in the health and social sciences about women's family and paid work, health, and health decision making is reviewed in Chapter 2. This knowledge is critiqued to identify gaps in understanding, limitations of current research, and directions for inquiry. Chapter 3 provides a description of the research design of the current study. The intellectual underpinnings of the critical feminist grounded theory method are explained and the implementation of the method in this study is described.

I present the findings of the current study in Chapters 4, 5, and 6 . Chapter 4 focuses on meaning and action in women's health work. I describe what health meant for women in this study and what actions they took in their everyday health work to take care of their personal and family health. Important common ground between women's health meanings and actions are identified and discussed. In Chapter 5, I examine social institutional influences on women's health decision making. In this study, the impact of the institutions of motherhood; the family; the education, health and social systems; and the workplace was evident in women's descriptions of how they made decisions that guided their personal and family health work. Women's experiences support the concept of "embodied context" that characterizes their awareness of the multiple social institutional influences on self-expectations and on expectations from their family, education, health, and social systems, and their workplace. Chapter 6 describes the process of women's health decision making. A substantive theory of "finding a balance" in personal and family health decision making is presented, including the phases of the process and the strategies women used to balance decisions. Routine decision patterns are identified and the conditions that influence change over time in women's routine patterns are examined. At the end of each of the major sections of these chapters, I discuss the relevant findings with respect to current health and social science literature and identify important continuities and discontinuities.

Each of the findings chapters is written in a distinct voice that is consistent with

the focus of the findings. Chapter 4 reflects the emphasis in health behavior literature on identifying major themes and reporting the frequency of occurrence of health meaning and actions. Chapter 5 reflects the influence of institutional or critical ethnography on the explication of social institutional influences on experience. Chapter 6 reflects the integrative process focus associated with critically-oriented grounded theory research.

In Chapter 7, I summarize major study findings and discuss implications for theory development in nursing and health promotion; health, social, and workplace policy; practice in nursing and health promotion; and critical feminist and nursing research design. The chapter concludes with my reflections on the continuing need for research that critically examines women's everyday experiences and reflects their diverse voices and experiences. The purpose of such research is to contribute to theory, policy, and practice which promote women's well-being by improving the circumstances of their lives.

CHAPTER 2

CURRENT KNOWLEDGE ABOUT WOMEN'S FAMILY AND PAID WORK, HEALTH, AND HEALTH DECISION MAKING

My research interests are situated at the intersections between health and social science disciplines including nursing, medicine, sociology, psychology, education, women's studies, and family studies. In this chapter, I will review and critique current literature relevant to the problem areas for study. Whereas researchers in the health disciplines tend to orient inquiry around health as a primary concept (e.g. women's health, family health, health promotion), social science researchers orient more to intrapersonal (e.g.. individual decision making) and interpersonal relations (e.g.. women and work, family relations) in the social world including health as a secondary concept.

My research interests require an integration of health and social science orientations, focusing on a critical examination of women's daily health decision making experiences as they live and work in the family, community, and broader social world. This examination builds on current knowledge about women's family and paid work, health, and health decision making experiences. Mothering and motherhood[3] frame women's experiences and provide the logical starting point for my review of current literature about women's family and paid work and their relationships to the health of women and their families. Current knowledge about women's health decision making concludes my review. My intention in this review is to discuss key concepts and understandings in current knowledge, identify gaps, and construct an appreciation of the complexity and interconnectedness of the multiple foci reflected in current literature.

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[3] My distinction between mothering and motherhood is based on a feminist critique that differentiates personal experience from social institutional influences on experience. In my usage, mothering denotes a woman's relational experience of interaction with her child(ren), whereas motherhood denotes a socially constructed institution in which the social role of mother is prescribed. This distinction is consistent with that made by scholars such as Rich (1976), although her distinction is made between experiential and social institutional aspects within motherhood, whereas I have chosen to apply distinct labels to each aspect.

Mothering and Motherhood

The generation of theory aimed at understanding and explanation of women's experiences of mothering and of motherhood has been a continuing focus in the health and social sciences during the past four decades. I concur with Bergum's (1997) conclusion that most research on mothering has been aimed at defining and evaluating mothering in order to facilitate professional practice framed as support of mothering. While valuable, such research and practice may fail to locate women's perspectives and experiences as central to theorizing about mothering and motherhood.

Rich (1976) brought scholarly attention to an important distinction between experiential and institutional meanings of the concept of motherhood, raising awareness that women's daily experiences as mothers were related to but distinct from the socially constructed institution of motherhood. Rich's feminist analysis of motherhood is recognized as a key work that stimulated interest in inquiry from the mother's point of view, particularly from feminist perspectives. Oakley (1979, 1980, 1985, 1986, 1992) also has made significant contributions to feminist theorizing about motherhood, examining women's experiences of pregnancy, childbirth, early mothering, and housework as women's work within the family.

More recently, Bergum (1997) discussed the "way of the mother"(p. 133), a relational and moral experience, in the context of motherhood in society. Women's experiences of becoming a mother were described using a phenomenologic approach to inquiry. Bergum recognized the distinctiveness of each mother, yet also the resonance among mothers' voices.

> Poverty, lack of employment opportunities, lack of parenting support services - such as flexible work hours and high-quality funded childcare - lack of support for mothers who stay at home full-time and for those who work outside of the home, and lack of financial assistance to keep good and healthy food on the table make the endless tasks that are involved in caring for the young child extremely difficult (Bergum, 1997, p. 141).

Issues are raised regarding the de-valuing of mothering in patriarchal societies, and both

the empowering and the disenfranchising potentials of mothering in current social, economic, cultural, and political conditions.

Social support was identified as an important mediating factor in women's experiences of mothering (Barclay, et al, 1997; Rogan, et al, 1997). Support from the woman's partner, family, and friends was considered crucial to women's experiences of becoming a mother. Support from health professionals was described as both a positive experience and an uncomfortable experience, related to women's perceptions of whether professional help served to increase or reduce their self esteem and confidence. The influence of broader social conditions on the women's experiences was not explored in these studies of mothering, although the researchers concluded that there is need for recognition of the "huge personal strength and resourcefulness these women exhibit in working it out alone" (Rogan, et al, 1997, p. 883) and "that preoccupation with individual women rather than their social context prevents full comprehension of their problems and limits the assistance provided to women" (p. 884).

McMahon (1995) considered the influence of women's personal, immediate sphere of interaction as well as the broader social context, particularly social class and the patriarchal social structure, on employed women's identities and experiences as mothers. Women's experiences were bound up in their identities, best understood as subjectively created products of their experience rather than as products of social gender role conformity, and in the socio-cultural context in which they lived everyday. Both middle and working class mothers experienced the development of their identity as mothers as a moral transformation centered on a focused responsibility for their children: In effect, children created mothers. Women's identities as mothers shaped their personal expectations and actions in their mothering, family, and paid work and framed their beliefs about their partner's responsibilities in fathering, family, and paid work.

In Western cultures, the institution of motherhood has been constructed as the ideal of the "good mother" presupposing that caring, self-sacrifice, and selflessness are inherent to women's nature and requisite to mothering (Thurer, 1994; Viliani, 1997). In the early second wave of feminism during the 1960's and 1970's, motherhood became

symbolic of women's complicity in reproducing an oppressive patriarchal society. Unfortunately, mothering and motherhood were equated and denigrated, even as the ideal of the good mother prevailed (Thurer, 1994). In 1976, Rich's examination of motherhood as personal experience determined by social institution, contributed to subsequent consideration of the complex relationships between personal and institutional aspects of mothering work. Feminist critique broadened to grapple with these relationships, attending to the frequent tensions between experiential diversity and the middle-class institutional ideal of motherhood.

The ideal of the good mother is pervasive in Western culture, framing women's everyday experiences of mothering. Wearing (1984) found that Australian mothers from diverse circumstances were guided by the ideal of the good mother, even as they recognized their inability to attain this ideal in everyday life. Hays (1996) described the current form of good mothering, "intensive mothering", as "a gendered model that advises mothers to expend a tremendous amount of time, energy, and money in raising their children" (p. x). Hays contended that employed mothers experience the cultural contradictions of motherhood in the United States as they are caught between the ideology of intensive mothering and the logic of individualism in the workplace. In the United Kingdom, Forna (1998) concluded that "beliefs about motherhood are passed off as 'traditional' and 'natural', as though the two words had the same meaning; and, as both traditional and natural, these beliefs have become unassailable" (p. 5). In Canada, McMahon (1995) considered motherhood to be symbolic of the noncontractual social relations that are personally valued yet subordinated to the commodity production and individual achievement values of the market economy. Smith (1987, 1989, 1998) and Griffith (1995; Griffith & Smith, 1990; Smith & Griffith, 1990) examined the social organization of mothering through the discourse of motherhood. Their work revealed the ways that this discourse is integral to the discourses of child development and family relations.

Summary

This selective review of current literature about mothering and motherhood

provides a background understanding of mothers' experiences and socio-cultural context as a basis for an examination of employed mothers' experiences. Employment and family work are identifiable, but not central, themes in the mothering and motherhood literature. I will shift attention now to focus more broadly on literature about the complex relationships between women (who are mothers) and their experiences in family and paid work.

Women's Family and Paid Work

Statistics that portray changes in the patterns of women's labor force participation during the past five decades in Western society fail to capture the meanings of these changes for women. Taking a life course perspective, Moen (1992) extensively reviewed the interplay between multiple responsibilities for women in the context of historical changes in working and parenting.

> The picture that emerges is one of continuity in women's accommodation of work to family roles, despite increases in the portion of their adulthood they spend in employment. The timing and duration of women's work roles may have changed, but their family roles continue to take precedence over work (Moen, 1992, p. 38).

Employed mothers' strategies for accommodating paid work to family and family to paid work have changed over time. Women have moved from the primary strategy of sequential scheduling in which they returned to the labor force once children were older, to several alternative strategies for concurrent scheduling including reducing hours of work to part time, working shift hours, and selecting less demanding employment (Moen, 1992). Employed mothers have used strategies to accommodate the family to paid work, including delaying childbearing, having fewer children, and purchasing services and products traditionally provided by women in the home (Moen, 1992). Women also have shifted an efficiency focus from the workplace to the family, resulting in reduction and streamlining of family commitments (Hochschild, 1997).

Hochschild (1989, 1997), provided substantial evidence for the gendered nature of experience across the "first shift" of paid work, the "second shift" of family work, and the "third shift" of the emotional work of balancing often competing demands. A feminist

sociologist in the United States, Hochschild documented both men's and women's experiences in family and paid work for dual-earner families. While men's time and energy commitment to the first shift, often but not always, was stronger than women's, women's commitment to the second and third shifts exceeded men's regardless of relative commitment to the first shift. In other words, women continued to bear greater responsibility for family work whether or not they shared responsibility for paid work. This inequitable balance of responsibilities is also reflected in Canadian studies of the division of labor in paid and family work (Brayfield, 1992; Duxbury & Higgins, 1991; Higgins, Duxbury & Lee, 1994).

Whether or not one ascribes to a philosophy of social justice with respect to gender relations and the division of labor in family and paid work, beneficial as well as costly consequences of women's labor force participation have been recognized. Benefits from their potentially increased economic power include access to personal financial resources and contribution to family resources. Women benefit personally from higher self-esteem and sense of well-being that contribute to greater satisfaction with family work, and interpersonally in development of more equitable social relationships (Brayfield, 1992; Moen, 1992). However, such participation also is costly as work-family strategies that reduce labor force participation can limit economic gains and longterm occupational progress (Moen, 1992). As well, women's labor force participation has personal costs such as guilt, fatigue, and limited personal time for health promoting activities (Woods, Lentz & Mitchell, 1993). There are also interpersonal costs including negative effects on relationships with male partners, children, and extended family and social networks (Moen, 1992).

Various factors that affect work-family experiences for women and their families have been identified through health and social science research: coping strategies and effectiveness, perceived social support, perceived justice in allocation of responsibilities, role expectations, role quality, commitment to roles, workplace conditions, and family conditions. Experiences of family and paid work are more positive for women with successful coping strategies (Killien & Brown, 1987; Meleis, et al, 1989), although

differences between the strategies most often used by women and men may produce family stress (Paden & Buehler, 1995). Women's experiences of paid and family work also are more positive when they perceive that they have social support from their husbands (Hall, 1992; Lemare & Home, 1992; McHale & Crouter, 1992; Vannoy & Philliber, 1992) as well as family and friends (Lemare & Home, 1992). Perceived fairness in the allocation of family and paid work responsibilities between a couple influences women's and men's experiences of paid and family work. The hours of women's employment and the proportion of time women spend in female-stereotypic housework compared to their partners are important predictors for both women's and men's perceived fairness to the woman (Sanchez & Kane, 1996). Women also tend to perceive fairness between them and their partner in the allocation of responsibilities and performance of family work when women feel emotionally rewarded in fulfilling their responsibilities (Thompson, 1991).

The relationships between role-related factors and work-family experiences are complex. Congruence between role commitment and role occupancy has emerged as an important factor in these relationships. Marital quality tends to be lower for women with nontraditional role expectations and traditional family responsibilities (McHale & Crouter, 1992), as well as for women who perceive their husbands to be less supportive in family work (Vannoy & Philliber, 1992). Interestingly, husbands also tend to experience lower marital quality when they hold traditional role expectations (Vannoy & Philliber, 1992). Women's perception of a balance of benefits over costs for them from combining paid and family work is an important aspect of their satisfaction in integrating work and family roles (Meleis, Norbeck & Laffrey, 1989; Tiedje, et al, 1990). In addition to threatening women's sense of benefit/cost balance (Meleis, et al, 1989), women's experiences of conflict between family and work roles is associated with lower quality of work life and lower life satisfaction (Duxbury & Higgins, 1991). Conflict arises from women's and societal expectations for family roles and workplace expectations for work roles. Women are normatively expected to make family roles their priority even as they are expected to make work commitments "just like men" (Duxbury & Higgins, 1991, p.

71). Women's ability to redefine their family and work role expectations by setting priorities and sharing responsibilities with partners can help them reduce role strain (Hall, 1992).

Several aspects of workplace conditions influence paid and family work experiences. The rewards of job challenge and complexity for women are associated with reduced stress in paid work (Roxburgh, 1996) and with a "positive-spillover effect" from paid to family work experiences that mitigate parental stress (Barnett, Marshall & Sayer, 1992). Workplace size has been related to women's family and paid work experiences. Large workplaces provide structural conditions such as health benefits and family policies, whereas small workplaces provide process conditions such as interpersonal relationships that relate positively to parenting, an aspect of family work (MacDermid & Williams, 1997). Women's higher time demands for paid work may contribute to a reduction in their family work demands concurrent with an increase in their husband's contributions to family work (Peterson & Gerson, 1992). Alternatively, women are far more likely than men to work part time in order to accommodate family responsibilities (Gold, 1994). Part time workers, about 70% of whom are women, typically receive lower pay, fewer benefits, and decreased opportunities for employment advancement. Finally, overall occupational quality has been associated with greater social and marital integration and higher sense of control for women and men (Wickrama, et al, 1997). Women, however, remain concentrated in nonprofessional and support occupations with fewer opportunities for control over decision making and policy compared to professional and managerial occupations more often held by men (Gold).

Family conditions, particularly those related to childcare, also influence women's experiences of family and paid work. Women's experiences of interference between paid and family work are related to their life-cycle stage and the age of children in the family. Women with younger children experience greater work-to-family and family-to-work interference compared to men with younger children and compared to women and men with older children (Higgins, et al, 1994).

Increasingly, the influences of contextual factors such as women's socio-

economic status and socio-environmental conditions are recognized as essential considerations in the study of women, work, and family issues. A socio-environmental approach that incorporates an examination of women's social, economic, cultural, and political contexts is increasingly supported by practitioners and scholars in the health and social sciences (Leuning, 1994; Stevens, Hall & Meleis, 1992; Woods, 1995; Wuest, 1993, 1995b).

Summary

Research about women, family work, and paid work has focused largely on either describing experience or identifying key influencing factors and attempting to predict relationships between factors and experience. Between these two foci is a "gap" in understanding how women manage the complex influences on their experiences. Current research reflects greater emphasis on factors related to women's personal attributes, such as coping and expectations, and their immediate family and workplace context. Only recently have some researchers broadened their focus to consider social, cultural, economic, and political contexts such as social constructions of motherhood and worker roles as well as economic pressures on workplace conditions. Approaches that reflect women's perspectives on how they manage the complex contextual influences on their experiences are necessary in order to "fill in the gap" between describing such experience and understanding relationships between influencing factors.

Women's Family and Paid Work and Health

The following review of literature addressing the relationships between work and health for employed women and their families provides evidence for the complexity of relationships, revealing no consistent either harmful or beneficial effect of multiple paid and family work responsibilities on health. An established body of literature addresses the health of not only the individual employed woman, but also of family members, of the family unit, and of the greater community or society in relation to women's multiple responsibilities.

Concept of Health

A socio-environmental approach to health broadens the definition of health to

reflect physical, psychological, and social environmental dimensions to people's experiences of health (Labonte, 1993). This approach is consistent with the more recent broadening of definitions of women's health that recognize the complex interconnections between not only biophysical and psychosocial health, but also between these factors and the social, economic, cultural, and political environments in which women live (Oakley, 1993; Stern, 1996; Woods, et al, 1993; Woods, et al., 1988). Such definitions of health are conceptually consistent with the alternative term "well being" used by some scholars (eg. Moen, 1992).

Women's Health

Current researchers are presented with the difficult task of generating knowledge about women, work, and health that reflects the complex inter-relationships between personal, interpersonal, and social influences on women's well-being. Until recently, research about women's health and multiple responsibilities tended to focus on the potential liabilities of combining family and paid work (Moen, 1992). The implicit assumption that such a combination is harmful has been successfully challenged particularly by feminist scholars (eg. Crosby, 1991; Moen, 1992; Rankin, 1993).

Psychological Well-being

Moen (1992) concluded that variations found in relationships between women's employment and psychological well-being reflect differences not only in focus on various aspects of the concept and in measures chosen, but also in inclusion of the diverse influencing factors. Research about the psychological well-being of employed women, particularly mothers, has used both qualitative and quantitative methods that incorporate various aspects of psychological health including self-esteem, satisfaction, stress, anxiety, and depressive symptoms.

Women's attitudes about their multiple responsibilities, particularly the consistency between attitudes and responsibilities, positively influences women's psychological well-being (Gove & Peterson, 1980; Kessler & McRae, 1981; Simon, 1997; Waldron & Herold, 1986). Specifically, women experienced greater psychological well-being when there was a match between their preferences for employment or

traditional home roles and their situations, compared to women whose situations did not match their preferences. Similar conclusions were reached by Meleis and colleagues (Meleis, Norbeck, Laffrey, Solomon & Miller, 1989; Meleis, Norbeck & Laffrey, 1989; Stevens & Meleis, 1991; Stevens, et al, 1992) in a study of the relationship between women's role integration and stress, satisfaction, and coping for women clerical workers. This study also reinforced the importance of considering the influence on this relationship of social context including women's family and job demands, workplace environment, economic stressors, and availability of support resources.

The stressfulness of daily social roles for women in multiple roles has been linked to women's psychological well-being through factors such as coping patterns and stressor source. Killien and Brown (1987) categorized the daily stressors and coping strategies of employed and unemployed, partnered and lone mothers and found substantial diversity in types and patterns of stressors between role configurations, experiences of stress related to health, and coping strategies. An interesting finding was that employed mothers, both lone and partnered, tended to take action to "fix the problem" whereas unemployed mothers tended to "talk out the problem". The stressfulness of daily social roles for women in multiple roles was also studied by Kandel, Davies, and Raveis (1985), supporting conclusions consistent with earlier similar research (eg. Gove & Geerken, 1977; Rosenfield, 1980) that "levels of depressive symptoms among occupants of different roles are lower among those who are married, parents and workers, and higher among the single and housewives" (Gove & Geerken, p. 73). Kandel and colleagues also noted, however, that stresses related to family work had more severe consequences for psychological well-being than employment stresses.

Perceived rewards as well as stresses have been recognized as influential on women's personal and professional lives. Rankin (1993) identified personal benefits, financial rewards, and improved family life as the major rewards for women. Lack of time, child-related problems, and maternal guilt were the major stresses identified. Women's experiences were analyzed in the context of prevailing social attitudes about women's mothering, family, and household work. These attitudes were reflected not only

in personal and family expectations, but also in social and workplace policy that continues to assign private responsibility for such work to women and families. In an examination of how women experience both conflict and enhancement in fulfilling multiple roles, Tiedje and colleagues (1990) challenged several proposed models (e.g.. Barnett & Baruch, 1985; Burr, Leigh, Day & Constantine, 1979), finding that "regardless of perceptions of enhancement, women who perceived their roles as conflicting were more depressed and less satisfied as parents" (p. 70) but not as employees. The researchers called for further study to explain how decision making and appraisal are linked to enhancement and conflict perceptions as well as to satisfaction and other psychological well-being indicators.

Although trends are evident, there are no predictable patterns of social influences such as educational attainment, employment characteristics, and family characteristics on women's experiences of health and work. For example, more educated women may experience greater psychological benefit from employment (Campbell, Converse & Rodgers, 1976), although other research (e.g. Meleis, Messias & Arruda, 1996; Meleis, Norbeck, Laffrey, Solomon & Miller, 1989) suggests that the relationship may be influenced by factors such as socio-economic status and employment conditions. Employment conditions such as prestige (Kessler & Cleary, 1980), sense of challenge or control associated with work demands (Lennon, 1994; Lennon & Rosenfield, 1992), and provision for family-responsive policies (Greenberger, et al, 1989) are associated with enhanced well-being for employed mothers. Meleis and colleagues, however, reported that women clerical workers identified stress as a significant health concern related to workplace conditions such as limited decision making control, crowded physical work space, and environmental hazards. Certainly, women's family circumstances influence experiences of paid and family work. When women perceive fairness in the allocation of responsibilities for family work they are less likely to be depressed (Glass & Fujimoto, 1994). Partners' supportive attitudes and contributions to family work enhance women's psychological well being (Kessler & McRae, 1982; Ross, Mirowsky & Huber, 1983). Life course patterns such as concurrent responsibilities for caregiving of children and

aging parents increase women's stress (Cleary & Mechanic, 1983; Rosenfield, 1989).

Influences of social class, social support, and social attitudes about gender roles have received limited research attention, although Woods and colleagues (1993) provided evidence that lower social class, less support, and conflict between personal and social attitudes are associated with greater stress and health damaging behaviors for women. However, the associations between such diverse influencing factors and women's psychological well-being remain poorly understood.

Physical Well-being

Review of research about the relationship between employment and women's physical health supports the conclusion that women engaged in both family and paid work are healthier physically than women engaged in either family or paid work alone (Moen, 1992). Good health has been associated with multiple roles, whereas poor physical health has been associated with perceived poor role quality (Verbrugge, 1986). Testing a model linking occupational conditions to physical health, Wickrama and colleagues (1997) demonstrated positive effects of occupational quality and marital integration on women's sense of control, contributing to fewer health risk behaviors and better health. Using extreme indicators of the effect of employment on women's health, researchers in the United States examined changes in women's morbidity and mortality rates including suicide rates over time. Employment was protective against death, stroke, and malignancy for a cohort of women studied longitudinally from 1970 to 1985 (Weatherall, Joshi, & Macran, 1994). Women's suicide rates decreased in the decade between 1970 and 1980, as women's labor force participation increased (Burr, McCall & Powell-Griner, 1997). Although the positive nature of the employment-health relationship seems clear, researchers continue to acknowledge that there is limited understanding of how women attempt to deal with multiple influences and little consideration of how social, cultural, economic, and political contexts influence women's experiences.

Well-being Overall

Women whose employment status was compatible with their attitudes toward employment tend to report better health than women whose employment status and

attitudes are incompatible (Waldron & Herold, 1986). Yet, the anticipated positive influence of women's strong role commitments may be countered by high role-related stressors and associated with negative health effects for women (Luchetta, 1995).

Several scholars have concluded that when work and family circumstances support women's labor force participation, women experience enhanced well-being (Crosby, 1991; Doyal, 1994; Facione, 1994; Kandel, et al, 1985). However, these same scholars acknowledge the possibility that self-selection occurs in that women who are healthier and better able to manage multiple roles and stress are more likely to engage in both paid and family work. For many employed women, particularly with a lower socio-economic status and less support, there are negative health-related effects including less frequent participation in health promoting behaviors, greater engagement in health damaging behaviors, and greater levels of stress (Woods, et al, 1993).

Women's expectations for themselves and their perceptions of other's expectations regarding role definitions and demands, as well as availability of personal and social resources such as coping skills, education, economic security, and social support emerge as important factors related to women's health in the context of personal, family, and employment responsibilities (Maunz & Woods, 1988; Woods, 1980, 1985a, 1985b, 1986, 1987; Woods, Lentz & Mitchell, 1993; Woods, Mitchell & Lentz, 1995; Woods, Taylor, Mitchell & Lentz, 1992). Woods, in an extensive multidisciplinary program of research in women's health developed during the past two decades, has documented and analyzed diverse factors related to women's experiences and decision making. Consistently, Woods' research supports conclusions that women's health experiences and behaviors are integrally linked with their daily experiences and the conditions of their everyday lives. Notably, while Woods' program of research engages quantitative measurement and analysis much more than qualitative interpretation, she is a vocal supporter of the continuing need for research investigation directed toward increased understanding of the meaning of health and health behaviors to women in the context of their daily lives.

In addition to the descriptive and correlational studies documenting the factors

influencing the experience of dealing with multiple responsibilities, a few studies have focused on nursing intervention aimed at assisting women in families to manage their multiple responsibilities (e.g.. Collins & Tiedje, 1988; Collins, Tiedje & Stommel, 1992). Women in these programs cited the informational component as well as the small group support aspect of the program as particularly helpful to them in dealing with the multiple responsibilities in paid and family work. Although the researchers examined what was helpful to the women in the program, they did not address how the women made use of the information and support, particularly how it was used in their decision making as they dealt with their multiple responsibilities.

Trends in Understanding

Moen (1992) provided a concise review of current knowledge about the relationships between women's well-being and their multiple responsibilities, presenting five considerations that preclude determination of causality in these relationships. First, women's personal preferences for role enactment, whether full time homemaker, full time employee, or some part time combination, is central to women's well-being. Social expectations for women continue to emphasize family over employee roles, yet the contribution of women's employment to personal and family well-being is increasingly accepted. As such, women's personal preferences are exercised in the context of conflicting expectations about the options they appear to have in terms of employment and family roles. A second consideration concerns the nature of the multiple role and well-being relationship. Several potentially competing alternatives have been proposed: role accumulation or overload, role conflict, role integration, and role balance. Is well-being determined by enacting multiple roles, by managing conflict between roles, by integrating potentially conflicting roles, or by balancing benefits and costs associated with multiple roles? Scholars remain divided about which alternative or combination of alternatives is most supported in current research. It is arguable that, given the complexity of the relationship, determination of a single alternative explanation is not possible. The third consideration relates to the first two and involves the nature of potential "spillover" between roles so that stresses arising from one role are compensated by satisfactions from

another role. Researchers have failed to generate consistent support for or refutation of a spillover effect. The fourth consideration recognizes the need to consider family and social contexts as dimensions of the multiple role and well-being relationship. Is it possible to determine causal relationships, given the complexity and diversity of personal, interpersonal, and social contexts that need to be considered? The fifth consideration attends to the influence of concurrent shifts in societal attitudes about gender roles. The dynamic nature of societal attitudes, their relationship to personal attitudes, and the effect of both on the well-being of women with multiple roles makes examination of long term trends and effects extremely complex. It is likely that the effects of women's employment on well-being have changed and will continue to change over time.

Whereas Moen (1992) questioned the focus on determining causal relationships, Killien (1999) questioned the adequacy of the dominant conceptual perspectives that have organized most work and health research: the role stress and illness perspective and the health benefits perspective. Killien's (1999) review of women's work and health literature complements Moen's review. The role stress and illness perspective focuses on the harmful effects on individual health and well-being of the stressors associated with specific roles and multiple role combinations. Role conflict and role overload theories reflect this perspective. In contrast, the health benefits perspective focuses on the enhancing effects to health and well-being of the resources provided by social roles. Role resilience theory reflects this perspective. Killien has advocated the use of alternative perspectives such as those focused on role balance or role integrations. These perspectives are considered more reflective of the concurrent effects of stress and resilience on women's health and of women's everyday experiences with multiple interconnected roles. The roles of parent, partner, and paid worker have received most attention.

I conclude that understanding the complexity of the relationship requires a "step back" from the pursuit of causal relationships to examine social process, particularly how women make decisions and meet demands in the contexts of their daily lives. Such examination is consistent with Moen's (1992) challenge of a primary focus on causality

and may contribute to the development of alternative perspectives, as advocated by Killien (1999), that integrate the complex contexts and relationships relevant to women's work and health.

Family Health

The effects of women's employment on marital and parenting relationships within the family have received considerable research attention reflecting both positive (e.g.. Simpson & England, 1981) and negative viewpoints (e.g.. Becker, 1981). Implications for family health, interpreted primarily as individual member health, have received less attention.

Partner's Well-being

Not surprisingly, many of the factors that influence employed women's psychological and physical well-being also influence their partners' well-being. Research in this area reflects prevailing social assumptions that women are partnered with men through marriage. Moen's (1992) review concluded that husband's psychological well-being tends to be lower when their wives were employed full time, but not necessarily part time. The effect of men's attitudes toward their wife's employment on the work-health relationship was similar to that noted for women and was inversely correlated with age (Ross, et al, 1983), suggesting that this effect may diminish as younger men, presumably with more supportive attitudes, move into marriage and family life (Moen, 1992).

The factors, such as perceived fairness and coping, that support men's and women's well-being are common to their experiences, but the pattern of influence differs. Perceptions of fairness in division of labor, both in employment and the family, and characteristics of family work such as control over tasks are influential for husband's psychological well-being (Barnett & Shen, 1997; Glass & Fujimoto, 1994), just as they are for women. Men are less likely to be depressed when they perceive fairness in the allocation of responsibilities and performance of paid work (Glass & Fujimoto, 1994). It seems, however, that as women's psychological well-being is enhanced by greater contributions to family work from men, men's well-being may be compromised.

Similarly, a study of differences between men's and women's preferred coping strategies suggested that husbands' and wives' strategies may be at odds. Whereas women tended to seek support through planning and talking with their husbands, men tended to cope with stress by restructuring or withdrawing from demands and to report that talking with their wives increased their stress (Paden & Buehler, 1995).

With respect to effects on physical well-being, several researchers have found few differences explained by gender alone (Greenberger, et al, 1989; Verbrugge, 1986; Wickrama, et al, 1997). Just as for women, men experience health benefits from reduced role burden (Verbrugge, 1986) and from supportive occupational conditions (Greenberger, et al, 1989; Wickrama, et al, 1997).

Children's Well-being

In contrast to assumptions that maternal employment would prove harmful to children's psychological, developmental, and physical well-being, few differences are found when children of employed and unemployed women are compared. "Generally, women's employment does not adversely affect the growth, health, or development of children for any particular group or age of children" (Rosenfeld, 1995). I concur with Moen (1992) that it is not the fact of employment, but the context of employment, family, and social life that merits attention. Discerning trends in well-being over time is complicated by concurrent shifts in these contexts. Research focused on family work, paid work, and health must attend to these contexts as integral dimensions of women's and families' experiences in daily life.

Summary

The application of diverse perspectives to research design and the complementarity between knowledge and theory generated from these perspectives is a necessary means to generating more complete understandings and explanations of women's experiences (Stevenson & Woods, 1986; Woods, 1987, 1995). A socio-environmental approach to health, in fact, requires such diversity and complementarity. Reflecting this approach, several scholars advocate critical analysis of the interplay between social norms about women's and family roles and responsibilities and current

social policy (Facione, 1994; Moss, 1990; Skrypnek & Fast, 1996; Wuest, 1993). They urge the development of policies and programs that support families and enhance the well-being of individuals, families, and the community. Nursing, as a practical discipline (Johnson, 1991), is well situated to contribute to practice applications of generated knowledge and theory that enable women to make changes to improve their lives and those of their families. Yet, without understanding how women make decisions to deal with their daily experiences, program and policy development may continue to be based on the inaccurate premise that the identification of influencing factors is sufficient to presume cause-effect relationships and that these are sufficient to predict intended outcomes.

Women's Health Decision Making Processes

Much of the health science research about women's decision making processes has focused on choices related to reproductive health and caregiving responsibilities. Reproductive issues have included fertility regulation (e.g.. Lethbridge, 1991; Matteson & Hawkins, 1993), pregnancy (e.g.. Currie, 1988; Williams, 1990), menopause (e.g.. Hunter, O'Dea & Britten, 1997; Logothetis, 1991), and screening and treatment for reproductive cancers (e.g.. Pierce, 1993; Salazar & Carter, 1993; Salazar & de Moor, 1995). Decision making processes related to caregiving responsibilities, particularly mothering, such as returning to work after childbirth (e.g.. Hall, 1987, 1992; Killien, 1993; Volling & Belsky, 1993), breastfeeding while working outside the home (e.g.. Morse & Bottorff, 1989), childcare alternatives (e.g.. Hertz, 1997), and care of ill children (e.g.. Bauchner & Klein, 1997; Semchuk & Eakin, 1989; Thompson, 1993) have also been studied. Both conventional and critical feminist perspectives are represented in these studies.

There is, however, limited current literature concerning *how* women make health decisions for themselves or for others in their care, while attempting to deal with the multiple demands of paid and family work. In the following section, I discuss the research most relevant to current understandings about how women, particularly employed mothers, make decisions related to their personal and family health. Some

decisions made by employed mothers, such as those about nutrition, lifestyle practices, and illness care, relate directly to health. Other decisions, such as those about returning to work after childbirth, accessing social support, and maintaining childcare generally, relate indirectly to health through their influence on stress and other factors influencing psychological and physical well-being. The relationships between these factors and health reflect complex personal and social processes that remain poorly understood.

Returning to Work

Hall (1987, 1992) studied Canadian women returning to work after the birth of their first infant, finding that these women engaged in a process of role redefinition that was influenced by their self-expectations; other's expectations including family, friends, and society; resources such as coping skills and social support; and demands from multiple roles as mother, wife, and employee. Comparison of the experiences of men and women in dual-earner families provided support for the gendered nature of these experiences, reflecting personal and social expectations about the roles of men and women as parents and providers in the family (Hall, 1992).

Women's decisions about returning to work are influenced by their need to respond to changing family and social circumstances. Killien (1993) examined women's decisions as part of a larger Western United States study of the impact of returning to work on postpartum mothers' health. Factors that influenced mothers' decisions to return to work were identified and implications for social and workplace policy discussed. However, Killien did not examine how women made decisions given multiple, sometimes competing factors. This was the focus of a prospective study of urban Canadian mothers that examined women's decision making processes concerning intention to continue breastfeeding following return to work after childbirth (Morse & Bottorff, 1988). Although mothers' decision making was premised on an awareness of the need for clearly set goals and evidenced meticulous preparation and extensive contingency-based planning, there was recognition that they could not control several major factors to which they must respond. As such, mothers' decision making was characterized as a flexible "playing it by ear" (p. 496) experience. Documentation of the extensive effort required by

employed mothers to manage breastfeeding decisions in the context of daily demands and uncertainties supports the need for research focused more broadly on the diversity of health related decisions women face as they engage in family and paid work.

Accessing Social Support

Women's decision making about their use of social support to manage family and paid work is related to their perceptions about available support. Harrison, Neufeld and Kushner (1995) examined how women in a western Canadian urban setting chose sources of informal support during a normative life transition. A major emerging theme of this descriptive, longitudinal study was the work-family experiences and responsibilities of women during the transition to first-time motherhood and of mothers during re-entry to the labor force. In making decisions about their use of social support, women considered a variety of factors including their and other's expectations, availability of voluntarily offered and appropriate support, potential for reciprocity in supportive relationships, and assessment of burden imposed on those providing the support. Women's perceptions of the relationships between the demands in their daily lives, their use of social support, and their health was not addressed in this study.

Caring for Others

In a feminist grounded theory study, Wuest (1995a, 1997b) examined environmental influences on women's caring, particularly in the context of current health care reform in Canada. Although not focused primarily on employed women as caregivers, the study findings supported the influence of workplace environments on women's caring experiences. Workplace ideals about women's caring influenced whether women received support within the workplace or experienced a schism between caring and workplace demands. Additionally, self, partner, family, and community ideals influenced women's experiences as they sought to manage competing and changing demands through a process of "precarious ordering" (Wuest, 1997b, p. 50). Women's decision making processes were implicitly evident in the descriptions of their experiences, but decision making was embedded in the primary focus in this research on processes of caring.

In an institutional ethnographic study of the unpaid work of "feeding the family" as an aspect of the social organization of caring as gendered work, DeVault (1991) richly detailed the decisions made by women as they engaged in daily activities related to the provision of family meals. Although half (15 of 30) of the women were employed, DeVault's focus was on the work of feeding the family, not on the experiences of employed and not employed women. Women described the choices and adjustments to special demands they made. DeVault, however, concluded that the "choices, and the sense of autonomy that comes with making them, combine to hide the fact that they are so often choices made in order to please others" (p. 157). As such, women's decision making was oriented to family caring, and considered a natural aspect of women's work. DeVault critiqued this orientation, contending that it reproduces inequitable power relationships between family members, particularly men and women, that disadvantage women personally, as well as socially. Does this critique apply to employed mothers' experiences in providing family health care, another aspect of women's unpaid work?

In a prospective study of health decision making within British working class families, Dowswell and Hewison (1995) found that maternal employment influenced school absence decisions for illness episodes in early school aged children. Mothers, whether unemployed or employed full or part time, cited similar reasons for deciding to keep an ill child home from school. Almost equal consideration was given to clinical factors related to the perceived severity of the child's illness and to social factors related to the school environment, school policies, and staff attitudes about school attendance for ill children. However, children of full time employed mothers were significantly less likely to be absent from school for minor illness compared to children of part time employed and unemployed mothers. Dowswell and Hewison speculated that this difference might be related to constraints on full time employed mothers with respect to the lack of workplace provisions for leave for family responsibilities.

An earlier Canadian study also cited workplace conditions, as well as childcare arrangements and social network, as contextual factors important to single employed mothers' decision making about health and illness behaviors for themselves and their

children (Semchuk & Eakin, 1989). The single working mothers' "responses to their children's illnesses, in terms of the amount of stress they experienced and their use of health services, appeared to reflect the degree of conflict they perceived between their roles as nurturers ('good mothers') and as providers ('good workers'), and their attempts to manage that role conflict" (p. 349).

The influences of both contextual and personal factors on employed mothers' decision making were also examined by Thompson (1993), in a United States based grounded theory study of employed mothers' decision making about childcare for children who became ill while enrolled in day care. Influencing factors included mothers' perceptions about the certainty and severity of illness, the relative advantages and disadvantages of available care alternatives, workplace flexibility, and availability of paid leave provisions. Thompson proposed a model of decision making, depicting how employed mothers developed and appraised childcare alternatives in relation to children's illness episodes. Although there are recognized limitations of this study in terms of the dual-earner Euro-American working and middle class sample, and the narrow focus on childcare arrangements for ill children in day care, questions can be raised about potential parallels with other samples, circumstances, and health decisions.

Caring for Themselves

Research about women's decision making related to personal lifestyle behaviors and health care practices focuses more on relationships between identified factors that influence decisions than on women's descriptions of their experiences, choices, and decision making processes. Selected research representative of both focuses will be reviewed, as each contributes to current knowledge.

Devine and Olson (1992) reported that women experienced conflicts between personal choices and demands arising from their multiple roles in family caring, social relations maintenance, and employment. In-depth interviews were conducted with a small sample of employed and unemployed mothers to explore women's perceptions about the ways social roles influence personal nutrition care. This was part of a larger study of women's dietary behaviors in relation to breast cancer prevention. How the women made

decisions and attempted to resolve conflicting demands among roles, however, was not addressed.

The relationships between women's social roles and decisions about personal health behaviors also have been examined using quantitative research methods. Two such studies merit review in this section.

Verhoef and colleagues (1992) identified parenthood as the social role most strongly influencing exercise participation. The authors conducted a secondary analysis of a large data base of urban Canadian women focusing on the relationships between social roles, their characteristics and combinations, and women's decisions to participate in exercise. Social roles included parenthood, marital status, and employment. Role characteristics included numbers and ages of children, childcare, number and flexibility of employed hours, type of employment, and number of hours spent on daily activities such as housework/childcare, volunteer work, and paid work. Employed married mothers were less likely to exercise compared to unemployed married mothers, employed unmarried mothers, and both employed and unemployed women who were not mothers. The apparent conclusion that the combination of social roles in employment, motherhood, and marriage reduces the probability of exercise for women merits further study. The question is also raised about whether this relationship holds for other health promotion activities such as maintaining balanced nutrition, ensuring adequate rest, and sustaining social relationships.

Woods and colleagues (1993) reported that women's social roles, gender role expectations, social demands and resources influenced their decisions about health damaging as well as health promoting behaviors. The study sampled middle-income urban women in the western United States. Roles included parenthood, marital status, and employment. Gender role norms reflected women's attitudes as either traditional or profeminist, egalitarian. Social support, social demands of daily life events, education and income as personal resources, sense of well-being and distress, and indicators of health promoting and health damaging behaviors were measured using established instruments. Support was generated for the conclusion that although women's social roles and

attitudes did not account for the complement of health behaviors chosen by women, a pattern of social advantage, including educational attainment, being partnered and employed, and exposure to fewer stressors promoted women's decisions to participate in health promoting behaviors. Employment, however, was also associated with health damaging behaviors such as increased alcohol use, reduced sleep, and fewer meals. Given the multiple influences of social resources and stressors on women's behaviors, the importance of "understanding the context in which women live their lives and the relationship between that context and how they care for their health" (p. 403) was underscored. Although each study examined women's personal health decisions in relation to social influences, none addressed the ways women make their decisions.

Summary

Each of the reviewed studies contributes to understanding selected aspects of how women make decisions to deal with health issues in the context of family and paid work. Some researchers have acknowledged the influence of women's family, social, cultural, economic, and political environments on women's health decision making both for themselves and for the children and adults in their care. However, few research have critically examined these influences as integral dimensions of health decision making.

Conclusion

There are substantial gaps in current understandings of how women deal with their daily work experiences and how these experiences are integral to the health of women and their families. These gaps exist within the extensive multi-disciplinary literature base in the area of women, family work, paid work, and health.

A minority of researchers have incorporated a critical examination of women's perspectives as they make decisions and deal with family and paid work. Women who are busy dealing with their daily lives may have limited opportunity for reflection about the complex personal, interpersonal, and social factors that enhance and constrain their experiences, but providing such opportunity is essential to understanding the complexity of women's experiences. Researchers have tended to examine either women's personal or family health and caregiving, presenting a fragmented view of women's daily decision

making and health work experiences. Research has emphasized the influence on women's experiences of their personal attributes, such as coping and expectations, and their immediate family and workplace context.

Most research has focused on middle-class and professionally employed women, largely ignoring the different circumstances faced by working class and non-professionally employed women. The social, cultural, economic, and political contexts of women's daily lives create conditions that result in often unchallenged and competing demands on employed mothers. Several researchers have acknowledged the influences of these contexts on women's decision making and actions. Yet, few researchers integrate a research focus on these influences, and fewer still critically examine and challenge the socially-constructed nature of these influences. Given recognized differences in health and social policy between Canada and other countries where most women's health research has been conducted, and the potential impact of recent Canadian policy reform, there is a need for Canadian research. Such investigation would contribute to a better understanding not only of the complex factors related to women's decision making processes, but also of the ways and means used by women to try to meet their multiple responsibilities in a Canadian context.

CHAPTER 3

RESEARCH DESIGN

I used a critical feminist grounded theory method to conduct this study. In this chapter, I argue that critical theory, feminist theory, and symbolic interactionist theory can be used together as complementary perspectives that inform an integrated research method. I also describe how the critical feminist grounded theory method was implemented in this study.

Critical Feminist Grounded Theory

The grounded theory approach was the qualitative method most suitable to this study, considering the relatively limited theory development in the area of interest to me and the process nature of the research problem and questions. I concur with Lowenberg's (1993) conceptualization of grounded theory as one of several methods developed within the broader approach of sociological ethnography, which is in turn part of the symbolic interaction/cultural studies approaches to interpretive research in the area of everyday life/hermeneutics. A critical feminist perspective framed my research approach to grounded theory as a method. In order to explain the formulation of a critical feminist grounded theory method for this study, the influences of symbolic interactionist, feminist, and critical theory perspectives on the grounded theory method[4] of inquiry must be examined.

Intellectual Underpinnings of the Study

A critical methodological analysis (Morrow, 1994) was conducted, comparing selected metatheoretical, theoretical, and normative assumptions underpinning the perspectives of symbolic interactionism, feminism, and critical theory. I contend that the

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[4] I acknowledge the critically-oriented distinction between method and methodology (Morrow, 1994). Method refers to the atheoretical "tools" of data generation, such as survey, interview, and observation. Methodology acknowledges the theoretically-informed approaches that guide particular strategies in the research design and the implementation of methods. For simplicity, however, I will use method except where I cite the works of scholars who use the term methodology.

three perspectives presented are complementary and can be integrated methodologically. Critical and feminist perspectives extend current developments in grounded theory to support attention to and integration of social structural analysis in the generation of explanations of human action and interaction in the social world.

Symbolic Interactionist Inquiry

The symbolic interactionist tradition encompasses a variety of theoretical orientations ranging from the more hermeneuticist to the more empiricist. However, all symbolic interactionists theorize from the point of view of individual perception and meaning. There is a central focus on language and communication that provides the symbolic means for humans to interact with each other in the social world (Craib, 1992; Layder, 1994; Stryker, 1992; Waters, 1994). The "Chicago School" of symbolic interactionism represents a realist (Baugh, 1990), humanist hermeneuticist orientation to the tradition. The social world is considered both objectively material and subjectively symbolic and is constituted through interaction between individuals (Plummer, 1996).

In the symbolic interactionist tradition, knowledge is generated from empirical observation of interaction between actors and observers (Layder, 1994), presupposing that the meanings, processes, and socially constitutive and constituting interactions are accessible to empirical investigation. Plummer (1996) discussed major developments that advance the tradition toward a stronger intersubjective focus, incorporating concern with language and providing "a critical form of social analysis which aims at amelioration" (p. 244) and democratic reform. Attention to critical social analysis, recognizing gender, culture, interaction, power, and class connections with meaning directs inquiry to address a broader interpretation of individual interaction in the social world than that associated with earlier symbolic interactionist practice (Plummer, 1996). Layder (1993), however, suggested that symbolic interactionism continues to focus attention on the self and situated activity, considering the social setting and macro-structural organization as context. As such, critical social analysis remains limited.

The pragmatist perspective of symbolic interactionism contributes to an orientation toward problem-solving or action-in-practice. Consistent with this

perspective, Plummer (1996) asserted that while the value-free stance of much symbolic interactionist theory has been interpreted as inherently conservative, "it is fairer and truer to see much (but not all) of interactionism as a sociology of democratic reform" (p. 243). Plummer contended that recent developments in symbolic interactionism indicate links with critical social analysis and evolution of "grounded political moral principles of change" (p. 244).

Feminist Inquiry

The core intention in feminist inquiry is the transformation from research "on" women to research "for" women (Harding, 1987; Klein, 1983), incorporating research directed toward understandings of women's experiences and examination of social change grounded in social justice (Duffy, 1985). The integration of theory and practice as praxis reunifies "life and thought, action and knowledge, change and research" (Mies, 1991, p. 68) and reflects the belief that knowing is doing (Campbell & Bunting, 1991). Reflexivity as reflection on and critical examination of the research process is central to feminist inquiry (Cook & Fonow, 1986; King, 1994; MacPherson, 1983). Researchers engage with participants in understanding and emancipation, reflection by women about their lives, consciousness-raising, making public the oppressive nature of women's circumstances, and acting for liberation. There is commitment to making generated knowledge accessible to those best able to use it, including the women participants, the lay public, academics, and policy makers (Wuest, 1995b).

Code's (1993) advocacy of acceptance of "a realist core" in which some match is achieved between knowledge and reality, "even when the reality at issue consists primarily in social productions" (p. 21), is central to the position developed in this study. The stance is taken "that *all* knowledge, necessarily, results from the conditions of its production, is contextually located, and irrevocably bears the marks of its origins in the minds and intellectual practices of those lay and professional theorists and researchers who give voice to it" (Stanley & Wise, 1990, p. 39). The concepts of sensory experience and evidence are extended to include linguistic representation, deconstructing the dichotomies between objective and subjective experience, therefore empirical and

nonempirical knowledge, creating a bridge between empiricist, interpretive, and critical programs (Nelson, 1990).

Conventional science conceptions of disengaged objective "truth" are rejected in favor of engaged intersubjective understandings and explanations. Knowledge, as an "intersubjective product constructed within communal practices of acknowledgment, correction and critique" (Code, 1991, p. 224), is accepted on the basis of critical dialogical appraisal of evidence (Longino, 1990, 1993; Nelson, 1990, 1993). The logic of justification is pragmatist, related to consideration of the usefulness of the generated knowledge or theory in everyday problem solving.

The core theoretical category in feminist theory is "woman" acknowledging the importance of additional categories such as culture, class, race, and sexual orientation. Marshall (1994, citing Leonard, 1990) described feminist theory as a "critical theory in action" (p. 149) that is concerned more with the practical demands met by theory than with a theoretical specification of emancipatory practice.

Feminist theory, grounded in a critical-emancipatory knowledge interest, is an explicitly normative theory. The fundamental commitment to a social justice or egalitarian ethic directs attention toward the potential for emancipation, transformation, and action. Feminist theory focuses on explication and elimination of oppression, concern with agency and empowerment, and development of "moral analysis that fits the actual world in which we live" (Sherwin, 1992, p. 21). Feminist ethics reflect the centrality of situated selves, interpersonal relations, and social interaction in the formation of moral positions (Benhabib, 1992; Tong, 1997). Feminist ethical considerations in research attend to solidarity and diversity in women's concerns, the rejection of a dichotomy between personal and political realms, and the stated intent to engage in a nonoppressive research process (Wuest, 1995b).

Critical Theory Inquiry

Morrow's (1994) presentation of a reconstructed critical theory as methodology provides a framework in which "critical methodology thus is concerned with careful explication of what *is* in order to ultimately liberate us from the destiny of what *has*

been" (p. 320). Critical theory reflects a critical realist stance, reconciling the distinction between the objective reality of the natural or physical world and the intersubjectively constructed reality of the social world, acknowledged to be outside of discourse (Morrow, 1994). Therefore, intervention as praxis, the integration of knowledge and action, represents a different model in critically oriented health and social sciences from natural science intervention. The epistemology of reconstructed critical theory is pragmatist and constructivist, implying acceptance of the necessity for pluralism in methodology and strategies for explanation. Warranted knowledge is established using the theory of argumentation, the justification of knowledge through informed debate, and logics-in-use, informal or practical logics used in everyday life to resolve inconsistencies (Morrow, 1994).

Methods of inquiry include critical review of extant knowledge and immanent critique of social structure and practice, a nonrelativist standpoint from which to critique ideology and promote emancipation (Morrow, 1994). Critical theorists also engage a variety of methods in the conduct of empirical research. Methodological strategies include obtaining unconstrained consent from participants as active agents, engaging with participants in reflective dialogue, attending to language use and meaning, explicating hidden assumptions and power imbalances, and supporting consideration of transformative actions (Campbell & Bunting, 1991). Critical theorists pursue integration of empirical and philosophical theory, integration of agency and structure in explanations of interaction in the social world, and explanations of the nature of power and domination relations in societies. The core category of critical theory is power in society, examined as a dynamic interplay between social and system integration (Morrow, 1994).

The fundamental normative presupposition of the critical theory tradition is the valuing of emancipation or freedom from oppression (the negative consequences of power and domination) as the ideal human condition in the social world (Billings, 1992). Given the integration of normative and empirical theorizing in critical theory, radical relativism is rejected in favor of contextualism, as a focus on knowledge, justice reasoning, and ethics in historical and social context (Morrow, 1994).

The central metatheoretical, empirical and normative theoretical positions of symbolic interactionism, feminism, and critical theory, as compared in this chapter, extend Campbell and Bunting's (1991) comparison of feminist and critical theory perspectives in nursing. The positions presented in this chapter are considered complementary, supporting methodological intergration in inquiry.

Toward Methodological Integration

What then are the implications for grounded theory guided by symbolic interactionist, feminist, and critical theory perspectives? I conclude that grounded theory method guided by symbolic interactionism remains consistent with the original description of the method by Glaser and Strauss (1967) and subsequent elaborations by Glaser (1978, 1992). However, grounded theory method does not compel researchers to extend their consideration of structural issues and influences to depth analysis of the setting and context, of intermediate and macro-social organization. It is just this extension that Layder (1993) urged in his proposal to locate "grounded theory on a broader canvas" (p. 51), thereby serving the critical interests engaged by feminists and critical theorists. Critically-interested grounded theory method, therefore, is intended to result in the generation of knowledge that contributes to meaningful understandings and explanations of human interaction in the social world, these in turn contributing to emancipatory transformation.

Scholars who have examined feminist grounded theory methodology (Keddy, Sims & Stern, 1996; Kirby & McKenna, 1989; Wuest, 1995b) have identified several strategies that contribute to integration of the perspectives. In formulating a feminist interpretive research process based on grounded theory methodology, Kirby and McKenna (1989) emphasized a need to orient knowledge in "a political awareness of the need for change" (p. 63), to gather information with a view to its subsequent use, this requiring critical understanding of the presuppositions which ground the knowledge, and to create a collaborative research environment for both the researcher and participants. The importance of locating the researcher as a participant in the research process is considered essential to feminist research (Lowenberg, 1993). Appropriately

acknowledging the influence of many feminist scholars, Wuest (1995b) supported attention to the usefulness, particularly for participants, of generated knowledge to engagement in nonoppressive research methods and to reflexivity in the grounded theory research process. Keddy and colleagues (1996) correctly concluded that the methods of feminist social scientists such as Smith (1987), Reinharz (1992), and MacGuire (1987) are informative in the formulation of a feminist grounded theory method.

A caution directed at the intention of both feminist and critical theory to integrate metatheoretical, normative, and empirical theorizing is the potential for ideological imposition by the theorist (Riger, 1992; Sears, 1992), although such potential is also recognized by Glaser (1992) as a general concern in research. I conclude that since all knowledge is value-based, the explication of presuppositions and intent serves to open them to critique, thereby providing a means of responding to this caution.

Given the increasing awareness and support among feminists of the need to consider socio-cultural as well as gender based influences on women's circumstances, and the awareness among critical theorists that gender has been a neglected influence, I contend that feminist and critical theory perspectives and approaches to inquiry are complementary. As such, the formulation of a critical feminist perspective is supported. This perspective guides inquiry to incorporate broader social, economic, cultural, and political contexts, as well as gender influences on women's experiences in everyday life.

A critical feminist perspective combined with the symbolic interactionist grounded theory method supports focus on the women's issues inherent in the study and the researcher's commitment to generation of meaningful knowledge *for* women (Harding, 1987). The blending of these approaches is supported both theoretically by scholars who have examined the compatibility between grounded theory and feminist theory (Keddy, et al., 1996; Kirby & McKenna, 1989; Wuest, 1995b) and practically in several empirical studies (Currie, 1988; Davidson, 1995; McMahon, 1995; Merritt-Gray & Wuest, 1995; Seibold, et al., 1992; Wuest, 1995a, 1997a, 1997b, 1998).

The Study

I will now describe the implementation of the critical feminist grounded theory

method in this study. The purpose of the study was to generate a theory of employed mothers' health decision making process that integrated the personal, interpersonal, and social contexts of women's everyday lives. Although I recognized the emergent nature of research in grounded theory, I identified four research questions at the outset of the study. These questions arose from my personal experience as an employed mother, my understanding of extant relevant knowledge, and, most importantly, my reflection with other women in the women's health community about the relevance of these questions to employed mothers' everyday experiences in caring for themselves and their families. The study was guided by the following research questions:

1. How do employed mothers make decisions related to personal health and lifestyle practices?
2. How do employed mothers make decisions related to the health and lifestyle practices of their family members?
3. How do employed mothers' expectations of themselves and attitudes about their responsibilities influence their health decision making?
4. How does the social context in which employed mothers live and work influence their health decision making?

The first two questions focused on the processes engaged by employed mothers in making health decisions for themselves and for their family members. The ways that women defined personal and family health, and the actions they took to promote health were examined as components of the focus on decision making processes. The third question addressed the influence on decision making of the women's perceptions of themselves and their responsibilities, providing a focus on the personal context of women's decision making. The meanings women constructed of their everyday activities as mothers and paid workers, and as partners, caregivers, and volunteers were explored. As did Garey (1999), I focused on employed mothers simultaneously as mothers and as workers to examine the interconnections and tensions between these dual identities for women. The fourth question explored the influence of family, social, cultural, economic, and political contexts on women's decision making, bringing consideration of context

into the examination of decision making process.

Sampling

The grounded theory approach dictated a form of sampling called theoretical sampling that drove the process of data generation (Glaser, 1978, 1992). The orientation was to adequacy in sampling events, not individuals. Sampling decisions were guided not by predetermination of a suitable number of participants or interviews, but by the identification of an initial purposive sample of women expected to have experience with the phenomena of interest in the research. The initial sample for this study included women who (a) were engaged in paid employment at least twenty (20) hours per week; (b) were responsible for the care of at least one child less than eighteen (18) years of age who lived with them; and (c) were able to speak, understand, read and write English. It is acknowledged that the term "family" is used throughout this study. In keeping with feminist theory directed by the women's perspective, the woman's definition of family was accepted.

Feminist theory, further, directed the study not only of women, but of women considered vulnerable, disadvantaged, or lower on the socio-economic scale than the middle class sample often obtained when volunteer approaches to sampling are used (Reinharz, 1992). Consideration of a study of female clerical workers that addressed work-family conditions from a vulnerability perspective (Meleis, et al., 1989; Meleis, Norbeck & Laffrey, 1989; Stevens, et al., 1992) supported priority recruitment and selection of women employed in what is often termed a support staff capacity. Compared to women employed as professionals or managers, women employed as support staff often experience less control and flexibility in their working conditions. Support staff positions also are more often associated with lower incomes, therefore lower socio-economic status. I recognized that this association would be more likely to hold true for lone mothers than for partnered women whose combined family income might be considerably greater, depending on the partner's employment status.

Recruitment of the initial purposive sample was supported by the local union representing both male and female support workers at a large urban institution in Alberta,

Canada. A notice was placed in the staff newsletter describing the study and requesting that interested employed mothers contact me by telephone or electronic mail (see Appendix A). The notice also was posted on bulletin boards and distributed to administrative offices, this latter strategy being the most successful in generating volunteers. As such, the sample was volunteer and self-selected. Subsequent theoretical sampling occurred as I selected from volunteers for variation in family characteristics and in workplace circumstances.

In grounded theory, it is not the size of the sample but the richness or density of the data that is of concern (Glaser, 1978). Therefore, sampling continued until there was saturation of the data related to the central focus of the study. Theoretical sampling guided the process of data generation in accordance with emerging theory (Glaser & Strauss, 1967). As initial data were analyzed, directions for subsequent sampling and data generation were identified. This was based on the emergence of substantive codes that named and described concepts and categories and of theoretical codes that described relationships between categories. This was consistent with Glaser's (1978) contention that only as the researcher "discovers codes and tries to saturate them by looking for comparison groups, does both what codes and their properties and where to collect data on them emerge" (p. 37). Saturation is reached when fresh data no longer contribute further to the development of either substantive or theoretical codes (Glaser, 1978, 1992). Theoretical sampling resulted in saturation of the central categories. As core categories were identified and saturated, practical decisions were made to limit data generation for categories related to single participants. These categories may be pursued in subsequent research, but were considered beyond the scope of this study.

As noted by Wuest (1995a), I found the decision to cease data generation through new interviews somewhat arbitrary, although due consideration was given to the saturation of central codes and categories, the sample recruitment strategies used, and the maintenance of a manageable scope for the study as a doctoral dissertation. The decision to cease data generation was also consistent with Morse's (1994) recommendation of a sample size of 30 to 50 interviews to achieve data saturation in a grounded theory study.

For this study, I conducted 39 in-depth individual interviews, 39 brief telephone follow-up interviews, and 1 focus group. The process of theoretical sampling to discover variation through constant comparison within the data could become open-ended. Focusing on saturation of central codes and categories provided a reasonable basis for ceasing data generation.

Data Generation

In grounded theory method, data generation strategies may include unstructured interviews, group interviews, participant observation, and review of written documents including relevant literature (Glaser & Strauss, 1967). My primary strategy was guided interactive individual interviews with 20 participants: 19 women were interviewed in-depth twice and 1 woman once. In addition, all women were interviewed briefly twice by telephone following their participation in individual interviews. The interviews took place between fall, 1998 and fall, 1999. A focus group was conducted in summer, 2000 following completion of individual interview data analysis. The intervals between interviews provided an opportunity for women's reflection about their experiences in health decision making as their circumstances changed over time.

I used general open-ended questions designed to guide interviews and promote responsiveness and interaction between the women and myself as the interview developed. This was consistent with the grounded theory approach as it facilitated participant "story telling" about the ideas and issues of the process being examined (Glaser, 1992).

Characteristics of Participants

In grounded theory, sampling is intended to provide sufficient depth and variation of data to facilitate understanding the central issues or themes of the problem area. I sought depth of data by interviewing women who shared selected family and employment characteristics. All women were currently responsible for the care of at least one child in the home and all were employed at a single institution in support staff positions with access to similar benefits and policies. I sought variation in the data by interviewing women in different economic circumstances and with different family responsibilities.

Differences arose from total family income, the number and ages of women's children, presence of a partner, and the contribution of the partner to family work. Variation was also sought in women's workplace situations in terms of hours of work, type of work (e.g. clerical, technical, service), and male- or female-dominated environment. I recognized that my recruitment and interview strategies were more likely to attract women from the dominant Anglo Canadian and European heterosexual culture. The distinctive strategies needed to involve women from diverse cultural and language minority groups were beyond the scope of the current study.[5]

Demographic characteristics. Because the characteristics of the study sample relate to theoretical sampling in the grounded theory method, I will describe the women here, rather than in the findings section of the study. In total 20 women participated in interviews. The women ranged in age from 27 to 45 years with an average age of 38 years. All women were English speaking and three were long-established immigrants from Eastern Europe. All but three women were employed in full time continuing positions, one was in a full time term (the academic year) position, and two were in part time term positions. The majority of women occupied clerical positions, two were in technical positions, and one in building services. Over time, two women transferred support positions within the organization, and two women moved to management positions, one with another large organization. More than half of the women had a post-secondary technical or trade education, four had undergraduate degrees, and five had high school or less.

Women cared for between one and four children whose ages ranged from newborn to 23 years. Two women gave birth to a second child during the study. Most women cared for two or more school age children. Women managed a variety of personal

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I refer to the research described in this dissertation as "the current study" or "this study", rather than "my study", to reflect my acknowledgement of the contributions of others to this research. In particular, the women who participated in interviews and the members of my doctoral committee contributed to the completion of this study.

and family health concerns as well as family issues, such as caring for a child with developmental problems or for an elderly parent. Eleven women experienced on-going personal health concerns including chronic conditions such as asthma, arthritis, peri-menstrual symptoms, and recovery from major surgery or injury. Nine women cared for children with chronic health concerns related to allergies, asthma, and developmental problems. Three women helped their partners manage asthma or cardiac concerns and four women were caregivers for an elderly or terminally ill parent.

Initially, 18 women were partnered with men and 2 women were not partnered. One of the women separated from her partner during the study. Women's partners were employed in trade or professional occupations and most had post-secondary trade, technical, or professional education. Family income ranged from $30,000 to more than $80,000 Canadian per year. Family configuration and income are diagrammed to depict the relative variation among women's family circumstances (see Appendix B).

Social class characteristics. The description of women as either working class or middle class was not a straightforward task, but was undertaken because social class differences among women were of interest in this study. Social class description was complicated because in Canadian society there is no widely used set of criteria to identify social class. As summarized by McMahon (1995), social class typically considers education, occupation, and/or income characteristics either singly or in combination. These characteristics represent market capacity, a concept used by Giddens (1973) who saw "the market in capitalist society as intrinsically a structure of power in which the possession of certain attributes advantages some groupings of individuals relative to others" (p. 101). According to Giddens, educational qualifications and technical skills are a major influence on individual market capacity and typically correspond to occupation. McMahon used education as the primary criterion and occupation as a secondary criterion to cross-check class categorization. I concur with her statement that education "is a good indicator of class differences in options and circumstances" (p. 44). Gerson (1985) considered educational attainment to be the most influential determinant of occupational access, affecting women's work and consequently family decisions.

Following McMahon's (1995) approach, secondary education as high school or less and employment in nonprofessional or support occupations such as clerical, technical, and service positions were categorized as working class. Post-secondary education as technical or trade certification or professional degree and employment in professional or management occupations were categorized as middle class.

In this study, women's educational qualifications varied: 5 women had secondary or less education and 15 had post-secondary technical, college, or university education. They were categorized as working and middle class respectively. At the beginning of this study, all women were employed as support staff, but two women assumed management positions during the study. Therefore, 18 of the 20 women remained in working class occupations. Partner's education and occupation were also categorized. I considered this important as it contributed to women's family circumstances, even though McMahon argued that women's status should be considered independently so as not to disadvantage lone mothers. My point is that women's daily lives in their families are influenced by the presence or absence of a partner and the potential accompanying resources available to women. Among the partnered women, 6 partners had secondary or less education and worked in trades such as construction and trucking, so were categorized as working class. Another 5 men were in trade occupations but had post-secondary education, so were categorized as middle class.

In contrast to determining social class by education and occupation, using income as the major criteria produced different results. All women would be considered middle income, since reported family incomes were above both the low income cut off (LICO) and the low income measure (LIM) generated by Statistics Canada (2001). The LICO is an income threshold below which a family is likely to apportion a significantly larger share (operationalized as 20% higher) of annual income for the necessities of clothing, food, and shelter than the average family. LICO thresholds vary by family and community size and are considered relatively stable over time. The LIM is an income threshold calculated at 50% of the annual median family income adjusted for family size and composition. Neither threshold reflects regional differences across Canada in the cost

of living. Accordingly, the women in this study would not be considered among the low wage or "working poor" (National Council of Welfare Reports, 2000). Caution, however, must be exercised in equating middle class with the range of middle income categories used by Statistics Canada. As such, the utility of Statistics Canada income categories as a primary indicator to distinguish between working and middle class circumstances is limited.

Regardless of the approach used to determine social class for the women in this study, it appears that most women lived in middle class circumstances, although they were employed in working class occupations and their market potential and socio-economic resources varied both across and within the identified class categories. Of the 5 women categorized as working class by both education and occupation, 4 were partnered with men also categorized as working class. Annual family income for the 5 women ranged within middle income categories from $40,000 up to $80,000 Canadian.

The Interview Process

With the exception of three interviews that took place in the women's home, all interviews occurred in an office or meeting room located convenient to the women's workplace. An appointment was made during a preliminary telephone call or personal contact with each of the women who indicated her willingness to be interviewed for the study. Interview times were chosen to minimize interruptions and optimize energy and focus on the part of both the women and myself (ie. during scheduled breaks or immediately after work hours). These measures facilitated women's comfort and sense of control as personal contact was made, they were in "their territory" and the timing was mutually established. Selected background information (see Appendix C) was collected for each woman. This information provided primarily demographic data about the women, including personal information such as their age and education, family configuration, employment conditions, and socio-economic resources such as family income. The data introduced each woman to me and proved useful in guiding probes related to family and workplace circumstances.

During the initial 1 - 1.5 hour interview, I used a general interview guide (see

Appendix D) to initiate and develop the conversation as needed. The initial interview guide required revision only to change the order of questions asked. I began the interview with a request for each woman to describe in detail a "typical" day in which she engaged in both family and paid work. Probes included descriptions of and the meanings she attached to her responsibilities. This open introduction to the interview was followed by questions focusing on her experiences of personal and family health and health decision making. The interview questions were ordered to guide the conversation from women's more concrete experiences of daily activities, health issues, and decisions to a more abstract reflection on how family, workplace, and social contexts influenced their experiences, particularly their decision making. When occasionally needed, typical health situations were offered to stimulate reflection on women's experiences and decision making. These situations included exploring how women made time for personal care or how they decided when a child was ill enough to require medical examination or to be kept home from usual activities.

The second or follow up individual 1 hour interview with each woman took place approximately 12 months (range 7 to 13 months) after the initial interview, once analysis was completed. Prior to this interview, each woman received a summary of the initial interview findings. The three page summary presented the findings as main themes that had been identified across all initial interviews. Multiple interviews served as an opportunity not only for checking my interpretations with women, but also for continuing to build rapport in order to overcome the problem of women limiting their disclosure to "public accounts" (Cotterill, 1992). This follow-up interview provided an occasion for women to confirm or clarify my presentation of their experience in the initial interview summary and to respond to my analysis and emerging theory. Guided by the codes and categories emerging during the data analysis, I developed a follow-up interview guide (see Appendix E) that required no revision as interviews progressed. All but one woman, who was dealing with a family crisis, participated in the follow-up interview. At one woman's request to consider on-going time pressures, her follow-up interview was conducted by telephone and discussion recorded as field notes.

Following data analysis of follow-up interviews, women who had participated in that interview received a second summary presenting my interpretation of women's health decision making process. My presentation of the process included verbal description and diagrams. During a 5 - 20 minute telephone interview, I asked each woman to comment on whether her experience was reflected in the summary and to make suggestions to increase the accuracy and clarity of any aspect of the summary for her.

In this study, the focus group complemented data generated from individual interviews as part of a multi-method strategy (Morgan, 1997). In contrast to individual interviews considered most suited to in-depth exploration of women's experience, the focus group provided "direct evidence about similarities and differences in participants' opinions and experiences as opposed to reaching such conclusions from post hoc analyses of separate statements from each interviewee" (Morgan, 1997, p. 10). The workplace, including employer policies and benefits, working conditions, and supervisor and co-worker relationships, framed the discussion in the focus group. Four women participated in the focus group. Most women considered focus group participation, but were unable to identify available times that were workable for gathering a group of women together. There were no common scheduled work breaks and most women needed to attend to family responsibilities after their work day and on weekends. The women who participated in the focus group had older children and felt comfortable meeting after work.

The focus group lasted about 1 hour, by consensus among women who participated. I acted as facilitator and used a general interview guide (see Appendix F) to stimulate discussion. The opening question was intended to introduce women to each other and to provide an opportunity for each woman to speak in the group setting. Subsequent questions were designed to promote a shared examination of important commonalities and differences in employed mothers' health decision making experiences. Selected findings from the individual interviews stimulated discussion as we referred to the two individual interview summaries women had received. Findings that addressed the influences of women's social contexts, particularly the workplace context, were the focus,

guided by the categories emerging from the individual interviews.

I retrieved secondary data about employment policies for all women, including policies related to provisions for personal and family leave, workplace health and safety provisions, and workplace health promotion programs. I had anticipated the potential importance of this data as an important influence on women's health decision making, so had generated it prior to beginning the initial interviews to facilitate in-depth discussion of the influence of the workplace on women's health decision making. In addition, I periodically collected relevant articles about mothering, "working mothers", family life, workplace policy, and on-going health and social reform from daily newspapers, magazines, and books. These materials were collected throughout the study period, from fall 1998 to summer 2000. Print media sources included local and national daily newspapers (e.g. Edmonton Journal, National Post), provincial and national weekly news magazines (e.g.. Alberta Report, Newsweek), and monthly women's magazines (e.g.. Chatelaine, Working Mother). Books were identified from the women's and family sections of local bookstores. Materials were selected to reflect the current range of views, from critical to supportive, about employed mothering, family, and policy issues. Reference was made to these materials during interviews as appropriate to stimulate discussion.

The Research Relationship

In order to facilitate the development of rapport between the women and myself and to promote my greater familiarity with the data, I conducted all interviews. This relative immersion in the research process and generated data promoted clearer and more accurate interpretation of the data. Both grounded theory and critical feminist approaches supported this type of immersion.

A critical feminist perspective promoted the development of a non-hierarchical rapport between the women and myself, a focus on the experiences of each woman through her own eyes (Seibold, et al., 1992), and a responsive participant-guided format (Reinharz, 1992). Additional strategies to promote rapport included deliberately adjusting language during the interview, for example to reflect women's choices of words, as well

as being sensitive to women's hesitancies and groping for words by providing them time and encouragement to "tell their story" in their own words (DeVault, 1990). Wuest (1995a) suggested that it is important to provide each woman an opportunity to tell her story by beginning the interview with an open question about her experience in the area of interest. Further, Wuest found that each woman who participated in her research did so for particular reasons, and that part of her researcher role was to recognize, respect, and respond to agendas without compromising the study. Both during and after interviews, Wuest gave women time to express their particular perspectives and discussed these in relation to the central focus of the research. These strategies proved to be important considerations in this study, also. Many of the women who participated with me in this study said they did so because they wanted to support a research focus that was personally important to them as employed mothers working in support staff positions. Several women also commented that they wanted to support student research as part of their contribution to the university organization. During follow-up interviews, many women indicated that they valued the opportunity to reflect on their experiences as employed mothers and to see how their experiences compared to other women's in the study.

Concern that the researcher-participant relationship not become exploitive (Acker, Barry & Esevald, 1991) guided me to adopt a "friendly stranger" (Cotterill, 1992) rather than a reciprocal friendship relationship (Oakley, 1981). The key difference between these two approaches was that the "friendly stranger unlike a friend, does not exercise social control over respondents because the relationship exists for the purpose of the research and is terminated when the research is complete" (Cotterill, 1992, p. 596). The issue of researcher self-disclosure as a means of promoting rapport and genuineness between researcher and participant was considered with attention to the caution voiced by Wuest (1995a) that "there is a fine line between genuineness, self-disclosure, and manipulation in the interview process" (p. 48). I heeded Wuest's suggestion to share personal information in order to establish some common ground with women when this was helpful to or requested by them. Most frequently, women asked me if I had children

and about my own experiences in managing the multiple demands of family and paid work. In fact, a few women established this before agreeing to participate in the study, indicating their unwillingness to talk with someone who had no experience as an employed mother. My own experiences with a parent death and with parenting a challenging child were shared with a few women in order to reassure them that I could appreciate the feelings and frustrations they expressed. This approach supported the creation of a nonjudgmental atmosphere in the interviews that facilitated women's comfort in sharing their thoughts.

Documentation of Generated Data

Interviews were tape recorded and transcribed verbatim. I listened to the tapes as I reviewed the transcripts. Because of my familiarity with interviews, I was able to include pauses, silences, hesitancies, and emotions. This latter is considered an important aspect of interview data supporting researcher sensitivity to the way experience is constructed through language (DeVault, 1990; Sandelowski, 1994).

Data generated by the interviews and the background data were augmented by recording field notes of my observations related to incidents and perceptions arising from the interviews (Field & Morse, 1985). These field notes were written in a journal as soon as possible after each interview in order to minimize the potential for memory loss and misinterpretation. The field notes included my description of the physical setting, the occurrence of unanticipated events or interruptions in the interview, and the observed nonverbal communication of women. These notes constituted an additional source of data about the interviews that was not available from the actual recording of the interview. Field notes were reviewed prior to conducting subsequent interviews.

I compiled the secondary data about employment and workplace policies and related media coverage. These were organized and filed for integration during the data analysis.

Data Analysis

The blending of a grounded theory method with a critical feminist perspective in the research had implications for the methods of data analysis. In grounded theory

research, data analysis proceeds concurrently with data generation in order to guide theoretical sampling and hypothesis generation and testing toward theory construction (Glaser & Strauss, 1967). Constant comparative analysis is the analytic technique used in the development of grounded theory (Glaser, 1978, 1992). This technique is a qualitative comparison of data that entails continuous data analysis and comparison concurrent with data generation. A critical feminist approach guided my analytic perspective, encouraging examination of underlying values, beliefs and social conditions that affect the experiences of the participants (Campbell & Bunting, 1991; MacPherson, 1983; Reinharz, 1992).

Consistent with grounded theory (Glaser, 1978, 1992), data analysis began with manual open coding of the data on a line-by-line basis. The aim of open coding was to summarize women's own meanings as succinctly as possible. I frequently used women's words verbatim to ensure that the concepts identified from the data were those of the women themselves and not my attributed meanings. The data were "broken down" into incidents and examined for similarities and differences. Incidents were constantly compared to identify emerging patterns. These patterns formed the basis for substantive codes that named the concepts and categories and described their properties, and for theoretical codes that guided the development of hypotheses about relationships between the categories. Emergent categories were reduced to form more abstract concepts that facilitated discovery of the major processes called core variables (Stern, 1980; Glaser & Strauss, 1967). Concepts were linked to form an integrated picture of the social processes occurring in the situation being studied. Diagraming the emerging process proved essential to developing conceptual links between categories that represented parts of the process. As diagrams evolved, the clarity of my interpretations increased. Diagraming also was useful in identifying the central or core category in the process. Selective sampling of the literature provided a basis for comparison of the observed emerging patterns with extant knowledge and identification of new theoretical concepts. In this way, extant knowledge was considered additional data that contributed to development of categories and patterns.

The secondary data about employment and workplace policies including the

applicable union contract and written policies related to personal and family benefits as well as related media coverage were analyzed concurrently with interview analysis. I used strategies for gender analysis, that guided "how and why" questioning of the differential effect on women and men of policies and social conditions (Bem, 1993; Status of Women Canada, 1998). Gender analysis focuses on a critical "appreciation of gender differences, of the nature of relationships between women and men and of their different social realities, life expectations and economic circumstances" (Status of Women Canada, 1998, p. 4). I reviewed workplace policies to identify policies relevant to women's needs to meet personal and family demands while employed. I analysed the file of media coverage for main themes related to the emergent categories of motherhood, the family, the education, health, and social systems, and the workplace as social institutions that shape women's everyday experiences. Analysis included the identification of underpinning assumptions about women, family, social roles, and work that were evident in policies and media articles.

As analysis progressed, areas of "thin" data were identified and further theoretical sampling and data generation undertaken in order to "densify" the analysis. "Through selective sampling, already discovered categories are expanded, dimensionalized, and limited" (Stern, 1980, p. 26). In addition to theoretically sampling in new interviews, I frequently went back through completed interviews to theoretically sample for additional incidents of an emergent category. The secondary data about employment and workplace policies were supplemented by a report addressing employee concerns from a workplace wellness perspective. I continued to theoretically sample relevant media coverage in local and national daily newspapers, as well as news magazines and popular press. The cycle of theoretical sampling, data generation, and data analysis leading to further theoretical sampling continued until "saturation" of the data was achieved for the core categories. The processes of reduction and selective sampling of literature and data supported the development of the emerging theory. As Stern (1980) noted, concepts had to be integrated into a well-fitting and workable theory. As a result of the process of reduction and comparison, the core variable for the study emerged. Once identified, data were

reviewed to determine the fit of the core variable.

A central issue was my ability to recognize and interpret the "story" in the data. Glaser (1978, 1992) discussed this as the skill of theoretical sensitivity. My task was to remain open and sensitive to patterns indicative of the emerging concepts and their properties and the emerging theoretical relationships between the concepts. This approach to data analysis was consistent with feminist theory that centers on women's experiences through their own eyes (Reinharz, 1992). Remaining theoretically sensitive to the data required that I acknowledge potential sources of bias arising from my own experience and knowledge. While these were part of the analytic process, they did not impose interpretation on the data. Theoretical sensitivity (Glaser, 1978, 1992) was promoted by the use of memoing. Memos were theorizing write-ups of ideas as they emerged during coding. As an essential part of analysis, memo-writing was used deliberately as a medium for reflection on and documentation of thoughts relevant to but not necessarily specified in the data itself. Coding and sorting of memos was an essential part of analysis and formed the basis of theoretical coding as they became a vehicle for putting "fractured" data together in a coherent, theoretical form. Glaser admonished that data analysis finished without extensive use of memoing is in fact incomplete. Therefore, theoretical memoing formed a central component of data analysis in this study.

Critical feminist theory emphasis on the reflection of women's experiences in their eyes fit well with the grounded theory approach which supported the emergence of theory from the data. Feminist approaches also emphasized the value of the participants' role in data interpretation (Campbell & Bunting, 1991; MacPherson, 1983; Seibold, et al., 1994). A component of feminist data analysis, supported by Seibold and colleagues, was the discussion with women of summaries of my emerging interpretations of the data. Women received and commented on interpretive summaries following initial and follow-up interviews. I asked women if the summaries reflected their own experience and what changes they would suggest to increase the accuracy and fit from their perspective. This encouraged women's involvement in data analysis, while leaving them in control of the extent of that involvement. The follow-up phone calls lasted a few minutes for women

who commented briefly and up to 20 minutes for women who made extensive and detailed suggestions.

All women in the study confirmed that the summaries reflected their own current experience, and women with older children also saw their earlier experience reflected. Several women talked about gaining a sense of shared issues among employed mothers from thinking about the summaries. These stimulated further reflection by the women on various experiences and issues in their daily lives. Women identified wording that resonated for them or that needed clarification. They also identified issues that merited greater emphasis and suggested modifications to the visual and written presentations of the decision making process. Women's reflections contributed to my on-going data analysis. Their reflections also served to direct and develop my own interpretations and the ways they were presented to women.

Data management and analysis were assisted by use of computer software designed for qualitative data. The Non-numerical Unstructured Data Indexing Searching and Theorizing (NUD*ist version 4) software was used. Advantages of this software included support for management of complex textual data, flexibility in retaining context while developing codes and categories, and availability of experienced users to "trouble shoot" if needed.

Ethical Considerations

The conduct of a critical feminist grounded theory study presented several ethical issues common to all interview research, and a few considered distinctive to the critical feminist perspective. These are discussed in terms of strategies to protect the women who participated in the study and to promote emancipatory outcomes.

Protection of Participants

Several strategies were used to protect the women who participated in the study. Strategies included obtaining informed consent for all interviews, maintaining confidentiality of data, and minimizing risks to participants.

Informed consent. Prior to beginning the initial individual interview, I discussed with each woman the purpose and procedures of the study including the process for

informed consent. Once all questions and concerns were addressed to mutual satisfaction, I obtained an indication from each woman about her willingness to proceed with the interview and obtained signed consent (see Appendix G). The consent for individual interviews was assessed as requiring a grade 6.88 reading level using WordPerfect 6.1 and the Flesch-Kincaid formula. The formal consent to participate in the study with permission to use the obtained data was reaffirmed verbally with the woman upon completion of each individual interview. The post-interview affirmation of consent was a modification of a procedure recommended as a feminist approach to ensuring knowledgeable assent by the participant to use of the data as it has developed during the interview (Seibold, et al., 1992). If any of the women had decided to withdraw consent following the interview, the tape would have been erased immediately and no data derived from that interview would have been used in any way in the study. All women affirmed consent at the conclusion of each interview.

Consent for participation in the focus group (see Appendix H) was obtained prior to beginning that interview. The consent was assessed as requiring a reading level of grade 7.04 using WordPerfect 6.1 and the Flesch-Kincaid formula. Women were informed of procedures to ensure confidentiality in the study tapes, transcripts, and notes. These procedures were the same as those described above for individual interviews. I informed women that I could not assure their anonymity, because other group members might disclose comments made during the interview. I asked all women to be mindful of the shared nature of the discussion and the importance of respecting all participants.

Confidentiality. Women were informed of procedures to ensure confidentiality and were asked if they understood the procedures prior to signing the consent. I used several accepted procedures for ensuring confidentiality. Only code numbers identified tapes and transcripts. Tapes, transcripts, and notes were kept in a locked file cabinet separate from consent forms and code lists. These will be kept for seven years after completion of the research. Consent forms will be kept in a locked file for at least five years. Data may be used for another study in the future if approved by the appropriate ethics review committee. Publication or presentation of the findings of this study will not

include information that might identify participants.

Risks to participants. Given the critical feminist grounded theory approach to this study, major ethical considerations beyond informed consent and confidentiality included (a) ensuring that women's interests were served as well my own; (b) responsibility in managing the potentially therapeutic and reflective nature of personal disclosure encouraged in the interviews; and (c) remaining "true" to the participants' experience (Lipson, 1994; Seibold, et al., 1994). Adherence to the principles and techniques of grounded theory and feminist approaches promoted ethical practice in the conduct of the study, especially in terms of reflection of women's experiences and promotion of on-going engagement in the data generation and analysis procedures.

No women revealed discomfort because of the personal disclosure nature of the research. Had such a situation developed, I was prepared to discuss this with the woman, to inform her of available counseling services and resources such as the employer-sponsored employee and family assistance program, and to facilitate a referral if this was deemed necessary. The informed consent form included information about my obligation to report evidence of child abuse or neglect to Family and Social Services. Had this occurred, I would have discussed this information with the particular woman prior to reporting, and a referral to the community health nurse would have been made for therapeutic follow-up.

Emancipatory Outcomes

The critical feminist perspective imposed an ethical obligation to promote emancipatory outcomes as a result of the research process. Emancipatory outcomes included women's increased understanding of the forces that shaped their everyday lives, their awareness of shared issues, and reflection about the need and potential for change to improve their lives. Outcomes also included promoting public awareness of inequitable circumstances that disadvantage women and working toward change in these circumstances.

In this study, all women valued the opportunity to reflect on their everyday lives, to consider personal beliefs and concerns, and to examine common issues as employed

mothers. Several women thanked me for providing an opportunity for them to examine aspects of their lives that they thought important, but seldom had time to consider. The sense of shared experience, "I am not alone", was valued by several participants in response to the written summaries of initial and follow-up individual interviews. Each woman will receive a summary of the completed study to use as she chooses. Women supported my efforts to understand their experiences and to present identified issues to those in a position to effect change. Women sought change in the workplace to promote the development and consistent use of policies and benefits that created a supportive work environment and helped them meet their personal and family health responsibilities. They supported my commitment to provide a copy of the research report to their union for consideration in future discussions with management. Women also sought increased social awareness of the issues of concern to them as employed mothers: the need for moderation in societal attitudes about and expectations of "good mothers", the availability of effective health and social services, and the importance of public and workplace policy that supported them to meet their multiple responsibilities. They supported my presentation of study findings at conferences attended by researchers and practitioners and my plans to publish findings not only in academic or professional journals, but also in popular media in order to make the knowledge available to women like themselves.

The use of quotes from women to illustrate ideas and support substantive theory effectively presents women's own voices in generated knowledge. Women appreciated this and supported my use of pseudonyms for each of them as more personally powerful than simple reference to one woman or another. In fact, when given an opportunity to choose their pseudonym, several women did so while others were willing to have me choose a pseudonym for them.

Strategies to Ensure Rigor

The conventional concepts of reliability and validity take on a somewhat different interpretation in qualitative interpretivist research compared to quantitative empiricist approaches. Guba and Lincoln (1989) argued that conventional criteria are inappropriate

for interpretive approaches, given their origins in empiricist assumptions that truth reflects attainment of objective knowledge about an external reality independent of human construction. Yet, the need for ensuring the accuracy and quality of generated knowledge is acknowledged. The concept of rigor has been proposed as an alternative approach to such evaluation (Hall & Stevens, 1991; Sandelowski, 1993).

Glaser (1978, 1992) asserted that if the coding and interpretations truly emerge from the data, then rigor is protected. The technique for doing so, namely theoretical sensitivity, is a necessary process in a grounded theory study. Rigor is assessed by the (a) "fit" between the emerging theory and reality in the eyes of participants; (b) "work" of the theory in explaining the major variations in behavior in relation to the processing of the participants' identified issues; (c) "relevance" to the realities of the participants and the focus process; and (d) "modifiability" or ability of the theory to accommodate subsequent findings in the field of study (Glaser, 1992, p. 15). These criteria were used to assess the rigor of the research as it progressed. The two interview summaries presented the emerging theory to women, who confirmed its fit with their experience. The work of the emerging theory evolved through my attempts to name and describe the central concepts, to identify links between concepts, and ultimately to concisely describe and accurately diagram the central theoretical process. Both the work and the relevance of the emerging theory for women in the study was evidenced by their positive responses to the summaries. Further evidence has accumulated from conference presentations of the theory and explanations to colleagues and informally to women who are employed mothers. The usefulness of the theory in nursing and health promotion practice and in policy development remains to be seen. The theory has been modified as it evolved during this study. The use of the theory in practice will further test its modifiability.

Hall and Stevens (1991) proposed specifically feminist criteria for judging rigor, these being complementary to those associated with grounded theory. The main criterion was adequacy which "implies that research processes and outcomes are well grounded, cogent, justifiable, relevant, and meaningful" (p. 20). Adequacy is in the research process and evaluated by ten criteria that serve to guide the researcher in ensuring the "truth" of

the analysis: reflexivity, credibility, rapport, coherence, complexity, consensus, relevance, honesty and mutuality, naming, and relationality. Each of these will be discussed in relation to the conduct of the research.

Reflexivity promoted awareness of the relativity of knowledge, fostering integrative thinking and reflection on how the research process influences the results. I engaged several strategies to promote reflexivity, including deliberation about the research process at all phases, focus on my relationship with women participants during data generation and analysis, and sensitivity to influences that affect women's responses and my interpretations.

Credibility focused on the "construction of credible descriptions and explanations of women's experiences that can be understood by both insiders and outsiders" (p. 21). I reviewed my interpretations with women as a means of ensuring insider credibility. Outsider credibility was promoted through review primarily with my research supervisor as well as with the other researchers who were members of my doctoral committee.

Rapport between the researcher and participants was critical to research adequacy, "reflecting how well participants' reality is accessed" (p. 22). Several strategies to develop rapport, described in the data generation section of this study, were used. These included provisions for personal contact during interviews, repeat interviews, choice of setting, and sensitivity to language and diversity.

Coherence of research conclusions was reflected in the degree to which they were grounded in or consistent with the data, the demonstration of systematic logical connections, the reflection of participants' stories and interests. The procedures of grounded theory supported development and documentation of coherence.

Complexity addressed the degree to which research "reflects the complexity of reality" (p. 23). Strategies include "locating the analysis in the context of participants' everyday lives; exploring the influences of larger social, political, and economic structures; and providing historical background" (p. 23). Complexity also connoted the recognition of diversity of experience. As such, the conscious attempt to identify differences while also searching for similarities was necessary. Each of these strategies

was incorporated.

Consensus was the "congruence among behavioral, verbal, and affective elements of particular observations, verbal responses, and written records" (p. 24). Data accuracy were increased by my attention to the confirmation of recurrent themes that revealed women's meanings. Consideration of negative cases and divergent experiences also strengthened conclusions. Inclusion of contextual influences such as social position, political environment, and experiential background was essential.

Relevance was judged with respect to the appropriateness and significance of research to issues of concern to women, that serve women's interests and have the potential to improve their everyday lives. Before and during the development of this study, I spoke with women from diverse backgrounds in order to affirm the relevance of the research problem to women's experiences. Women in the study affirmed their valuing of the opportunity to reflect on their experiences and to compare these to experiences shared by other participants. I remain committed to working with women to promote the identification of and action on women's issues. My participation in the local women's health community has been one avenue for meeting this commitment.

Honesty and mutuality concerned the nature of the researcher-participant relationship. The research did not include deception of participants about the purposes and design of the research. The informed consent was written at a level that promoted understanding of the research and participants' commitments prior to engaging in the research. Mutuality was promoted through the construction of the interviews and the relationship between the women and me as the researcher. My genuine interest in and concern for women's lives proved important to ensuring mutuality.

Naming reflected sensitivity to the power of language to construct experience. The selection, definition, and description of themes, substantive and theoretical codes, and categories remained close to the language used by the women who participated in this research. The themes, codes, and categories were reviewed with women during subsequent interviews. In their responses to interview summaries, women supported the "names" attached to core categories and descriptions of their experiences.

Relationality addressed the importance of collaborative working methods as "a means of increasing reflexivity, accuracy, mutuality, and therefore the adequacy of the feminist research" (p. 26). Through the course of the research, I developed a relationship with women that enabled their contribution to the emerging theoretical categories. I maintained a close working relationship with my dissertation supervisor with whom I discussed emerging ideas, shared developing writing, and reflected on the research process.

As anticipated, the main threats to rigor in this study centered on my ability to be theoretically sensitive to the data and to create the "honest, open story-telling" expected of the women. Intended to address these threats, strategies were engaged to promote the development of a non-hierarchical participant-researcher rapport and careful adherence to the analytic strategies of the critical feminist grounded and feminist theory method.

Conclusion

The study was conducted with careful attention to the procedural and relational strategies mandated by the critical feminist grounded theory method. The following chapters (4 to 6) present the major study findings: meaning and action in health work; social institutional influences on health decision making; and the process of finding a balance in health decision making. Each of these chapters is written in a style that is consistent with the focus of the findings in the context of current literature. The style in Chapter 4 of reporting findings about women's meanings of health and their actions in health work reflects the emphasis in health behavior literature on reporting themes and frequencies of events. The explication in Chapter 5 of social institutional influences on women's experiences, specifically on their health decision making, is consistent with the style used in institutional or critical ethnography. Finally, the integrative process focus in Chapter 6 on women's personal and family health decision making is reflective of a critically-oriented grounded theory style of presentation. The final chapter, Chapter 7, addresses implications of this study for theory development and health promotion practice, including a focus on policy and program development, as well as on work with women and their families.

CHAPTER 4

TAKING CARE OF HEALTH: MEANING AND ACTION IN HEALTH WORK

Women's meanings of personal and family health framed the context of their daily experience of making decisions about and caring for their own health and their family's health. I asked women four questions about health and health actions: What does being healthy mean to you? What do you do to take care of your health? What does having a healthy family mean to you? What do you do to take of your family's health?

In this chapter, I present what health meant for women in this study and I describe what actions women took in their everyday health work to take care of their health and their family's health. As well, I examine three aspects of common ground between women's health meanings and actions in health work: themes common to being healthy and having a healthy family; personal meanings of health for women; and congruence between women's health meanings and actions.

There were differences among women in their inclusion of and relative emphasis on various aspects of health, reflecting diversity in their experiences and social contexts, yet, shared themes about women's meanings of being healthy or having a healthy family were identified. Several themes were common to the meanings of being healthy and having a healthy family. Women also described the personally meaningful nature of health and the everyday work of balancing personal and family health. All women reflected an attitude of individual responsibility for taking care of their own health. As well, all women assumed primary responsibility within their family for family health work. Women's assumption of responsibility was reinforced by their recognition that family health work is associated with social expectations of motherhood in Canadian society. Being healthy and having a healthy family were conceptualized by women as complex, dynamic, and part of everyday living.

Women's Health

Women in this study described "being healthy" as multi-faceted and changing over time and circumstances. Women tended to use "health" and "being healthy" interchangeably in their descriptions of personal health meanings and health work.

Women included both the absence and presence of various attributes of being healthy and reflected an orientation to everyday function, coping, and satisfaction. More than half of the women spoke of the meaning of being healthy in the context of chronic health concerns such as recurrent headaches, asthma, or arthritis. These women described themselves as healthy, in so far as they remained able to manage their everyday lives and responsibilities.

Women's talk about their meanings of being healthy reflected their categorization of health into physical, social emotional, and spiritual dimensions. All women used the categories of physical and social emotional, psychological, or mental health; a few women also talked about spiritual health. Most women used more than one category, and all but one woman used at least the physical category. The use of these categories is consistent with mainstream Western cultural views of health. The biopsychosocial conceptualization of health (Engel, 1977), which identifies biological, psychological, and social components or categories of health, became a widely-accepted view of health in recent decades.

Rose's description of being healthy illustrated the inclusion of physical, social emotional, and spiritual dimensions as an interlocking whole. In talking about being healthy, Rose expressed concern that people are placing their health at risk by ignoring dimensions of their health as they lead extremely busy lives. Rose explained:

> ...physical, emotional, social, spiritual...all of those, they have to be joined as one and interlocking like that game....All of the parts, if you pull parts of them away, the rest come down. And it depends on how big a part that's removed as to whether the whole tower will come down or whether it can still stand.

Rose compared health to a Jenga® game. In the game, wooden blocks are stacked in an interlocking pattern to construct a single tower. Players take turns removing a block from within the tower and placing it on top of the tower. The object of the game is to avoid causing the tower to unbalance and collapse. Rose's analogy of health as a Jenga® game vividly captured women's views of the dynamic and multi-faceted nature of health for them. Her comment suggested that the integrity of the whole structure depends on the relationships between dimensions that change over time.

Individually and collectively, the women illustrated ways of being healthy and doing health that exemplified their descriptions of physical, social emotional, and spiritual health for themselves and their families. These illustrations supported a second strategy of categorizing meanings of health: "not being healthy", "being healthy", and "doing health". "Not being healthy" describes problems or signs, symptoms, and behaviors associated with poor health and illness and health is seen as the absence of these. "Being healthy" describes the presence of characteristics or states associated with good health and wellness. "Doing health" describes actions associated with healthy living, including lifestyle activities, role functioning, and managing daily life.

Not Being Healthy

Twelve women included dimensions of not being healthy in their descriptions of personal health. Most of these women spoke of not being physically ill or disabled. As well, half of these women spoke of not feeling mentally miserable or drained and one of not being mentally ill. Geri's response included both physical and social emotional dimensions of not being healthy:

> ...if you don't have the desire to do anything then your mental health is suffering. And if you aren't physically able...and not suffering from too many aches and pains.

As did many of the women, Geri considered both conditions of poor health (eg. aches and pains) and limited capacity (eg. no desire, not physically able) as indicators of not being healthy.

Being Healthy

Of the 18 women who illustrated ways of being healthy, most talked about a social emotional dimension or a physical dimension, but only 2 about a spiritual dimension. Being healthy socially and emotionally meant feeling happy, contented, and relaxed; having a positive attitude to life; and being in healthy relationships. Being healthy physically meant feeling fit, strong, energetic, and able to manage daily activities. Being healthy spiritually meant feeling connected to others by feeling part of a greater power and having a sense of personal identity within a collective whole. Daria, who was

dealing with an extended post-injury recovery, focused on being able to fulfill her everyday responsibilities in her paid employment, and in her family as a mother and wife:

> My challenges are to be able to keep up, to be able to manage life, to be able to do my job, be a mom, be a wife.

Similarly, Scarlett, who had previously experienced serious health problems, described her current experience of being healthy:

> I have enough energy to do what I want to do. I feel positive about my life. I feel strong emotionally, physically, psychologically. I am able to do what I want to do. I feel joy in the morning when I get up.

The comments by Daria and Scarlett illustrate the many capacities important to women in being healthy in their everyday lives. Being healthy meant having the capacity to meet demands, fulfill roles, and experience a sense of enjoyment and satisfaction in everyday living.

Doing Health

Fifteen women reflected aspects of health as action in their descriptions of being healthy. All of these women spoke of a physical dimension and most women spoke of a social-emotional dimension of doing in health. Both dimensions were reflected in the primary focus for women on managing their daily lives, facing challenges, and taking care of themselves and others. Additionally, six women included a focus on physical health activity such as exercising or active living and eating nutritiously. Few women spoke of social emotional activity related to enjoying and growing through life. The focus on everyday activity was captured by Emily's description of health:

> Health to me means to wake up every day, face new challenges, enjoy life. Enjoy whatever comes at me, whether it's good or bad. Just enjoying the fact that you are on this earth.

Haley also illustrated women's views when she commented:

> Health encompasses everything. It is how we function in the day-to-day, it's how we take care of each other, and it's how we take care of ourselves.

As Emily and Haley illustrate, women described health as an active experience that enabled everyday living.

The descriptions of being healthy by women in this study support philosophically

derived conceptualizations of health (Smith, 1981) and empirically generated meanings (Bruenjes, 1994; Litva & Eyles, 1994; Woods, et al., 1988). Smith (1981) proposed 4 categories of views of health: clinical, role performance, adaptive, and eudaemonistic. A clinical view of health focuses on the absence of signs or symptoms of disease or disability, whereas a role performance view focuses on the performance of social roles with maximum expected output. An adaptive view emphasizes flexible adaptation to the environment and a eudaemonistic view encompasses exuberant well-being. Woods and colleagues (1988) reported empirical support for Smith's categories and connected them with the emergent categories of negating, being, and doing. Negating, the absence of problems, was consistent with a clinical view of health. Being, the presence of desirable attributes, reflected both the adaptive and eudaemonistic views of health. Doing, the health-related activities, fit with the role performance, adaptive, and eudaemonisitic views of health. Women's use of the more conventional categories of physical, emotional, and spiritual health was evident in Bruenjes' (1994) study of middle-aged women's definitions of health. Women's descriptions of health emphasized a sense of well-being evident in the capacities for meeting demands and enjoying daily life. The focus on this sense of well-being in everyday life was also reported by Litva and Eyles (1994) in a study of the meanings of health and healthy for people in a small Canadian town. A distinction was identified between health as an abstract disease-oriented concept applicable to others compared to being healthy as a personal experience of capacity in everyday life.

In this study, women's inclusive descriptions of being healthy suggest that health encompasses multiple dimensions that are experienced as integrated, not mutually exclusive, aspects of health. Women's descriptions included the absence of disease or disability, while emphasizing role performance, adaptation, and an overall sense of living fully. Their descriptions also emphasized ways of being healthy and doing health related to physical and social emotional health. Although women used the terms health and being healthy interchangeably, their descriptions clearly emphasized the personally meaningful experience of health in everyday life.

The capacity for everyday living was central to women's descriptions of being healthy. The women in this study incorporated living with acute and chronic health concerns in their descriptions of a sense of overall well-being. These descriptions are consistent with the World Health Organization (1986) definition of health as "a resource for everyday life" (p. 426). Yet women's descriptions contrast with the popular lead-in to that definition of health as "a complete state of physical, mental and social well-being" (World Health Organization, p. 426). Whereas women, particularly those with chronic health concerns, considered themselves healthy given their capacity to manage everyday life, they did not claim to be in a complete state of well-being. Although women's descriptions reflected health as a state or entity, they emphasised the continuously changing experience of health in everyday life.

Women's emphasis on their capacity to meet changing demands, to manage the challenges of everyday life, and to feel good about their lives is suggestive of a salutogenic view of health (Antonovsky, 1979, 1987, 1998). This view accepts that all people exist in "a dynamic state of heterostatic disequilibrium" (1987, p. 130), meaning that people exist amidst continuous change. In this view, people actively try to comprehend or understand their world, to manage or believe they have access to resources needed for coping with demands, and to find meaning or make sense of and feel engaged with events in their lives. These activities are characteristic of people's sense of coherence in life and it is their sense of coherence that frames their health. The pervasiveness of stress in daily life and the need to manage tension or cope with daily stressors are considered central to promoting health from a salutogenic view. Women's descriptions of being healthy in this study are consistent with the key concepts of the salutogenic view of health.

Women's view of health as a capacity for everyday living and the inclusion of social relationships as part of being healthy also reflects a social ecological or socio-environmental view of health (Labonte, 1993). For example, women's descriptions were similar to the descriptions of health compiled by Labonte (1993) during professional health promotion training workshops: being loved, having friends, family,

giving/receiving, able to do things I enjoy, spiritual contentment, wholeness (p. 16). An ecological view of women's health integrates women's individual characteristics including genetic makeup, knowledge, and skills with their social contextual characteristics such as family responsibilities, social support, adequacy of income and living conditions, and access to health and social services (Writing Group of the 1996 AAN Expert Panel on Women's Health, 1997). This view, as did women in this study, emphasizes multiple aspects of women's whole lives and lived circumstances as aspects of women's health.

Women in this study recognized the discrepancy between their inclusive view of being healthy and the dominant biomedical and behavioral views reflected in the current Canadian health care system. Women believed that their view of health was more consistent with their everyday experience than the view reflected in the health care system. This latter was considered consistent with the medical function of the health care system that supported women in caring for health problems. However, most of women's health work was carried out in their daily family and community experience outside of the health care system.

Taking Care of Their Health: Women's Health Work

The majority of women in this study talked about active living, balanced nutrition, adequate sleep, and access to medical care when needed as regular aspects of taking care of their physical health. Almost half of the women spoke of personal care activities related to hygiene and their appearance. Emily's listing of personal health care actions that emphasized self-care, health practices, and access to medical care was typical of women in the study:

> I am not big on taking vitamins or extra pills or whatever. I always make sure that I have enough calcium and I have enough grains, and sort of going down the list. I make sure I get enough sleep. I drink lots of water. I get up in the morning, have a shower. I do go to the doctor once a year, go to the dentist.

As had Emily, all women described a variety of ways that they took care of their health.

Most women stated that they attended to their own health less than they believed they should and knew that they relied on their general good health status to counter their

inattention. Naomi talked about placing lower priority on taking care of her own health compared to her family care actions. As did several women, Naomi relied on her general good health, but recognized the need to shift priorities when personal health problems arose:

> So often things that are for myself are actually, usually at the bottom of the priority list. And sometimes I feel that this is something that I just have to do and then I bump it up. Unless I am sick, if I am actually physically sick then obviously I have to look after that first. But for the most part, I am fairly healthy so I don't have to worry about that too, too much.

Naomi recognized her tendency to wait until she experienced health problems before making self-care a priority, but believed that her general good health protected her. Haley, who also relied on her own good health, talked about the consequences of selectively ignoring her own health care:

> You know, you let this go and you let this go and then all of a sudden you get to a point where you can't function the same way you used to. And that's when my alarm bell goes off. So the immediacy moves up the priority list. It all comes back to responsibility. I think you owe it to the kids and the spouse and all of these things to get fixed. I often think if I had done this sooner, it wouldn't take me as long to come back from it.

As Haley's comment illustrates, women's recognition of the selective neglect of their own health reflected their awareness of the potential risks involved. Women knew that they risked developing more serious problems when they neglected their own health, and that these problems put at risk their ability to fulfill their responsibilities for paid and family work.

Most women also talked about taking care of their social emotional health through activities to maintain daily routines, support caring relationships, promote coping, and reduce stress. These activities included time for themselves, as well as social time with family and friends. Geri commented:

> I do try to, even if I can't see a friend, I try to ensure that I can talk on the phone with a friend because it's nice to know that somebody cares about you, chooses to spend time with you, whether it's on the phone or in person.

Geri's time for herself included maintaining social relationships. Ilana's focus in taking

care of her social emotional health included a variety of social activities:

> I think my involvements, like the cultural association and the social concern involvement, kind of take care of that side of it. Also, it is important for me to keep on learning. That's why I guess I take these courses. I have a few friends that I try to meet here and there once in a while. My children, of course, they give a lot to me. I get a lot of love from them. My husband and I have been able to make a couple of short trips.

As evidenced by the quotes from Geri and Ilana, women engaged in many activities to care for their social emotional health. These activities reflected the importance women placed on being socially and emotionally healthy and their inclusive view of social emotional health.

A few women talked about periodically reflecting on their sense of well-being and their everyday circumstances as an activity directed at consciously keeping track of their health. Haley described this as "a 5000 kilometre checkup, once a year". Jenna spoke of being "in tune with your body, with what's going on". These women tried to maintain an awareness of their own well-being that did not rely exclusively on the development of signs and symptoms of health problems.

All women in the current study experienced occasional acute illness such as the common cold and twelve of the women managed chronic physical health concerns including recurrent headaches, allergies, asthma, arthritis, and perimenstrual symptoms (PMS). Most women managed these concerns through self-care activities in order to moderate activity and enhance energy. Self-care was supplemented by medical or pharmaceutical treatments when needed. Mora was one of several women who talked about strategies to manage perimenstrual symptoms that interfered with her ability to fulfill daily responsibilities in paid and family work. Mora moderated her activity over her monthly cycle in order to ensure adequate energy to deal with her symptoms and responsibilities:

> I suffer severe symptoms of PMS. I have been trying to tell my husband that if he wants me to continue working, I have to take care of myself so I can be able to deal with all this. I make sure I go to bed and leave everything, because otherwise, no way I could continue on. When I get better, I catch up on this time and that's how I work regarding my PMS schedule. I feel fine then my energy's there so I

keep up what I left during this other time.

For Mora and other women, the creation and maintenance of workable routines responsive to changes in the symptoms associated with chronic health concerns was an important self-care.

Women used a multi-strategy approach, including self-care and medical and/or alternative care, to take care of chronic health concerns. Dol, who experienced several concerns, combined all three approaches to care:

> I actually have more health problems this last year than usual, one of which is asthma and it's getting worse. I had actually gone to the doctor many times. The last time they also concluded that I probably have an ulcer. The monthlies that I go through, I can just barely catch it. I have about a half an hour to take the right pills. If I do, then I am fine. If I can't, I have to have somebody literally drive me home. I've had headaches for 20 years. I have started taking these herbal teas and an herbalist was examining my diet. She said, "while I'm treating you for the asthma, could you please stay away from corn products, dairy products, and MSG?" I went 18 straight days without a headache, I went through my period without dying, and I also went off my ventolin at the end of those days.

In addition to the medical and alternative care she described, Dol's self-care strategies included keeping track of her well-being, maintaining healthy lifestyle practices, and regulating her activity. Dol was one of six women who regularly used alternative care strategies to manage chronic health concerns such as headaches, to reduce stress, and to improve their overall health. Strategies included holistic nutritional supplements, massage therapy, and chiropractic treatments.

Stress was an explicitly identified concern for half of the women. They talked about headaches as a common physical consequence or symptom of stress. Women managed stress-related symptoms through a combination of self-care and alternative strategies. Leandra's experience was typical:

> I think probably in the last six months I have become more aware of my own health and that's just through personal struggles with coming back to work. Maybe it was the stress. I often have tension headaches, stress headaches and I go once a month for massage therapy. Before that I used to be taking over the counter medication constantly for headaches so I rarely do that any more.

Leandra preferred to manage her stress-related concerns through alternative therapy,

rather than through medication. This preference of alternative over traditional medical treatments for stress concerns was common to women in the study.

Some women experienced serious stress-related illnesses that compromised their daily activities and required medical treatment. One woman's stress reaction had presented as a life-threatening auto-immune disease:

> I was diagnosed with a disease that was stress related. We have since figured out that it was all stress. It was my body saying, "I don't like you any more!" I got rid of the family problems, my stress level went down, and I was healthy again.

In response to the medical diagnosis, this woman made changes in lifestyle practices and dealt with identified family problems in order to reduce her stress. These actions contributed to an alleviation and eventual resolution of disease symptoms. The focus on changing lifestyle practices was shared by each of the women who experienced serious stress-related health problems.

Whether or not women acknowledged stress as a more or less serious health threat, all women recognized the need to manage stress in order to preserve their ability to manage daily life. However, women voiced frustration that problems requiring stress management were easier recognized than resolved, given their multiple responsibilities in paid and family work. Lea's frustration was evident in her account of seeking medical care for stress-related physical symptoms:

> I am experiencing some physical symptoms of severe stress and I had a doctor ask me what I thought I could do to reduce my stress load. I said, "I don't know. I have my job, my kid, my dream! What would you like me to give up first?" So he went, "Oh well, here's a prescription for some anti-anxiety medication." I am trying little things like paying my sitter extra to vacuum my house and dust every night. I have to find little things to help reduce the stress a little. I'm like in fire fighting mode all the time. I know I don't get enough sleep, I live in my car, I don't eat anywhere near close to properly. With this kind of a job, half the time we don't have time to eat. I try and make up for not getting to eat by snacking a lot and eating healthy snacks. I was trying to work out. I don't think I'm doing much except running around.

Lea's experience of persistent stress related to managing her daily responsibilities was typical of many women's experience in this study, although admittedly more intense than most. The multiple stresses that Lea faced included being a lone parent to child with

special needs and a limited support system, and an employee in a service position where work demands were unpredictable and management was in transition.

Lea's frustration with limited practical help from medical care was repeated in Dol's recent experience with medical care for a newly diagnosed ulcer in addition to her chronic health issues. Dol recounted her response to her doctor's medical advice:

So she just said, "Take it easy," and I said, "And when should I schedule that in?" For Dol, as for other women, stress arose not only from their everyday demands, but also from their attempts to deal with stress-related health concerns. Women's management of stress entailed making health decisions and taking health actions to preserve their ability to manage the multiple demands of their daily lives. Decisions and actions were motivated by the recognition of stress as a real health issue for many of the women in this study.

The health work activities of women in this study to take care of their health were consistent with activities commonly documented in studies of women's health promoting and health damaging behaviors. Woods (1985b), studying women's self-care, identified everyday health and illness activities from analysis of women's daily health diary entries. Health activities most often cited were taking vitamins, using contraception, taking prescription medications, and to a lesser extent, managing diet and activity. Illness activities commonly included taking over-the-counter medication, moderating activity, and taking prescription medication. In subsequent research, Woods and colleagues (1993) reported that women were more likely to engage in health promoting behaviors such as adequate sleep, exercise, and diet if they were partnered, employed, and well-educated. These demographic characteristics were similar to those of most women in the current study.

In another large study of health and lifestyle behaviors, Blaxter (1990) reported that the most commonly engaged health activities for women aged 18 to 59 years focused on fitness or sports, active living, and diet. Less commonly identified health activities related to social activities, positive attitudes, medical treatment, and employment. A detailed analysis was conducted of smoking, alcohol consumption, diet, and exercise as

important, common lifestyle behaviors. Smoking, alcohol consumption, poor diet, and low exercise were considered potentially health damaging behaviors, whereas not smoking or consuming alcohol, good diet, and high exercise were health promoting. The majority of women's lifestyles reflected a mixed pattern of health promoting and health damaging behaviors. Women who reported mostly health promoting behaviors tended to be 40 to 59 year old employed professionals and at home wives of professional men. In contrast, women in the current study were somewhat younger employed non-professionals. Most women reported mostly health promoting behaviors, with the exception of high exercise. The differences in study findings might be related to the health promoting or health damaging behaviors selected by Blaxter. The four behaviors have been a continuing focus for popular health promotion campaigns during the decade since Blaxter's study. Women's reports in the current study reflected a mixture of health promoting and damaging behaviors when a broader range of activities, such as self-care and stress management, were considered.

The tendency of women in the current study to rely on their own healthiness and place priority on family caregiving responsibilities over self-care is consistent with existing research about women's health activities. Studying women's personal nutrition care, Devine and Olson (1992) reported that women, who perceived themselves to be healthy, focused on their family caregiving responsibilities. Efforts to provide positive nutrition for their family were relied on to support meeting personal nutrition needs.

The findings of the current study that women with chronic health concerns adopt a self-care orientation and multiple strategy approach to fitting their health activities with their everyday circumstances support the findings of two previous studies. Studying women's health-seeking behaviors for chronic perimenstrual symptom concerns, Woods and colleagues (1992) reported that women engaged in multiple activities to relieve symptoms. Typically, women focused on strategies for self-care and self-control. Self-care strategies related to activity, rest, diet, and medication. Self-control strategies related to distraction and control over daily activities such as simplifying work and altering schedules. In a study of women's perspectives on chronic illness, Anderson, Blue, and

Lau (1991) reported that women restructured their lives to deal with their chronic illness. Restructuring activities included establishing routines for medical and alternative treatments, moderating activity to ensure adequate energy to meet daily demands, and securing resources to support expected self-care. This restructuring was framed within the social context of self-care and individualist ideologies held by the biomedical system and general Canadian society. Yet, the researchers argued that "the situations that people face in their everyday lives that influence their experiencing of illness are outside the medical discourse" (p. 110). Unlike women's multi-strategy approach to their chronic health concerns, the medical system tends to function within a relatively narrow biomedical focus that is considered largely outside of the circumstances of women's everyday health work.

Women in this study emphasized activities to care for their social emotional as well as physical health, in contrast to the dominant focus on physical health needs in research about women's health and illness self-care activities. Women associated stress with physical and social emotional health concerns. Intense or conflicting demands from women's multiple responsibilities in paid and family work were sources of stress for women. Women's awareness of social expectations about women's family roles increased pressure on women to maintain primary responsibility for family caregiving. Many women identified their paid work as a source of stress relief from family demands. These findings are consistent with current research about women's social emotional health activities which is framed primarily within literature about stress and coping. A large study of health and lifestyle behaviors in the United Kingdom (Blaxter, 1990) reported that, for women, increased illness symptoms and decreased psychosocial health were associated with stress. Blaxter concluded that while lifestyle behaviors were relevant to women's health, they were less so than conditions such as stress in women's social environment. Motherhood is associated with psychological distress and is the primary source of stress for women with family and paid work roles (Barnett, 1993). Women's family roles were characterized by limited control, relentless demands, and great responsibility that exposed women to multiple frustrations and failures. "Compounding

this picture and adding to the stressfulness of women's family roles is the cultural expectation that women should perform these roles naturally and with no negative consequences. To admit to the stress is tantamount to admitting to failure as a woman" (p. 437). In contrast, women's workplace roles were associated with overall well-being, even in low-status and more-so in high-status positions. The current study findings support the conclusions from both of these earlier studies about the sources and impact of stress on women's daily lives.

Stress management was part of caring for women's social emotional health as women focused on stressors related to the multiple demands in their everyday lives. This focus is consistent with the work of Lazarus (1993), who advocated that stress be viewed as an aspect of emotion that arises from demands that tax or exceed an individual's resources. The emotional response associated with stress is indicative of the individual appraisal or meaning of stress in everyday circumstances. This view is consistent with the argument that the influence on health of microstressors or "hassles" experienced in daily life varies with the meaning of events to the individual (Macnee & McCabe, 2000). This view is also consistent with the findings of the current study.

Women in the study described experiences of stress and coping consistent with current literature, and support an association between social emotional health, physical health, and activities that promote coping with stress. Stress has been associated with physical sensations such as headache, fatigue, and muscle tension (Lyon, 2000), in addition to psychological and emotional distress. Stress also contributes through a multifaceted effect on the immune system to physical diseases such as infection, tumor development, and auto-immune disorders. Individual efforts to manage or cope with stress typically focus on appraisal of the situation (emotion-focused coping) and problem solving to resolve the situation (problem-focused coping) (Lazarus, 1993). Women in the current study described both types of coping strategies to manage stress and stress-related health concerns. Women used both types of coping as complementary strategies, rather than relying on one or the other type.

In summary, many of the health experiences of women in this study are examined

in current women's health literature: the multifaceted nature of health, the experience of health in the capacity for everyday life, the multiple strategies used to care for health, and the emphasis on self-care and individual responsibility for health. However, unlike current literature, women in this study focused on social emotional health as much as on physical health, and their focus broadly incorporated a positive attitude to life and good relationships, as well as coping with stress. Women's health scholars (eg. Blaxter, 1990; Killien, 1999; Woods, 1985a; Woods, et al., 1993) have advocated repeatedly in recent decades for a more inclusive approach to women's health care that reflects consideration of women's everyday circumstances and the influence of social context. Yet, women continue to experience a disjuncture between the focus of their experiences and that of the health care system. This disjuncture is reinforced by the individualist self-care ideology evident in the health care system (Labonte, 1993) and Canadian society more broadly (Eichler, 1997). Whether women, including those in this study, accept this ideology or simply the practical need to work within the ideology, they value their ability to maintain good health and manage health concerns as part of everyday living.

Family Health

Just as women described personal health meanings and actions, they also described what family health meant to them and what they did to take care of their family's health. Women's descriptions of family health were multi-dimensional, reflecting a focus on the absence or presence of attributes and on everyday action. Women engaged in a variety of health actions that reflected these same dimensions in their everyday health work.

Women's descriptions of having a healthy family addressed both individual family members, primarily children, and the family group as a collective. The descriptions reflected women's consideration of state and action dimensions of not being or being healthy and doing health, as well as of physical, social emotional, and spiritual dimensions of family health.

Not Being Healthy

For most of the women in this study, having a healthy family meant not having

family members who were physically ill or disabled, whose lives were constrained by dietary restrictions or medication requirements, or who struggled socially and emotionally. Not being healthy was oriented to individual family members rather than to the family as a group. Almost all of the women's comments addressed their children. Just five women included their partners in the consideration of not being healthy. Olivia's description of family health included numerous aspects of not being healthy for both her children and her partner:

> We're not talking chronic disease...they cannot have colds all the time. They are not over weight...Not just surviving, not just making it.

As did other women, Olivia considered the presence of disease or disability, of conditions such as obesity that increase the risk of disease and interfere with daily activity, and of subsistence rather than coping in everyday life.

Being Healthy

Most of the women described being a healthy family, emphasizing a social emotional more than a physical dimension. Many of the women focused their comments on their children and the others spoke of the family as a group. Women included their partners in the family as a group, but partners were not singled out as children were. Being physically healthy for children in the family included capacities to be active, well nourished, energetic, and able to live fully. Being physically healthy as a family group focused on the capacity to live fully. For children in the family, being socially and emotionally healthy meant being happy and having a sense of being loved and secure. As a family group, being healthy socially and emotionally meant having a collective sense of openness and reciprocity in relationships. Faith's description captured many of the aspects of being healthy for children in the family:

> I want them to grow up happy and be able to do everything that other normal kids do and at the same time feel bonded and loved and cared for and secure.

In addition to expressing a description similar to Faith's of being healthy for children, Rose emphasized being healthy for the family group:

> Family health has got to be give and take, it's got to be discussion, it's got to be openness and being able to accept constructive comments.

Being physically and social emotionally healthy applied to individual members as well as to the family group. Women particularly emphasized being socially and emotionally healthy for the family group.

Doing Health

Nearly all women also described physical and social emotional activities or doing aspects of family health and they focused either on children or on the family as a group. Women did not address comments to their partners as individual family members. Women described family health for children as meaning that they physically took care of themselves and carried on day to day. Being healthy also meant that children cared for each other and were growing up in a positive social emotional environment. For the family group, being healthy included physically dealing with challenges as well as social emotionally caring for each other, sharing, facing challenges, and managing proactively. Leandra focused on everyday activities related to children's health within the family:

> They can swim, they can walk, they can jog, they can play with the dogs, they can ride a bike. They can go to school. They can shoot a few hoops with a buddy. They can live. That's healthy.

In her description of health in terms of family group as well as individual action, Rose concluded:

> They are all part of helping each one of us. They all work, not just for themselves but for the good of the group.

As Leandra's and Rose's comments illustrate, women emphasized the activities of everyday living in identifying the ways that families "do" health.

Women's descriptions of the many attributes and actions that characterize family health provide support for Walsh's (1993) transactional conceptualization of family health. This conceptualization reflects both typical and optimal functioning and development over time. Similarly, in the Developmental Health Model (DeMarco, Ford-Gilboe, Friedemann, McCubbin & McCubbin, 2000), health in a family context is viewed as a way of living that encompasses continuous opportunities for development and coping in everyday life.

Few studies have empirically examined family's images and meanings of family health. One notable exception is a recent series of family health studies (Denham, 1995, 1999a, 1999b, 1999c, 1999d). Women's perspectives on family health in the current study are consistent with Denham's (1995) ecological conceptualization of family health as "the everyday lived experience of a family" (p. 12). Denham further elaborated her ecological conceptualization of family health in subsequent research with rural (1999a), grieving (1999b), and economically disadvantaged (1999c) Appalachian families. Family members in diverse circumstances were asked to define family health, to recount experiences with individual member health and illness, and to describe family health routines. Based on these three studies, Denham (1999d) proposed a definition of family health as "the dynamic ways that members holistically care for one another using communication, cooperation, and caregiving to develop and sustain health routines within the contextually embedded household" (p. 215). Individual family members experienced personal health and illness within the family, yet continued to identify themselves as members of a healthy family collective. In these studies as in the current study, the concept of family health was recognizably complex, multi-dimensional, and dynamic.

In this study, women's descriptions of social emotional health included a feeling of happiness and contentment as well as a sense of coping in everyday life. These descriptions contrast with the findings of a study of lay knowledge about mental health in working and middle class families in England (Rogers & Pilgrim, 1997). The researchers reported that participants focused on physical healthiness and mental illness when asked to describe family health. Additionally, when prompted to consider mental healthiness, participant descriptions were limited to aspects of coping and tended not to include either emotional aspects such as happiness or relational aspects such as feeling loved. In contrast, the women in the current study not only described family health in more inclusive and wellness focused terms, but also did so unprompted and with apparent ease. The different findings may be explained by the differences in focus between the studies. Rogers and Pilgrim studied family members' views of mental health. In contrast, the broad focus on meanings of health in the current study may have elicited more inclusive

responses reflective of women's daily health experiences. The different findings might also reflect differences in the study samples. Whereas the current study sampled Canadian women, the mental health study sampled both men and women in England. Gender as well as cultural differences may have contributed to the different findings between these studies.

In the current study, not being healthy was viewed as an experience of individual family members, whereas being healthy and doing health reflected both individual and family group experience. This finding is consistent with a view of illness as an individual experience that occurs within a family context (Danielson, Hamel-Bissell & Winstead-Fry, 1993; Denham, 1999d). Support is provided for a conceptualization of family health, such as that suggested by Danielson and colleagues (1993), that recognizes both collective family processes and family member health. The dual focus on individual members and the family group is an important aspect of defining family health. I concur with Backet's (1990) critique of the implicit assumption in family health research of a relatively homogenous "family health culture" that fails to concurrently examine health-related differences among individual members within the family group. The findings in the current study support Backet's contention that both individual family members and the collective family health culture be integrated in the study of family health.

Taking Care of Family Health: Family Health Work

Women in this study identified numerous health actions they took to take care of the health of their children, in particular, and of their family as a group. While six women also assumed responsibility for taking care of their partner's health, most women considered their partners responsible for their individual health activities. Olivia's statement succinctly captured most women's attitude:

> I don't feel it is my responsibility to take care of my husband. So I will state that now.

Women felt that as adults, their partners were mainly responsible for their individual health actions. All women included caring for their partner's health as part of caring for the family group.

In taking care of the physical health of family members, all women talked about ensuring balanced nutrition and half of the women also talked about active living, adequate sleep, personal hygiene, and access to medical care. Alternative care in the form of nutritional supplements and dietary recommendations was supported by a few women as part of family nutrition activities. As well, two women took their children for chiropractic treatments. Just as she did for herself, Leandra emphasized self-care, lifestyle practices, and access to medical care for her school age children:

> I am always trying to think of different ways to feed them that they will actually eat their fruits and vegetables. I encourage them to be outside whenever possible. The kids go for regular dental checkups and that kind of thing. We are always pretty insistent that they get their rest.

Leandra's comment illustrated several of the ways women promoted a variety of healthy practices in their family: balanced nutrition, and regular activity, rest, and medical care. In doing so, Leandra and other women tried to create the conditions to support these practices. Women felt challenged to make health practices acceptable and attractive, particularly to their children.

In addition to all women's activities to care for their children's physical health, some women also cared for their partners by supporting health practices and offering assistance in accessing medical care. Emily stated:

> I choose to cater to my husband. I'll make his lunch every day. He also does things for me. I think that's what helps our whole family unit, at home, at work. It sort of just all works together because we support each other.

Emily's comment reflected her strong feelings about taking care of her partner as an individual and about the way this contributed to their family health.

Most women also talked about taking care of their family's social emotional health, both for individual family members, primarily children, and for the family group. Women engaged in activities to maintain daily routines, support caring relationships, reduce stress, and promote coping. These activities included reading and talking with children, creating or promoting children's time for themselves, and encouraging children's social time with family and friends. Scarlett described taking care of her

children's health, including her partner in care activities:

> We take the kids, we go skating, we go swimming for fun, we get out and do physical things. They go to school, they do well in school. They have friends. They have a lot of stress in their life, so we spend a lot of time in our house sitting and talking about things. A big thing in our house is being happy with yourself, accepting who you are.

Scarlett's actions, typical of women's in this study, focused on promoting family health within the context of everyday activity. Olivia also reflected this focus in her comments about helping her children cope with stress:

> I make sure that the schoolwork is done, but that's on a different level, that's not a health issue. Actually, that's not true because part of the reason they do well in school is because we try and help them cope with that. I am trying something that we were never taught, trying to teach them how to cope with stress.

Women's recognition of stress as a family health issue was evident in their talk about taking care of their children's social-emotional health.

In addition to caring for their children's social emotional health, women also spent time with their partners to reduce stress and to maintain a caring relationship as a couple. As one of the women who felt responsible for her partner's health as well as her children's and family's health, Emily reflected:

> I think part of health, too, is the stability that you have in your family, in your home life, in your day-to-day activities. If there is stability in the home and there is no tension, I think that really contributes to one's health, to your peace of mind, especially for the children. I want them to know that mom and dad love each other. I want them to know that our home is a safe place and the door is always open. I do that with my husband, too.

Illustrated by Emily's comments was women's consistently inclusive view of health activities in their descriptions of how they took care of their family's health. This view included the creation and maintenance of a home environment that nurtured caring relationships among members, as well as an environment that was physically clean and well-ordered. Naomi's comments reflected her inclusion of house work as part of her family health work to promote health and reduce stress:

> I like to make sure that we start the week with a clean house and laundry done and that. So that we can be relaxed during the week if things start to fall a little bit

> behind. I feel that we're very busy and when it's time to relax, we really need to relax. That relaxation is a lot more easily accomplished if the house is clean and things like that.

For Naomi and many of the women, taking care of the family home was part of taking care of family health.

Creating individual and family routines around daily nutrition, rest, and activity as well as family gatherings and social outings were important activities for women in taking care of their family's health. For Beth, the creation of family routines was important not only in taking care of her daughters' social emotional health, but also in integrating her partner's children in their blended family:

> I took the health of this family on as my total responsibility. I was being pulled in many different directions. Being pulled in the direction of trying to be the perfect wife, the perfect mother, the perfect step-mother, trying to make this family. I felt pulled because of wanting to still be as close to my kids as I was before and trying to start this new relationship with these new kids. They had their shows that they liked to watch and I always made the effort to sit down with them and watch. I was the one that was there.

Under less stressful circumstances than Beth, but sharing the focus on family routines as family health care activities, Aryn talked about family meals and regular activity patterns as family health activities. Activity patterns also included breaks from the weekday routine of paid work and school:

> For us, I try to make sure that we sit down for dinner, we're always sitting together as a family. The whole time they were growing up they had to get dressed, they had to eat. They've had that routine since they were born. Saturday mornings, I'd let my son stay in his pajamas on till 11 or 12 because it would be the highlight of his day because he was always going every morning.

Women believed that the creation and maintenance of family routines supported family health for individual members as well as for the family as a group. Family routines were a means of fostering health promoting behaviors such as adequate nutrition and caring relationships. Family routines also provided an element of predictability in daily life that supported coping with the stress of daily demands for busy families.

More than half of the women talked about deliberate action to keep track of or monitor their family's health, both for individual members and for the family group.

Naomi described herself as the one in her family who was responsible for monitoring family health:

> I try and be fairly alert to how they are reacting, whether they are happy, whether they're requiring more attention, or sometimes less attention, or a specific need one way or the other.

Haley vividly captured the essence of keeping track of family health:

> I guess there's a big thermometer and you're the one that kind of measures these things that go on.

As evidenced by Naomi and Haley, women felt responsible for keeping track of family health. In addition to monitoring health, women kept track of the frequency of health behaviors or concerns and the need for regular medical care.

In their everyday health work, women responded to changes in circumstances over time by using a variety of directive, collaborative, facilitative, and modelling approaches to taking care of their family's health. Women's approaches varied with their sense of individual or shared responsibility for health activities. Kyla described how she took care of her preschool and school age sons' health:

> I make sure they eat right. The kids have to have their fruit and they have to have their veggies and their bran and whatever. They have their regular checkups and I make sure they get their sleep.

Kyla's comments reflected her sense of responsibility for children's health care and her direct approach to taking care of her children. Although addressing similar areas of concern, Geri took a more collaborative and facilitative approach with her adolescent children:

> I do try to provide them with a variety of healthy choices for food. I try to guide the kids in the choices of their activities, to get them to think about their choices so that they have a bit of down time, instead of rushing pell mell through another week, another month, another year. And then, of course, they have the annual dental checkup, go to the doctor.

Geri guided her children's actions and facilitated conditions that supported healthy actions. In general, women took a more directive approach with young children who were not considered able to be fully responsible for their health actions. As children grew older they were considered more capable of participating in their health care activities.

Women's actions became less directive and more collaborative, working with children to support their participation in health care activities. In taking care of adolescent children and partners, women recognized the greater responsibility of these family members for their own health care actions. Women tended to facilitate health care activities with adolescent children and partners by creating supportive conditions for activities. Such support included ensuring the availability of healthy choices in daily activities, giving reminders about health promoting activities, and being involved in medical or alternative care when asked to do so.

Whether directive, collaborative, or facilitative in their approach to family health care, all women also incorporated an awareness of the importance of modelling healthy actions for family members. Aryn recounted a recent example of intentional modelling:

> Yesterday was a very, very stressful day and I had to take my kids swimming and I wasn't going to take them and I thought, "No! It's not teaching them anything if I don't take them." And so they went swimming and I did boxing exercises.

Aryn was aware of the importance of setting an example for her school age children by taking them with her and exercising, even when she did not want to after a stressful day. Aryn, as did all women, considered their own health actions as a means of modelling health promoting activities for their children.

In this study, descriptions of everyday family health work revealed women's construction and maintenance of family routines as a strategy to support family health. Daily routines typically included activities related to nutrition, rest, self-care, active living, coping, relationships, and the family living environment. These daily routines were supplemented by regular attention to medical and alternative care as needed. In keeping track of family health, women tended to focus on these routines, looking for changes that signalled emerging health concerns as well as for indications of the need to change routines to accommodate individual or family group needs.

Women's focus on family routines in health work is consistent with the similarly described concept identified in the series of studies of family health by Denham (1999a, 1999b, 1999c). Family health routines were "complex social constructions used by

members to translate individual health beliefs, values, and knowledge into structured family behaviors" (Denham, 1999a, p. 142). Family health routines that were identified as common to families included dietary practices; sleep and rest patterns; activity; self-care, caregiving; stress management and coping; preventive care, particularly for high risk behaviors; medical consultation; and illness care and health recovery. These routines were the means by which family members dealt with everyday health needs within the household context, taught children health behaviors, and identified boundaries supportive of stress management. The function of routines to monitor or keep track of family health, identified in the current study, was not addressed by Denham. This function, however, was evident in Lauritzen's (1997) report of mothers' accounts of caring for their infant's health. Mothers described routinely assessing infant health by continuously monitoring infant physical features, feeding, and happiness. Women of infants in the current study similarly focused on these aspects of health, while women's focus broadened as described above in monitoring the health of their older children and partners.

Noteworthy is the relative scarcity of empirically-based literature addressing two aspects of the findings in the current study: women's dual focus on family members and the family group in family health work and women's use of varying approaches to family health work. The need for recognition and examination of the dual focus on both family members and the family group in family health work is supported by Backet's (1990) critique of current literature about family health culture. Backet contended that the focus on family health culture typically assumes homogeneity among family members that does not recognize individual member differences in health experiences and activities within families. However, the relevance of focus on family health was recognized when addressing the influences of family life on health and health behavior. Denham (1999a, 1999b, 1999c) provides an exceptional example of dual focus on individual and family group in studying family health. In fact, Denham (1999d) extended this dual focus to support the continuing development of a framework for family health "with multiple dynamically interacting individual, family, household, and community variables" (p. 217).

Women's approaches to providing family health work, examined in the current study, was not an identifiable subject of empirical work in my search of health and social science literature. There is an obvious connection between women's approaches and human development theory, in that women's approaches tended to vary according to the developmental capacity of the care recipient. Although women's approaches as described in this study might appear somewhat self-evident, I believe further study is merited to deepen understanding of women's approaches to health work, their variation over time and circumstances, and how they influence family health, health decision making, and health work.

Common Ground Between Personal and Family Health

Three areas of common ground between personal and family health are identifiable from women's reflections on their meanings of health and on their health work. These areas relate to women's meanings of health and the congruence between meaning and action in women's health work.

Being Healthy and Having a Healthy Family

In this study, several themes were common to women's descriptions of being healthy and of having a healthy family. These common themes reflected a focus on individual members as well as the family group. Both an individual and a family group focus were evident in women's description of being healthy as being energetic, able to do things, and happy. Common themes for the doing aspect of family health included activities to take care of themselves and others, to manage day to day, and to face challenges. Women's descriptions support the extension of individual focused categories (Smith, 1981; Woods, et al., 1988) to a family focus. This extension appears somewhat self-evident when individual family member health is considered. The difference between meanings of health as an individual and as an individual member in a family context could be expected to be minimal. However, extending individual meanings to group meanings, considering the anticipated impact of group dynamics and the collective rather than individual focus, represents a noteworthy departure from existing theory about the meanings or images of individual and family health.

Although I contend that a recognition of common ground between individual and collective aspects of health is important, this recognition does not discount my contention that a dual focus on individual and collective aspects is essential in family health research and theory. I suggest that both are important aspects of developing deeper understandings of health in everyday life.

Personal Meanings

Women's expressions of the personal meaningfulness of health were grounded in the context of their everyday lives and reflected diverse orientations to health: as a state, as a process, and as an outcome. Health as a state was evident in Haley's belief that "it's central to who you are" and in Geri's sense that she was "just very lucky" to be healthy and to have healthy children. These women spoke of health as a state or entity that could be possessed. Health as a process was reflected in Daria's statement that "I can really only do the best I can in order to help". Daria's orientation to the process of promoting family health implicitly reflected being healthy as a process over time. Health as an outcome or goal was apparent in Emily's conclusion that "It's an accomplishment actually...I know I am doing a good job". Health as an outcome presupposed health as a state, and emphasized women's sense of responsibility in producing that state.

The orientations to individual and family health of women in this study are evident in current literature. Notably, the World Health Organization (1986) definition of health reflects state, process, and outcome orientations in defining health as " a complete state of physical, mental and social well-being...[that] is, therefore, seen as a resource for everyday life" (p. 426).

Women's sense of responsibility for both personal and family health was consistently reflected in their comments. Women recognized social expectations that hold mothers responsible for the care and well-being of their families. Women's personal sense of gratitude, pride, and relief at having a healthy family related to these social expectations about motherhood, as well as to their own expectations about caring for their families.

Meaning and Action in Health Work

In the current study, congruence between meaning and action was evident from two perspectives: considering the internal consistency in each woman's description of individual and family health, and considering the consistency across women's descriptions. Each woman's talk reflected an overall congruence between her meaning of being healthy or having a healthy family and the actions she engaged in her health work. Women described physical and social emotional dimensions as well as not being, being, and doing dimensions of personal or family health. They described actions focused on promoting these dimensions. Additionally, there was remarkable congruence between women's meanings and actions related to their own health and to their family's health. How women thought about and took care of health for themselves was similar to how they thought about and took care of their family's health. Both thought and action reflected the experience of being healthy and having a healthy family as living fully in everyday life. Not surprisingly then, much of women's everyday health work was located within the family as personal and family work. While women felt supported by their access to medical and alternative care services when needed, their focus for personal and family health work was on creating and maintaining the conditions for everyday living. Women's talk primarily reflected an individual responsibility orientation to health and health work, consistent with the dominant view in Canadian society.

Women's focus in this study on individual responsibility for health and health work is consistent with current research about lay health perspectives on individual (eg. Blaxter, 1993) and family health (eg. Backett, 1992; Denham, 1999a, 1999b, 1999c). The focus on individual responsibility for health work was also evident in the study by Rogers and Pilgrim (1997). However, they identified an apparent incongruence between the health work focus and participants' socially-focused explanations of contributors to poor health. I concur with the speculation by each of these researchers that the individual focus in health work, regardless of the potentially broader view of health, reflects a pragmatic orientation to everyday strategies within individual control. Just as many of the women in the current study spoke of the need for broader social change to support health, their

everyday experience focused on what they could do to take care of their own and their family's health. This focus is reinforced by the individualist ideology dominant in the biomedical and behavioral bases of the health system and in the neo-liberal socio-political organization of Canadian society.

Conclusion

The meanings women make of personal and family health are part of the context within which women make health decisions for themselves and their families. A limited number of qualitative studies have described women's images of personal health (eg. Bruenjes, 1994; Perry & Woods, 1995; Woods, et al., 1988) or images of family health (eg. Denham, 1999a, 1999b, 1999c; Niska, Snyder & Lia-Hoagberg, 1999). Some researchers have examined the associations between women's meanings of health and perceived health concerns or threats (eg. Charles & Walters, 1998; Lauritzen, 1997) and between social roles or circumstances and health activities (eg. Devine & Olson, 1992; Nies, Vollman & Cook, 1998; Verhoef, Love & Rose, 1993; Woods, et al., 1993). But, the relationship between women's meanings of health and the activities they undertake in their health work has received limited attention, with a few exceptions, in health and social science research (eg. Backett, 1990, 1992; Denham, 1999a, 1999b, 1999c; Rogers & Pilgrim, 1997). This relationship, situated within women's meanings of health and the activities they undertake in their health work, was a major focus in the current study. Additionally, most previous research has focused on either the individual or the family as the unit of interest. The current study examined both individual and family meanings and actions from the women's perspective.

Throughout this chapter I have used the term "health work" in examining the health-related activities engaged by women in this study for themselves and their families. I adopted the term during first round interview data analysis when the parallels with my use of the concepts of paid work and family work became evident. I identified parallels between women's descriptions of their activities in paid and family work and the health-related activities women described. Each area of activity required attention, effort, and deliberate action in order to attain results, whether those actions were focused on

employee tasks, family care, or health care. Although unintentional, my use of the term health work is similar to the concept of health work described in the Developmental Health Model of family nursing (DeMarco, et al., 2000). In the model, health work is a central theoretical concept that "reflects the process through which families develop or learn problem-solving and growth-seeking skills over time" (p. 315). The aim of health work is to deal with challenges to family health and to promote continuing development of family capacities and resources to achieve health goals. In the current study, women accepted the concept of health work in everyday life, finding it applicable to both personal and family health activities.

For women in this study, meanings of health reflected both generally shared dimensions and personally meaningful connections constructed in their family and social context. Women recognized both personal and shared meanings as integral to their everyday lives. This integration implicitly rejects a tendency to dichotomize approaches to defining health as either wholly personal or universal (Labonte, 1993). Alternatively, support is generated for the recognition of inclusive definitions of individual and family health that reflect health as a capacity for everyday living. As already discussed, women's descriptions of health in this study are consistent with aspects of many current definitions of health. Clinical, role performance, adaptive, eudaemonistic views of individual health (Smith, 1981) are supported with emphasis on the latter. Transactional (Walsh, 1993), and ecological (DeMarco, et al., 2000; Denham, 1995, 1999d) views of family health are upheld. Additionally, salutogenic (Antonovsky, 1979, 1987, 1998) and social ecological or socio-environmental (Labonte, 1993) views of individual and family health are advanced. Admittedly, the identified views of health might be considered a somewhat eclectic combination. I suggest, however, that study support for each of these views of health reinforces the recognition of health as dynamic, multi-dimensional, personally meaningful, and socially contextualized. I concur with Nettleton's (1995) conclusion that "people hold a multiplicity of accounts about health and illness, and that this is hardly surprising given the multifaceted nature of people's lives and lifestyles" (p. 49).

The view of health as the capacity for everyday living raises an important issue

that centers on concerns alternatively labelled "healthism" (Lupton, 1995; Nettleton, 1995) or "the new temperance" (Wagner, 1997) in the health and social sciences. At issue is the location of health and health actions within personal and/or social domains. These scholars have described the development in North America since the 1980's of increasing emphasis on healthy lifestyles. It is argued that an "imperative for healthy living" (Lupton, 1995; Nettleton, 1995) has emerged. This imperative locates the solutions to identified everyday health risks such as inactivity, high fat diets, substance abuse, tobacco use, and sexuality in individual responsibility for behavior change. The contribution of social structural circumstances as risk conditions and the need for attention to social change remain comparatively ignored, in favor of the popularly accepted ideology of individual rights and responsibilities.

Ironically, inclusive definitions of health such as the "capacity for everyday living" view that emerges from the current study, have tended to further rather than challenge the individual responsibility ideology of the current health and social systems in Canada and the United States. The convergence of concern about identified health risks across the range of political ideologies from "right to left" has resulted in a persistent focus on healthy lifestyles without concurrent attention to the underlying social risk conditions (Wagner, 1997). Wagner concluded from his examination of the development of the "new temperance" movement in the United States that while such "movements and campaigns target behavior that certainly can be dangerous or unhealthy, they all tended to exaggerate the risks of life while de-contextualizing them from their social environments" (p. 167). The result has been the emergence of popular support for increasing social control over individual behavior, for example drug testing in the workplace, without concomitant attention to addressing the social conditions that underlie risk behaviors.

In recent decades in Canada, a biopsychosocial view of health (Engel, 1977) has been generally accepted among health professionals (Labonte, 1993). Despite the inclusion of non-medical psychological and social components in this view of health, a relatively pathological focus and clinical perspective have been retained in practice (Antonovsky, 1987; Ruzek, Clarke & Olesen, 1997). In the current Canadian health

system, health-related concerns have tended to be "medicalized"; they have been defined and managed within a disease focus on biomedical and behavioral strategies. As Ruzek and colleagues (1997) contended, medicalization has presented a "mixed blessing" for women. While needed legitimacy and attention have been given to health concerns such as severe perimenstrual tension, health experiences such as pregnancy and menopause have become problematized and controlled by medical professionals.

The danger then of promoting an everyday living view of health within the current social-political context arises from the inadvertent promotion of individual responsibility for health and health work and the potential medicalization of everyday life. Yet, I suggest that a greater danger arises from not promoting this view of health. Failure to challenge the dominant individualist biomedical and lifestyle orientations of the health care system relegates the system to partial measures in improving the health of the Canadian population. As the women in this study described, the health system typically supported their medical management of health problems. However, this support was often considered ineffective in addressing aspects of health concerns related to women's life circumstances and was irrelevant to most of women's everyday health work. The challenges women faced in their health work, such as stress and providing a supportive environment for personal and family development, are not outside the boundaries of the health system in theory but appear largely so in practice.

In conclusion, I concur with Backett's (1992) contention that the construction of health meanings, health decision making, and the practical implementation of health actions in everyday family life

> is currently *particularly* problematic because the stress laid by health promotion experts on specific and supposedly modifiable behaviors tacitly denies the lay experience of complex integration of these behaviors into broader systems of social behavior. Thus in lay systems, health and its relevant behaviors are evaluated and become meaningful contingent on particular social contexts and their associated choices, priorities and constraints (p. 271).

In this study, I share Backett's (1990, 1992) intention to develop an understanding of

"health and its relevant behaviours as *part* of everyday life, with a special focus on the family and domestic context" (Backett, 1992, p. 256). My interests extend to the inclusion of a focus on decision making in addition to health and health behaviors in everyday life. Additionally, I am interested in an examination of workplace and broader social contexts as well as the family and domestic context as influences in everyday health decision making and action. This chapter described women's meanings of health and health actions in their everyday health work for themselves and their families. In the following two chapters, I examine the social contextual influences on women's health decision making and describe the process of health decision making engaged by women in their everyday health work.

CHAPTER 5
SOCIAL INSTITUTIONAL INFLUENCES ON WOMEN'S HEALTH DECISION MAKING

Women's accounts of their everyday experiences of health decision making as mothers engaged in family and paid work was the point of departure for my research. What follows is an explication of the ways that women's decision making were socially organized through the institutions of motherhood; the family; the education, health and social systems; and the workplace.

Social institutional influences were reflected in women's talk about how they made health decisions and their responsibilities as mothers, partners, caregivers, volunteers, and paid workers. On the surface, employed mothers' health decision making appears to be an individual cognitive process that takes place in an admittedly complex social context. However, this would not reflect the way women in this study described health decision making in everyday life. Complex social institutional influences were integrated within their overall process of decision making, including the impact of their social roles such as mother or worker; organized relations such as supervisor-worker; and formal organizations such as education institutions, the health system, or government.

Social institutional influences were experienced by the women as expectations, demands, constraints, and resources which had to be accounted for and accommodated as they made health decisions. In making decisions in their daily lives, women continuously negotiated what they believed they should do, trying to meet expectations and demands, with what they felt they could do, trying to work within constraints and resources. Women wanted to be seen as competent and good at what they do. Women placed particular importance on fulfilling the roles of "good mother" and "good worker". Social institutional influences were also apparent in women's descriptions of the ways that their daily family and workplace circumstances, available health and social services, and the broader social and economic environment provided resources and imposed constraints that affected their health decision making.

Social institutional conditions contributed to women's stress and directed them to

care for their families, often at the cost of caring for themselves. Many women faced the stress of meeting high expectations and demands under the constraints of limited time and inadequate or inconsistently available resources in their family, their workplace, or the health and social system. The social emphasis on women as caregivers for others reinforced women's sense of obligation to family care over self-care. Women's everyday health decision making reflected these influences.

Motherhood acted as the organizing social institution, the point of reference, for women's experiences within other institutions. Women explicitly acknowledged that their daily lives and the decisions they made would have been very different had they not been mothers. Despite an official shift toward gender equality and neutrality in Canadian public policy, women continue to be held to and often embrace a traditional view of motherhood and the family. This view centers on selfless caring, family primacy, and individual responsibility for family well-being (Eichler, 1997). This view is reinforced by developments in the education, health, and social systems that emphasize family responsibility.

In Canada, primary and secondary education, health care, and social service systems are publicly funded through government-administered tax dollars. In Alberta between 1993 and 1999, the provincial government policy of fiscal restraint resulted in funding reductions to these systems (Harrison & Kachur, 1999; Neu, 1999; Taft & Steward, 2000). These systems underwent restructuring based on political goals to promote fundamental family and community values, to decentralize authority and increase system responsiveness to local needs, and to rationalize the workforce for greater efficiency in a globally competitive economy. Since 2000, the provincial government has shifted to selective, often one-time project funding increases within the health and education systems. The shift reflected the recent provincial budget surpluses generated primarily by revenues from high world oil prices. Concurrently, the provincial government has emphasized fiscal responsibility as an adjunct to the previous emphasis on fiscal restraint. In the workplace, employed parents have benefited from a growing recognition of the contribution of "family friendly" workplaces to work-family balance

and worker well being (Alvi, 1994). However, employed mothers continue to compromise paid work and make occupation adjustments to meet family demands more often than employed fathers (Conway, 1993).

The discussions in this chapter address selected aspects of motherhood; the family; the education, health, and social systems; and the workplace as social institutions influencing the health experiences of employed mothers. Quotations from the study illustrate social institutional influences on women's personal and family health work and decision making. Citations provide examples from the extensive literature relevant to this discussion. My reading focused on academic journals and books in the health and social sciences, as well as popular print media from newspapers, magazines and books.

Motherhood

Women's accounts of family health decision making were richly descriptive of how they viewed mothering in their daily lives. All women talked about the importance of caring relationships with their children. Faith described mothering her infant daughter as "rewarding", involving "caring, loving, bonding, teaching and learning". Mora talked about her relationship with her school age and adolescent children in terms of "loving them, talking to them about their problems and always, always being for them". Many women also talked about the challenges and difficulties of mothering. Scarlett said:

> I think being a mother is the hardest thing in the world. I love my children dearly. I think the best gift I can give my children is very strong wings to fly and to know that they have unconditional love.

Scarlett, like other women in the study, recognized the stresses and frustrations as well as the pleasures and satisfactions of her mothering experiences with her children.

Evident in the way women described their experiences was an important distinction between mothering and motherhood. Descriptions of their mothering as personally meaningful contrasted with their talk about the imposed expectations and pressures associated with motherhood as a social role. Mothering describes a personal, relational, and ultimately moral experience between a woman and her child(ren) (Bergum, 1997, 1989; Hartrick, 1996; McMahon, 1995). In contrast, motherhood names a

social institution, historically constructed in society as a "discursive ideal". Motherhood as an ideal denotes an ideologically prescriptive role (Forna, 1999; Griffith, 1995; Hartrick, 1996) or social position that defines expectations and characteristics associated with occupancy of that social position. Motherhood has been incorporated as a normative stage or task of women's development and is often considered an essential aspect of women's identity (Phoenix & Woollett, 1991).

The women in this study embodied the social expectations of motherhood that emphasize caring for and giving themselves to others: Women embraced these as personal expectations that centered their everyday lives. Even attention to their own care was framed within their sense of obligation to caring for their family, and such attention often arose only after a health crisis threatened women's ability to fulfill their responsibilities. Pressure to meet motherhood expectations combined with the everyday demands of mothering, family, and paid work created constraints within which women tried to balance their health decision making. The dominant ideal of "the good mother" powerfully influenced women's experiences and their health decision making. Expectations for women to live up this ideal combined with their multiple demands in family and paid work frequently lead to feelings of guilt and time pressures. For many women, guilt and time pressures imposed constraints on their ability to make health decisions without sacrificing self-care in order to care for their families.

The Good Mother

Women in this study tried to live up to personal and family expectations and to social ideals about being a "good mother". This goal meant making motherhood their first priority, being available to care for their family, and volunteering in children's activities. Ilana, one of the women who spoke most extensively about social expectations on women as mothers, commented:

> It is important for me to be a good mother and do as good of a job on it as possible. I am trying to be the kind of mother that my kids feel very close to and I try to give them as much time as I possibly can and guide them the best way I can.

The women in this study felt that as mothers, they were held responsible for family health

care. Continuing her thought, Ilana said:

> The unfortunate fact is in most cases mothers are the decision makers when it comes to health. Who do the kids go to? Usually mothers. I suppose they instinctively take this responsibility to have the knowledge and skills and experience and then the other family members more or less just follow. Just count on you and just hop on the sleigh and you pull, kind of thing.

Ilana felt that her family was typical of most families in that they looked to the mother to make health decisions and take care of family health needs. She also found that women took this responsibility on themselves, thereby reinforcing family expectations.

Fully half of the women observed that motherhood ideals are reflected throughout society. Women noted that depictions of motherhood in the media, television, and movies tended to emphasize these ideals. They also believed that the ideals were evident in the community's expectations that mothers be available to their children not only as caregivers in the family but also as volunteers in the school and community. Tensions existed between the social ideal of motherhood and the daily reality of employed mothering. As Ilana talked about her experiences over the years, she reflected:

> The whole society still seems to think that if you are a mom you are supposed to be there for your kids every little happening, whatever it is....Social expectations. There is too much of that still. I don't think any one of those who put these expectations on us knows what on earth working mothers are going through. Somehow it filters through the school system, the TV, wherever.

Ilana was frustrated with the expectations imposed on mothers by the broader society. She questioned the source of these expectations and their apparent lack of connection to women's everyday experiences.

Women's own expectations for themselves reflected many of the attributes framed as "natural" to women in the dominant social ideals of motherhood. Seven of the women talked about these natural aspects of motherhood. They referred to maternal instincts, that is instinctively knowing their children and taking responsibility for caregiving, as well as natural predispositions to worry, to be sensitive, and to care about others. Yet, these women also questioned the imposition of "natural" ideals and the consequences of these ideals in daily life. Kyla commented:

> I am a worry-wart. I think most mothers are, though, that just comes when a first child is born, I am convinced. I expect a lot from me and I just can't get it all done...This societal, you know. Who's making this up? Not very many women are, that's for sure. I'm not really a so-called feminist, but I hear this and I am like, 'what gives you the right to tell me if I am a good mother or not because I am working?'.

Kyla voiced the tensions between her beliefs about mothers' natural predispositions to worry about and focus on their children and her frustrations with societal pressures on mothers to devote themselves exclusively to their children.

Uncertainty about the consequences for their children of their decisions as employed mothers was intertwined with uncertainty about the legitimacy of these "natural" attributes of motherhood. A few women tried to deal with their uncertainty by focusing on the related practical issues of managing family and paid work. Olivia said:

> Nobody can be sure all the time. If your kids are sick, you don't know...is it because you are working? I don't know where that comes from, if it's instinct or society. It doesn't matter where it comes from, that's just there. It's not in your head, it's in your heart. And when they are healthy again, it's fine because your head takes over.

When her children were ill, Olivia described having doubts about whether her employment contributed to their poor health. She also recognized that she was able to reasonably reframe these doubts when her children were healthy. By focusing on practical management of family and paid work, Olivia and other women were able to set aside periodic uncertainties they felt as employed mothers facing societal ambivalence about the merits of women holding dual roles in the family and the paid workforce.

A few women deliberately distanced themselves from traditional motherhood ideals. Scarlet spoke of raising feminist awareness in her daughters:

> I've always told the girls, 'You live in a very non-traditional household in many ways. Get a grip, realize I'm your mother. You are going to have to deal with that the rest of your life and I don't fit into a lot of categories. I have my own way of doing things and you're just going to have to learn to handle that.' I don't like people putting me in a box and I don't like my kids being put in a box.

Scarlett, who openly rejected traditional roles for either her or her daughters, found that she needed to resist continuous social pressures to adopt these traditional roles. And Lea,

as did other women, spoke of the difficulty of distinguishing personal expectations from those socially imposed. She also spoke of the consequences of this difficulty:

> I fell into the superwoman trap way early. I never learned about boundaries, or what's mine and yours or when to quit. I never learned how to define that for me and it's hurt me really badly to be like that. So, I am trying to unlearn a lot of it, but it's hard when you're getting different messages from all around you.

Lea found that trying to identify and live up to her own mothering expectations was complicated not only by social pressures to live up to the good mother ideal, but also by inconsistencies in what was expected of good mothers.

"The good mother" ideal has persisted in Western cultures as the dominant motherhood ideal more or less since its construction during the early modern period (Thurer, 1994). The good mother ideal, alternatively represented as the perfect, all-powerful, natural, martyr, and most recently, super mother (Viliani, 1997), presupposes:

> anything less than full-time mother will somehow damage the children; all feelings about motherhood must be good; motherhood is instinctive; motherhood is nirvana; and a "good" mother must sacrifice her life in order to be loved by her children; a mother who has needs outside the mother role is selfish and therefore does not fit into the "Good Mother" persona...and to have it all, a woman must do it all (pp. 117-118).

In Canada, the good mother ideal is most closely associated with the post-war years of the 1950's; a period that remains idealized by current promoters of "traditional" gender roles and family values. The good mother ideal is evident not only in North American culture (eg. Griffith, 1995; Griffith & Smith, 1991, 1990; Hays, 1996; McMahon, 1995; Rich, 1976; Smith, 1987, 1989, 1998; Smith & Griffith, 1990), but also in other regions of the western world (eg. Forna, 1998; Wearing, 1984). The fact that the ideal of the good mother is generally shared throughout the western world effectively reinforces the belief that being a good mother is an inherent aspect of women's natural aptitudes and not a social construction of the modern period.

Employed mothers regularly confront comparisons between their daily lives and dominant social ideals through the portrayal of mothers and motherhood in the popular

media. Maclean's national news magazine (March 1, 1999) questioned "the mother load": Is superwoman burned out? Should mom stay home? The cover pictured a harried-looking woman in a business suit, talking on a cellular telephone while holding the "baggage" of the day: briefcases, purse, diaper bag, and crying baby amidst baby paraphernalia strewn on the floor. The National Post (February 1, 1999; November 6, 1999) featured film images of mothers, acknowledging the frequent portrayal of sacrificial mothers epitomized by the terminally ill mothers in Stepmom and One True Thing. These mothers were contrasted with the sexual and selfish mothers in The Graduate and Mommie Dearest. Occasionally, a balanced portrayal of mothers was given, such as the lone mother trying to build a satisfying life in Anywhere But Here. The Edmonton Journal (May 14, 2000) presented a full page feature on television portrayals of mothers including cartoon characters, in a range of at home and employed, partnered and single mothers. The feature emphasized the love and frequent sacrifice of mothers, while commenting on the relative realism of characterizations as "flawed, but with great, good hearts". Alberta Report provincial news magazine (March 29, 1999; April 19, 1999) has presented motherhood as instinctively loving and sacrificial, frequently citing support from socially conservative organizations such as REAL Women and the Calgary-based National Foundation for Family Research and Education

Although motherhood is a recurrent topic of interest in popular media, portrayals of motherhood seem to rarely reflect the complex daily reality of mothering, particularly employed mothering. While such portrayals are not entirely one-side endorsements of the good mother ideal, the ideal remains a pervasive image that implicitly sets an unrealistic standard for women as mothers in general, and for employed mothers in particular.

Guilt

Often the result of not living up to motherhood ideals, guilt was discussed by all women in this study. For Lea as a lone mother, guilt was a regularly confronted issue. She spoke of the guilt associated with societal expectations of motherhood and guilt arising from her own acceptance of these expectations:

The guilt, you get it from all sides. It doesn't matter what you do, you get it

> coming and going. I have always internalized that to a far greater degree than I am happy with and it's really hard because our society is set up to believe these misconceptions. So I can be a single mother with a full time job and my son in day care and taking care of all these other things and going to school and depending on what goes on in any given day, any given person can say, 'It's because you are this or that'.

Guilt emerged as a seemingly unavoidable consequence of Lea's efforts to live up to the good mother ideal.

Women were aware that their sense of guilt was grounded in societal expectations of "the good mother", yet, women were unable to disengage fully from these expectations, even when they talked about the importance of doing so. They had embraced central aspects of the motherhood ideal as personal expectations of themselves as mothers. Geri reflected:

> I want to be a good mother. If my own expectations matches what other people think I should do, my neighbours, my parents, the school, whatever, then that puts more pressure on me to meet those expectations. It just makes me feel even worse if I am not living up to it because it's not just me letting myself down, it's me letting myself down and the world!

Geri felt pressured to conform to the social ideal of the good mother, even as she tried to focus on her own expectations. She recognized that the guilt she felt when she did not meet her own expectations was magnified if she also had not met other's expectations of her. Effectively, Geri faced two sources of guilt: from her own expectations, and from societal expectations on her. This sense of double guilt was acknowledged by all women in the study.

In her examination of "motherguilt", Eyer (1996) critiqued the contribution of popular media and academic literature to women's guilt as mothers. The popular media portrayal of motherhood and the invocation of "expert" authority have created unrealistic images of mothers as noble, self-less, and focused only on caring for their families. Eyer contended that an extensive portion of social science research has contributed to motherguilt as it has been problem-focused, implicitly assuming problems for women and their families when mothers were employed. Additionally, this research has defined all but at home mothers as deviant and has largely overlooked the role of fathers in family

caregiving. Finally, this research has failed to promote change for social issues. Eyer contended that both media and research have tended to reflect an implicit acceptance of individualism and traditional gender role and family values.

Even when traditional views have been challenged, individualism has often been accepted, contributing to individual self-blame and guilt feelings when change does not occur, ignoring the contribution of social conditions to individual behavior, and negating any sense of social responsibility to promote change. For example, Peters (1997) presented a social view of maternal guilt and self-sacrifice. Peters contended that guilt and sacrifice have resulted from Western emphasis on mothers' often exclusive obligation to the guardianship of children's welfare. However, Peters' recommended solutions emphasized individual women's responsibility to change their mothering and to share family management. The emphasis on individual rather than social change implicitly reinforced the view of individual responsibility for change.

Time Pressures

For many women in this study, guilt was associated with time pressures. All women recognized time pressures from trying to meet the multiple demands of motherhood and their employment. Time was an all too scarce commodity. Olivia said:

> Time, there is never enough time. You can't do it all, no matter what the magazines and Martha Stewart with her cute little decorations say. It's just not possible, this is just not real.

Voicing a sentiment similar to Olivia's, Lea said:

> I don't think there's time enough in the day for all the things you want to do, plus all the things that need to be done.

Olivia, a partnered woman with comparatively independent adolescent children, talked about time pressures in much the same way that Lea, a lone mother of a young school age child with developmental problems, talked about time. They, as did all women in the study, shared a pervasive sense of time pressure in their daily experiences as mothers and paid workers.

The time pressures associated with employed motherhood were brought into popular as well as academic press with Hochschild's (1989, 1997) studies of "the second

shift" for women in dual-earner families and "the time bind" experienced by employed women and men with family responsibilities. The extent of a full "second shift" for women has been challenged (Pleck, 1993), although gender-based time differentials in family work, both household and childcare, were acknowledged. In their reviews, Pleck (1993) and Barnett and Rivers (1996) concluded that in dual-earner families, men's contribution to housework has increased over the past three decades to about 35% compared to women's 65%. Statistics Canada data support a similar differential, even when calculations include primary childcare (The Vanier Institute of the Family, 1998). However, women's persistently greater responsibility for most low-control daily repetitive family work and young childcare (Barnett and Rivers) remain significant issues in women's lives. The dominant motherhood ideal reinforces such responsibility as a natural aspect of good mothering within the individual rather than the social domain.

As employed motherhood has become the normative rather than deviant condition, attention has shifted to family time issues. There have been increasing public and academic concerns about the consequences on families, particularly children, of time pressures associated with current employment, family, and community demands on employed mothers (eg. Daly, 1996; Hochschild, 1997). A recent Canadian study found that nearly 85% of employed mothers felt they had insufficient time to accomplish everything they needed to do (Lee, Duxbury & Higgins, 1994). In a national survey, one-third of married mothers employed full time were considered highly time-stressed, nearly double the proportion of fathers (The Vanier Institute of the Family, 1998). These studies become part of the persistent controversy about the potentially damaging effects on children of mothers' employment and associated time pressures.

The motherhood ideal as well as ideals of fatherhood and the family frame the issue of family time and remain invisible when gender neutral language does not reflect social reality. A recently released Statistics Canada study (Silver, 2000) provides an interesting example of how the issue has been framed. Silver's study compared time spent with children by full time employed mothers and fathers, documenting a decreasing time difference as children grew older. Silver attributed the change in time spent to children's

age-related demands rather than to gender roles. Silver's inattention to the gendered pattern of mothers' greater responsibility for childcare and lower hours of paid work with young children suggests an implicit acceptance of this pattern as natural. The media headlines "Time not on kids' side" (National Post, June 14, 2000) for this research focused not on the time comparison, but on concern about inadequate and "shrinking" time spent with children in dual-income families. The media assumption that children in dual income families increasingly are victims of their parents' overly busy schedules is arguable based on a comparison to 1992 Statistics Canada data (The Vanier Institute of the Family, 1998). Analyses of these data found that not employed mothers spent 2.3 hours per day in primary childcare (definition similar to Silver's report, but children's age not specified) compared to 1.3 hours for full time employed mothers and 0.9 hours for full time employed fathers. While data support a time differential between employed and not employed mothers as well as between employed mothers and fathers, the total times are less than those reported in any of the age ranges (2.6 - 6.4 hours/day for mothers compared to 2.7 - 4.3 for fathers) in Silver's study. The assumption that children in dual income families increasingly are victims of their parents' overly busy schedules can be questioned.

Persistence of the dominant social ideals of motherhood as caregiver compared to fatherhood as provider serves to implicate mothers more than fathers in victimizing children, even when a gender neutral reference to "parents" is used. I share Eichler's (1997) conclusion that a gender neutral position about gendered experiences renders invisible, therefore unchallenged, social institutional influences on women's experiences compared to men's. Further, evidence from research indicates that there has been a limited shift to fully shared responsibility by mothers and fathers for family work despite a shift toward gender neutrality in media and policy language. Certainly, issues of family time pressures merit attention. My concern is that such attention include explication and examination of underpinning assumptions so that the issues might be understood as multi-dimensional with complex contributing conditions, rather than as uni-dimensional arising from mothers' employment and loss of traditional family gender roles.

Sacrifice

Many women in this study compensated for the time pressures and the guilt of unmet expectations by reducing personal health activities in order to attend to family and paid work responsibilities. Lea said:

> I don't take care of myself anywhere near as well as I could because to take the time and make the effort would take away too much from what else has to get done. What I try to do is take what I have and spread it as far as I can. I am trying to do that on a consistent basis without killing myself.

Lea described relentless pressures on her time. She deliberately minimized time spent for her own care in order to ensure time to deal with family care and paid work responsibilities.

Women in this study focused on their responsibilities to others, sacrificing attention to themselves. Most women accepted, even expected, that they would place their personal needs secondary to their family responsibilities. These responsibilities encompassed volunteer and paid work as well as health and caregiving work, as each contributed to family well being. Nine women, including Lea, gave up personal time and attention in order to ensure family care. Five women reduced personal goals and career aspirations to retain paid work flexibility or security. Mora chose to remain in a paid position she found to be as frustrating as it was satisfying:

> I am happy I have this job but I know I am not using my full potential. But I like the hours, there are so many things I like here. And I know if I take some other risk, if something goes then my family has to sacrifice and I don't want to do that.

Mora gave up pursuing more challenging paid work because she did not think she should place her family at financial risk for her interests. Also concerned about family financial security, three women gave up their personal preference to be at home in order to provide financially for their family. Two women focused on being mothers and wives to the extent that they felt they had lost themselves as women. Leandra reflected on her paid work preferences and her lost sense of self:

> Now I am realizing I also have to be a woman and I haven't been that for so many years it's very difficult to find that person. It's a struggle and I want to be a good mother. I wanted to be at home with my kids, not full time but at least part time.

Leandra struggled with her decision to give up her preference to be home with her young children and to be employed part time. After becoming a lone parent, she continued to struggle with her need for full time employment to provide financially for her family. She also came to realize that she had grown accustomed to giving up her personal identity during her years of focusing on her obligations to family caregiving.

The women in this study spoke less of sacrifice than of trade offs, of gaining one thing while giving up something else. Typically, women felt they gained better family care by giving up self-care. Trade offs were ideally based on identified priorities and anticipated consequences. Women consistently placed family over personal priorities and believed that they would remain healthy enough to justify the trade offs.

Women accepted the need for trading off their own interests to family interests. Some women considered trade offs to be natural to their motherhood, other women accepted trade offs as a practical means to deal with competing interests, and a few women recognized the sacrifice inherent in positioning themselves last.

Half of the women talked explicitly about taking care of themselves so they could take care of their families. Several of these women had experienced health crises that had threatened their ability to care for their family. Diana expressed this idea most simply:

> In order for me to keep my family healthy, I need to be healthy and if I'm not healthy I don't know what's going to happen.

Women acknowledged the importance of attending to their personal health primarily because of their value as mothers caring for their families and as paid workers providing for their families.

The socially perceived naturalness of maternal sacrifice is apparent even from scholars whose stated intent was to promote awareness and change for women. For example, Roiphe (1996), introducing a discussion of mother guilt and anger, noted that there "is inherent in motherhood a continual giving up of self" (p. 74). In another example, Rubenstein (1998) examined evidence supporting biological mechanisms that promote maternal nurturing and protective responses. She argued that "the biology of

sacrifice is a trifecta, nature's triple whammy of female hormones, genes, and natural tendencies" (p. 27). Rubenstein inaccurately equated nurturing and protection with sacrifice. Contrary to her stated intention of challenging maternal sacrifice, Rubenstein implicitly promoted sacrifice as necessary to nurturing and protecting children.

While interest in the experiences of employed mothers has popularized guilt and sacrifice as themes of motherhood, research supports the influence of guilt and sacrifice on both employed and at home mothers. Viliani (1997), from interviews of separate samples of at home mothers in 1978 and 1995, concluded that motherhood ideals of the sacrificial good mother contributed to women's loss of self, resulting grief, narrowed choice, and risk of psychological crises. With emergence of the "supermom" myth of motherhood, mothers faced added pressure to embody "all the attributes of the Good Mother ideal - perfectionism, selfless altruism, sacrifice, martyrdom and the like, with the added dimension of industry *à la* Martha Stewart" (p. 119). DeMies and Perkins (1996) speculated that "supermom" perceptions may be problematic for both employed and at home mothers when they fail to achieve expectations arising from this motherhood ideal. Garey (1997) concluded that the dominant motherhood ideal results in employed mothers' exhaustion and guilt from feeling that they are never doing enough even as they are trying to do everything.

Guilt when the motherhood ideal is not realized and time stress associated with attempting to achieve the ideal reinforce women's focus on the primacy of their obligations to others and subsequent selective self-neglect. Ultimately, neither women nor their families are healthier for this pattern of behavior (Rubenstein, 1998). Changing the pattern will likely require not only individual but also collective challenge to the dominant motherhood ideal in Western society.

Women tend to place a great deal of pressure on themselves to meet the expectations and demands associated with being a good mother. In addition to their own expectations, women feel pressured to meet socially-imposed expectations arising from the good mother ideal in Western society. Family expectations, embedded in family relationships and circumstances, are also central to women's everyday mothering

experiences and contribute to the pressures on women.

The Family

Among the women in this study, some diversity was evident in family form. Eighteen (90%) of the women were married. Of these women, 2 (11%) had formed blended families. Three women (15%) were lone parents, one of them separated but still married. This variation in family form reflects current families in Canada. Recent statistics indicate that 85% of families in Canada are husband/wife families, 30% of which are blended following remarriage by one or both partners (Conway, 1993). About 11% of families are headed by a female lone parent (The Vanier Institute of the Family, 1998). In 1991, about 70% of mothers in two-parent families and 60% of lone mothers were employed (Conway).

The very definition of "family" is a subject of academic, social, and political debate. Most women in this study considered nuclear, then extended family members in their talk about family relationships, family work, and health decision making. A few women also considered close long-term friends equivalent to family members. Recognizing the greater diversity in current Canadian society, the Vanier Institute of the Family (2000) defined family as two or more persons bound together over time who have assumed responsibilities such as care and socialization of members. However, Statistics Canada (2000) defines family as married couples, common-law couples, and lone adults with never-married children living together. This definition guides much of Canadian family policy. Canadian families of the 1990's represent significant shifts toward greater diversity (eg. higher proportions of families that are dual-earner, lone father or mother, blended, never married, and gay or lesbian partners with children). This diversity contrasts with the idealized 1950's middle-class family form comprised of a breadwinner father and caregiver mother living as a married couple with their children (Parsons & Bales, 1955). Yet it is this traditional form that remains influential in social discourse about the family.

Women in this study recognized influences on their health decisions of social expectations about gender roles and about the provision of support within families.

Traditional gender role expectations in families reinforced women's obligations to family work as women's work, in contrast to paid work as men's work. These obligations constrained women's health decision making by supporting their focus on family care over self-care. Additionally, women faced constraints on their decision making if family members did not provide the support assumed by society to be available in families. When available, family support was a valuable resource for women in making health decisions to manage personal and family health work.

Gender Roles in the Family

Women in this study considered partner participation in family work as an important contributor to family health. Women expected their partners to share family work, including caregiving and household work. While women recognized that they and their partners might perform different tasks in family work, none of the women ascribed to traditional gender roles that distinguish women's private family work from men's public paid work.

Within the institution of the family, the discourses of motherhood and fatherhood organize much of daily family life. These discourses are evident in on-going debates about solutions to current concerns about the quality of family life, particularly in dual-income families. Proponents of the gendered "separate but equal" solution tend to focus on the theoretical complementarity of the gendered roles of caregiver and breadwinner in the relatively separate spheres of family and paid work (eg. Evans, 1994; Gairdner, 1992; Horn, Blankenhorn & Pearlstein, 1999). Those who question solutions that emphasize "traditional" motherhood and fatherhood ideals consider the lived reality of provider fathers largely absent from nurturing relationships and caregiving mothers made dependent economically and socially (eg. Coltrane, 1998; Ruddick, 1997).

Most women in this study described some degree of shared responsibility with their partners in contribution to family work. The three women who considered their partners to be equal participants in family work retained primary responsibility for monitoring and organizing activities. Olivia's statement captured women's family responsibilities succinctly: "The work is shared, the responsibility is mine". For four

women whose partners shared some aspects of family work, their partner's contributions became minimal when employment demands removed them from participation in family life for days to weeks at a time. Six women, including the lone mothers, carried full responsibility for family work, despite their expectations of partner participation.

A few women talked explicitly about the differences in societal expectations for men and women in families. Ilana concluded:

> Well, men work and that's all they do, you know, kinda seems to be more or less the general attitude still. Whether they have a family or not. I am hoping that that will change because if that changes then I am sure the attitudes to working mothers will have to change as well.

Ilana observed that social expectations of fathers continued to focus on providing financially for their families through paid work. These expectations meant that fathers remained largely exempted from obligations for the family caregiving and household work that has been socially defined as mothers' work. In contrast, employed mothers have been expected to add paid work obligations, yet retain primary obligations for family work. Ilana believed that social expectations of both fathers and mothers would change when fathers changed their behavior to include family caregiving and household work as well as paid work as equal aspects of family obligation. Ilana's hope, shared by women in this study, was that such change would lead to a shift in how family obligations are met by fathers and mothers facing concurrent obligations for family and paid work. Further, women hoped that such a shift in family work would become better supported in the workplace, social systems, and society in general.

Social and economic trends have contributed to women's participation in the paid workforce and their assumption of concurrent caregiving and economic responsibilities in the family. Gender roles, however, have shifted inconsistently for women and men: "women have adopted most of the roles previously occupied by men, but men have not taken over half of the tasks previously done by women" (Eichler, 1997, p. 60). There appears to be increasing recognition of the value of caregiving work as an important aspect of fatherhood (Levine & Pittinsky, 1997, not simply to relieve tension from inequitable contributions to such work, but also to promote family health and stability.

Yet, family caregiving responsibilities continue to affect predominantly women as the primary family caregiver in the majority of Canadian households. A positive feedback cycle functions between socially institutionalized ideals of women's work as caregivers, women's acceptance of these ideals, and their continuing primary responsibility for family caregiving.

Support

In managing daily family life, most women looked to their partners, all husbands in this study, for support. To a lesser extent, women also sought support from extended family members and, for a few women, from their adolescent children and long-term close friends. The availability of needed support from family members was an important resource for women when they made decisions about family health work. Ilana commented:

> So if there were support from the family, it is great. Everybody automatically assumes that it is the mothers that have to do all these things. I don't think there is going to be any change unless maybe society could take some part. The first thing would be if you could train your partner and if you are fortunate enough right from the beginning and have the kind of partner who is knowledgeable about health issues and is willing to take at least half of the load.

The interwoven relationship between the institutions of motherhood and the family was illustrated by Ilana's comment. Social ideals about mothers as caregivers intertwine with ideals about support in families and individual responsibility for family care.

Inconsistent or limited support with family and caregiving work was a concern for half of the women. Concerns focused on expectations of support from partners or extended family members. Haley's comment was typical of partner support concerns:

> I think we end up doing more because our husbands can tolerate a lot more of the things, and they don't worry so much, but we do. How our kids turn out is still a reflection on us [mothers]. I try to delegate to my husband who then delegates to my son.

Haley expected her partner to provide support with family health decisions and work and was frustrated with his inconsistency in doing so.

In addition to limited partner support, Leandra was unable to access extended

family support:

> I don't have any family in this city and it is so difficult that I just can't call up grandma or grandpa and say, 'can you come and help me out' because it's not there.

Leandra, whose extended family lived in another region of the country, had never been able to rely on the support that is often socially assumed to be available from grandparents and other relatives.

A few women had difficulty accepting social support, even when it was available. They were concerned about their ability to reciprocate support, felt they should manage without support, and were uncomfortable revealing sensitive issues beyond family members. These women also acknowledged that they would willingly provide support to others under the same circumstances they were hesitant to accept support. Leandra felt this very strongly after she became a lone parent:

> A lot of friends have extended their support. It's hard for me to take it because it's something that I probably know that I am not going to give back, it's just taking. And that's a hard thing for me to take and not be able to reciprocate. And a lot of them have certainly made it clear that they're not expecting anything either...I would be more than willing to help out a friend and never expect anything. But yet, it's so hard for me to accept it the other way.

While Leandra was reluctant to accept support because she was uncertain she could reciprocate, Haley was reluctant because of her sense of personal and family responsibility for caregiving:

> I want to take care of my own myself. You pull in and you get tighter and you try and fix it yourself first. And it is only when you can't that you start to open up the doors just a little bit and let people in. It's a trust thing, it's that internal family that we are supposed to be able to solve all these things [health concerns] ourself.

Haley tried to manage family health work by herself, in keeping with her expectations that this was her work as a mother. Only when she realized she could not manage alone, did she reluctantly seek support from others.

Social support is defined as "interactions with family members, friends, peers, and health care providers that communicate information, esteem, aid, and emotional help" (Stewart, 2000, p. 85). Family members typically specialize in practical and emotional

support. Neufeld and Harrison (2000) concluded that women often accept their primary caregiving responsibilities, excusing others from providing support, and prefer unsolicited support within close relationships. In addition, maintaining a sense of personal adequacy or competence and a sense of reciprocity in supportive relationships are important for women. Women may not accept support that they anticipate might threaten their sense of competence or reciprocity. In Canadian society, the provision of social support within family and close relationships and the opportunity for equitable and reciprocal exchange of support have become norms (Stewart). These norms operate within the construction of social support as a social institution. These norms combined with motherhood and family ideals constrain women's decision making about seeking and accepting social support to manage everyday personal and family health demands.

The individual model of family responsibility (Eichler, 1997) remains the dominant orientation in Canada. This model is overtly gender neutral, holding women and men responsible as mothers and fathers for family caregiving and as spouses for family income. The model supports the assumption that families provide most of the needed support for members to fulfill their daily responsibilities. Women's preference for support from family members, as those most likely to represent long-standing and close emotional ties (Neufeld & Harrison, 2000) reinforces this assumption. Provision of social support within the family has been institutionalized as a family function. But the perpetuation of the motherhood ideal holds women responsible for caring work independent of available social support from family members.

Education, Health, and Social Systems

Conversations with the women in this study occurred during a period of provincial restructuring of the education, health, and social systems in Alberta and, to varying degrees, across Canada. Popular media regularly featured both political support for and opposition to the changes as well as issues related to public uncertainty about the impact of restructuring on daily life. For women in this study, issues were evident related

to volunteer demands in the education system, management of unconventional children[6] in the education and health systems, access to health services within the health system, and availability of satisfactory childcare in the social system.

Education System: Volunteering

Women in this study considered volunteering in children's activities part of their mothering responsibilities for caregiving. Women believed that attending and volunteering at these activities contributed to children's social emotional health. Women's ability to meet volunteer demands was constrained by the timing of school activities that frequently conflicted with women's paid work day. The ensuing guilt when they did not volunteer reinforced women's focus on family over self-care, contributing to additional stress and selective self-neglect.

In this study, all ten mothers of elementary school age children faced demands from the school system and their children to volunteer in school activities. Mothers of adolescents found that volunteer demands steadily decreased as their children progressed into junior high and high school. Volunteer demands included supervision of children during field trips, support in classroom activities with reading programs and individual student attention, assistance with the preparation of teaching materials, fundraising for additional activities and supplies, and representation on school councils. Such activities often conflicted with the regular paid work day, resulting in guilt when women missed activities or tension if they took time off from paid work. Aryn, with two school age boys, said:

> I feel way more guilt now that my children are at school. Every time you turn around they are wanting you to sign a form. How many days a week can you volunteer? Can you read to the children? Can you go on field trips? They didn't have to have all this support before. You know then you are trying to explain to your children who say, "Well, Mom you were the only one not there".

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[6] I use the term "unconventional children" as Comfort (1992) did to describe children who "learn, behave, think, react, and play differently from most of their peers" (p. 114). As such, the term is intentionally inclusive of parent experience as well as medical diagnoses and professional labels applied in the health and education systems.

Aryn tried to reduce her guilt about not being available for day time school activities by volunteering for activities that could be completed at home in the evenings. She still felt guilty about disappointing her children, and was concerned that teachers might consider her a selfish and inadequate mother.

Five women talked about issues between employed and at home mothers related to volunteer work in the school. Women valued the contribution of at home mothers who volunteered regularly at school. Several women, however, experienced a sense of conflict between employed and at home mothers. Haley talked about how school demands for volunteer work highlighted apparently polarized views of motherhood between employed and at home mothers:

> There's a lot of stay at home moms and I think we've always polarized ourselves. We've never worked together. We always seem to think, 'well, she's a stay at home mother and ne'er the twain should meet, you know.

Haley felt that women missed opportunities to work together and support each other when they focused on assumed differences between employed and at home mothers' interests. Cass found that the option of monetary contribution to activities in lieu of volunteer time captured the tensions for employed mothers with the school and at home mothers:

> It's not just the school though. When you are at the schools, it's those non-working mothers that can try to make you feel guilty for being a working mother. Where I don't volunteer and they want money for something, I am paying the money.

Women were frustrated about the tensions with other mothers and school personnel if volunteer expectations were not met. Women who experienced these tensions felt unsupported by other mothers and teachers who were inflexible in their expectations of women as mothers.

Volunteer demands contributed to women's sense of guilt, time pressures, and stress reinforcing decision making that supported their children's care and sacrificed self-care. For a few women, volunteer expectations highlighted personal tensions between their financial need to be employed and their personal preference to be with their

children. Volunteer expectations also added to demands on women that were particularly stressful because they associated these demands with their family caregiving responsibilities.

In the Alberta public education system since 1993, a provincial policy of fiscal restraint contributed to the structural reorganization of school boards and the loss of their authority to generate a portion of education tax dollars (Peters, 1999). While the changes have resulted in a more equitably funded system province-wide, they were accompanied by overall funding reductions to school boards (Harrison & Kachur, 1999). In response, school boards reduced staffing levels and salaries for teachers and support staff, as well as budgets for supplies to individual schools (Mackay & Flower, 1999). Volunteers, often parents, are relied on for fundraising as well as for unpaid work as teacher aides in the classroom and as support staff for activities such as photocopying. The introduction of school councils as a formal means of parent participation in school policy and program development has been viewed as a positive move from a community participation perspective. Unfortunately, such participation has also increased volunteer demands on parents. Mothers, as primary caregivers, face the increasing stress of time pressures from such volunteer demands in addition to their daily family and paid work responsibilities.

Women in this study recognized the importance of being involved in their children's education and felt responsible for ensuring that children completed their homework. This responsibility typically required either personally supervising the homework or arranging for their partner or, occasionally, a babysitter to do so. Women also recognized their responsibility for staying informed about the teacher's views of their children's progress. Although time consuming, women accepted these responsibilities as part of their mothering work during family time. However, many women questioned the extensive demands for school volunteer commitments. When seen as conflicting with paid work and family time, these demands became a source of stress for women.

Current fiscal policies have expanded demands for parent involvement, particularly as unpaid workers, in the education system. Volunteer demands, however, are not a new development in the education system. Smith and Griffith (Griffith, 1995;

Griffith & Smith, 1990, 1991; Smith, 1987, 1989, 1998; Smith & Griffith, 1990) contended that public education in Canada has integrated the discourses of motherhood, child development, and child-centered education. This integration socially organizes the education system, particularly in elementary years, around the dictates of child development and relies on extensive participation by parents, both at school and in the home. According to the motherhood ideal, mothers should be readily available and able to participate in school activities. In this way, mothers' work in the family has been coordinated with that of the school, to ensure children's school readiness, attendance, and achievement. Smith and Griffith (1990) concluded that employed mothers work to coordinate school and workplace schedules that largely function as separate and uncoordinated institutions. While it may be argued that the organization of the family is within women's influence, the organization of the education system and the workplace certainly are not. Employed mothers are caught, therefore, between the institutional organization of the family, the education system, and the workplace.

Health and Education Systems: Unconventional Children

For women in this study, the demands of caring for unconventional children frequently constrained their health decision making not only for the children, but also for themselves and the family unit as a whole. These demands typically took priority over other personal and family needs. Frequently, these demands conflicted with women's other paid and family work responsibilities, creating time pressures and stress. Stress was also created by the intensity and recurrent nature of the demands associated with caring for an unconventional child. The constraints women faced from caring demands with unconventional children could be off set by available resources to help women meet demands. An important resource for women was access to supportive health and education system professionals and services.

Six women in this study cared for a child whose development or behavior was noticeably different from peers, presenting difficulties for the child, the mother, and the family. Four children were girls and two boys; two children were school age and four adolescents. Their ages ranged from six to nineteen years. Formal diagnoses of

developmental or behavioral problems had been identified for four of the six children; the remaining two were identified by their mothers as having histories of recurrent academic, behavioral, and social problems. Canadian data from the 1996 National Longitudinal Survey of Children and Youth (NLSCY) support a prevalence of approximately one in five children who have emotional and behavioral problems such as attention deficit, depression, and aggression.

Women in this study found that caring for an unconventional child raised issues when their children's development and behavior did not conform to socially held norms. This lack of conformity was stressful but generally manageable within the family. It became a source of recurrent tension when problems occurred in broader social settings. Women faced intense, often urgent demands to deal with family, school, and social difficulties with their children. Lea, the lone mother of a school age son, expressed the frustration:

> This has to do with my child being ADHD and having dyslexia. Maybe I could fix this if I could just be everywhere at once. It's not realistic, but it's there and it's an expectation that we tend to wear as women, too. We've always been the caregivers and the fixers and the cleaner-uppers.

Lea recognized that expectations to manage, even resolve, her son's problems were imposed by health and education systems, as well as by her own acceptance of expectations about good mothers. Diana talked about dealing with her adolescent daughter's behavior problems:

> Since about grade 4 when it started, it's been a constant battle. I have tried everything I can try, gone to the schools, talked to the teachers, taken her to a wonderful therapist and we've actually discovered some of what might be causing the problems and tried to fix them. But still these problems are here. The funny things is she's such a good kid when she wants to be. But, boy, she is so tough to handle at times. So it is very, very stressful for me.

Diana's description of dealing with her adolescent daughter both within the family and the school reflected the long-term investment required to address recurrent problems.

Haley reflected on the tensions between her expectations for herself as a mother and social expectations that consider mothers responsible for their children's behavior:

> I don't live through my children, but what they do does still impact on me. That's what frustrates me with my daughter, because she doesn't conform. I care what people think. I wish I didn't, but I do.

For Haley, as for other women, tension was framed by an awareness of social attitudes that viewed children's behavior as a reflection of mothering ability.

Attention deficit and hyperactivity appear to be the most common problems (NLSCY, 1996) and have received professional and public attention in recent years. Most children do not, as was previously believed, "outgrow" problems during adolescence, although about one-third experience decreasing problems into adulthood (Cipkala-Gaffin, 1998). Problems tend to be long-term and pervasive. The child's erratic behavior presents difficulties at home, at school, and with peers. Family dynamics are disrupted and parents often struggle to sustain consistent management of problems (Comfort, 1996; Shealy, 1994).

Although formal diagnosis is usually a prerequisite for obtaining treatment and special programming, labeling presents potentially negative consequences such as stigmatization for children and parents. Some professionals suggest that the diagnosis is used to excuse children's unacceptable behavior where such behavior should be dealt with through greater discipline and better parenting, not medical treatment or individualized programming. These views are reflected in popular publications such as Armstrong's (1997) "The Myth of the A.D.D. Child". The views also are evident from education professionals who argue that the diagnosis has become socially desired by parents, caregivers, and teachers seeking to excuse their failure to manage children's behavior (Ellis, 1996; Smelter, Rasch, Fleming, Nazos & Baranowski, 1996). Such views typically focus on parenting, implicitly or explicitly holding parents largely responsible for both the development and the resolution of the children's problems. This focus contributes to often intense stress for parents, particularly mothers held responsible as family caregivers, who are already stressed by the difficult family dynamics associated with caring for unconventional children. Stress is further compounded by the acknowledged association between child behavior problems and family dysfunction. The

presumption by professionals in the health and education systems of ineffective, if not dysfunctional, parenting is evident in mothers' accounts of their interactions with professionals (Mickelson, 2000). Even when carefully qualified as a contributing, not causative, factor in some but not all families (e.g. Barkley, 1995), the association between low parenting quality and children's problems may subtly frame approaches to management. Parent responsibility for managing children's problems is reinforced both socially and within the family, placing intense demands on mothers as primary family caregivers.

In this study, ability to access needed resources and confidence in available resources in the health system were issues for the women caring for unconventional children. Women's experiences with health system support for their children's needs varied among women and over time for individual women. Identifying and developing an on-going relationship with knowledgeable and trusted health providers was particularly important for the women whose children required medical treatments such as medication. Lea described securing satisfactory medical care for her son:

> My first role of business was to get him diagnosed. It was a year and a half of hard work, talking and not taking no for an answer, and not allowing myself to be talked down to and talked out of, and things like that to get a doctor who was willing to deal with a child his age. And then get him treated properly which means don't over medicate my son to the point of submission. Help me deal with this.

Lea's description illustrates the persistence valuable in advocating for her son's care with medical professionals.

The need for persistence was also a concern for Haley who had recently moved from another city and was dealing with the resulting changes for her daughter's care:

> We had many, many years of struggling. No one knew what the heck was wrong with this kid. Information is not easy to get... I know that she needs to have a check up in 6 months with this specialist and that specialist and I know that if I call back to the doctor where we came from I will get a name and I will get on a list and I should probably be doing those things now.

Haley talked about the difficulties in identifying problems, in establishing relationships with providers, and in locating resources to assist with her daughter's developmental

problems. She faced the demands of having to deal with these difficulties to secure care for her daughter after moving to a different region. Until needed care providers and services could be identified, Haley expected that she would have to make decisions about potential concerns with her daughter under the constraints of inadequate available resources.

The medical diagnosis and treatment of attention deficit and related emotional and behavioral problems remains controversial. While the diagnosis has been formally incorporated as a mental disorder, its legitimacy has not been universally accepted (Cipkala-Gaffin, 1998). The lack of a definitive diagnostic "test" and the diversity of associated signs and symptoms compound the problem of diagnosis. Armstrong (1997), for example, considered the lack of a diagnostic test and the recognized interaction between social environmental and biological factors in challenging the legitimacy of the diagnosis. Even among researchers and professionals who accept the legitimacy of diagnoses and acknowledge the complex etiology of developmental and behavioral problems, management of children with problems places considerable emphasis on parenting skills. "A very disconcerting factor for the parents and for professionals...is that there is tremendous demand for coping strategies, ways to manage behavior, and means of dealing with difficult children, but there are no recipes for these problems" (Comfort, 1992, p. 116). Yet, parents typically are held responsible for direct intervention to sustain positive parent-child interactions, to create a supportive family environment, and to advocate for their child in the health and education systems. Parents are also held responsible for indirect intervention, through advocacy, to ensure that others who deal with their child serve the interests of the child. The highly structured and hierarchical organization of the health system and the current emphasis on economic efficiency can present major barriers for parents seeking care for their unconventional children.

For women in this study, school interactions typically brought into sharp relief any differences in children's behavioral and social development. The identification of their child as different was both a relief and an additional source of tension for the women. While the labeling of problems was important for obtaining treatment in the

health system, the response in the school system varied. Women found that understanding and support for classroom and program adaptations for their children were inconsistent among teachers and administrators not only between schools but also within a school over time. Lea, who had described on-going frustrations during her son's grade one school year, expressed cautious optimism the following year, even as additional problems were identified:

> Since we've moved, we've also changed day cares and schools and once his environment changed and his input changed, so did his ability to learn. It seems to have improved. Now I am working with him in other areas. Now we're seeing where the deficiencies actually are because the behavior isn't masking it anymore.

Lea's optimism arose from her recent experiences of support from her son's teachers and childcare workers in dealing with his special needs. Lea remained cautious, however, having experienced the frustrations of unsupportive teachers and care providers before her move.

Geri described recurrent difficulties that placed pressure on her as an employed mother and on her child who "did not fit" in with an education system only partially responsive to his unconventional behavior.

> There was one year, I would get to the office and the secretary would have already for me a message from the school. So I'd go to my office and I'd close the door and take a deep breath and phone the school and they'd say, 'Well, we have a problem and you'd better come and deal with this.'

Geri continued to deal with school-related issues even as her son approached late adolescence. She talked about the challenges of finding information, identifying alternatives, and negotiating solutions within the mainstream education system:

> My child is not a good fit with what is generally available. I have done research into it and have looked at different alternatives and it means doing battle with school boards because of course they don't want to give over that power of choosing where the kid goes to school. I guess you put on your armor and go off and do battle.

Geri and the other women who cared for unconventional children had learned that they needed to strengthen and rely on their personal resources in order to be able to manage decisions about their children's care and education. These women's efforts were

constrained by their other responsibilities in family and paid work, as well as by inconsistently available resources to help them deal with decisions.

Within the education system, the on-going debate about classroom integration versus special program segregation for unconventional children provides an example of the barriers to parents in obtaining appropriate and effective programming for their unconventional children. Ewashin and colleagues (1992) described a multi-focal program for progressive integration into mainstream programs of adolescents with behavior difficulties. Emphasis was placed on pre-selection of suitable candidates, individualized programming, and extensive coordination between teachers and parents. However, Duff (1997) contended that the current structure of teaching practice and the mainstream education system mitigate against such programs. He concluded that the system has been designed for the efficient processing of a collective average student population. Recent education reforms have emphasized economic efficiency in education and reduced the size but not the organization of the bureaucratic hierarchy. The education system is mandated to provide special education programming even as it is resistant to the effective provision of the individualized programming recommended for unconventional children's special needs (Duff).

For women in this study, inconsistencies in health and education system responses to their children's special needs as well as changes as children grew older meant that solutions to problems were often temporary. Problems recurred or new ones arose over time with each perceived non-normative change in the child's development, with changes in health and care providers, and with changes in classroom setting, in teacher or administrator approach, or in school policy regarding special programming. The inconsistent responsiveness of the health and education systems may be obscured by the social orientation toward individual family responsibility for children that integrates the institutional ideals of motherhood, fatherhood, and the family. These ideals are effectively co-opted by the health and education systems in holding parents responsible for the on-going management of sometimes complex regimens of care, whether or not adequate supports and resources are available.

Social System: Childcare

For the women in this study, childcare was considered a child health issue and decisions to secure satisfactory childcare were health decisions. Satisfactory childcare arrangements became a resource to women in their personal and family health decision making and in their everyday management of family and paid work demands. Women's stress and guilt were decreased and they felt less constrained in making personal and family health decisions. However, all women felt somewhat constrained by their need to see themselves as good mothers, their awareness of the impermanence of childcare arrangements, and the pressure to maintain satisfactory childcare without consistent support from social policy and programs.

Affordable, satisfactory childcare arrangements were a priority for all thirteen women with pre-school and school age children and were recalled as essential by women whose adolescent children no longer required childcare. Eight women, including all five women with preschool children, used a regulated day care center, family day home, or after school program. Although day care centers associated with women's employers existed, women chose childcare convenient to their homes and children's schools. Three women relied on an adolescent child to supervise a younger school age sibling at home and two women had school age children home on their own before or after school. One woman's work hours allowed her to be home after school, and two women had partners who were able to do so. Ten of the thirteen women felt pressured to ensure that they left work on time in order to be home with their children promptly. The three who did not feel pressured had partners who were available to pick up children from care or to be at home.

None of the women currently had childcare provided in their home, although several women expressed the view that in home care would be more convenient for them and better for their children. The anticipated cost of full time nanny care, however, ruled out this option for women. Care provided by family members such as grandparents was valued by women. Just two women, both now with older children, had such care available to them in their homes. This care had never been an option for the women without family

in the area, nor was it for women whose extended family members were also employed.

In Canada, 40% of pre-school children and 26% of school age children are in care while their parents work or study (The Vanier Institute of the Family, 1998). Of these children, approximately one-quarter are in regulated formal care arrangements in a day care center or family day home. The majority of children, therefore, are in unregulated situations in which care is provided by a relative or other person, or by the children themselves. Compared to national data, a greater proportion of the women in the current study used regulated formal childcare: 100% of preschool and 37% of school age children were in such care. Those school age children not in formal care were looked after informally by older siblings, rather than extended family or paid informal care providers.

Women in this study worked to ensure the satisfactory quality of care for their children. This work increased for women who found that available options for care were limited. Naomi, whose toddler son was in daycare, voiced this as an issue:

> You don't want to be bringing him there if he's really unhappy. There's quality and then there's things they may not be able to control like other children that he may be having conflicts with and maybe that's why he doesn't enjoy being there and maybe it's something you'd rather him not be exposed to. Just the same, you don't have much choice. So then you try and talk to them [daycare staff] about it. Sometimes it's effective, sometimes it's not.

Quality of childcare was a particular concern for women with infants or toddlers.

Women felt an over-riding obligation to protect their young children who were more dependent on others and less able to report problems if they arose. Jenna reflected this concern as she talked about childcare for her infant daughter during the previous year:

> I think it's almost that they can't talk for themselves so you never know what's really going on and what's happening. Whereas, my daughter's starting to talk and so we'll ask, 'well, what did you do today?' And she'll tell you and that just relieves you because you know that if something did happen that shouldn't have happened she would say something at least or her behavior would be more readable than an infant who cries and you don't know why she's crying.

Jenna had worried intensely about the quality of her daughter's childcare before she was able to talk about what happened to her in care. Since then, Jenna felt more able to

monitor the quality of care through her daughter. Characteristics of satisfactory childcare that were evident in women's talk included a caring provider relationship with the child; positive interaction between the child and other children in the program; a safe and stimulating physical setting; care provider responsiveness to the mother's requests and concerns; and convenient hours and affordable cost of care.

The quality of non-parental childcare is at the center of issues related to the adequacy and availability of childcare in the current Canadian context. Regulation through licensing standards, affordability of care, and access to care are issues for proponents of quality childcare. Licensing standards in most Canadian provinces are the means of regulating formal childcare (Howe & Jacobs, 1995). Standards typically regulate maximum group sizes of children, maximum center size, staff to child ratios, and early childhood training for staff. Such standards influence the quality of childcare and child development outcomes (Howe & Jacobs). In Alberta since 1991, the provincial government has increased staff to child ratios for infants and toddlers, raising concern about eroding standards of care (Doherty, Friendly & Oloman, 1998). In the past decade, issues about the affordability of regulated childcare became interconnected with space availability issues. Critics of current childcare policy contend that less affordable regulated childcare results in lower demand for space as parents seek more affordable, but unregulated, alternatives. In Alberta between 1991 and 1998, provincial funding for operating grants to daycare centers was reduced, promised increases in parent subsidies did not occur, parent fees to centers increased, and the total spaces available in regulated childcare decreased (Doherty, et al.). These changes contribute to a reduction in employed mothers' choices for the type of childcare available and an increase in their use of unregulated care, child self-care, or shift work so one parent can be home with the children.

Women in this study recognized the need for greater support for childcare alternatives. A few women associated quality care with that provided by extended family members. Most women, however, focused on the importance of affordable and convenient alternatives for quality childcare so that they had choice in meeting their

children's needs. Several women also noted the need for childcare services that are open to children during illness. Ilana spoke about this:

> It would be very helpful if the province or the city or whoever could arrange care providers that could come to look after your sick child if there is a situation where the mother simply cannot stay home. I am sure it would be excellent but I don't think such a thing exists. Except, if you are wealthy enough you obviously have a nanny at home. And then you would not have this problem to start with.

Ilana recalled the difficulties and guilt she had faced when her children had been ill and she had been unable to arrange time off from her paid work. Difficulties had included her partner's unavailability to assist with these demands, her lack of extended family support, and, as she identified, the lack of ill-childcare in the formal childcare system.

Baker (1995) concluded that a mixed responsibility model of childcare exists in Canada in which childcare services are provided by both the public and private sectors, including voluntary non-profit organizations, for-profit centers, and employers. Low income families are given priority for financial subsidies. A system of tax deductions or credits for childcare is provided by provincial and federal governments. Compared to a public responsibility model of childcare where access to quality services is considered a right and services are heavily tax supported, the mixed responsibility model generally results in conditions of space shortages and greater variation in the quality of services, costs, and subsidies available to families. Canada's childcare system has been ranked well below those of most of the countries studied in terms of these conditions (Bronfenbrenner, 1992; Goelman, 1992; Lamb & Sternberg, 1992).

Childcare policy has moved on and off of the Canadian public agenda in the past three decades. During this time, it has been framed alternatively as a health, an education, and/or a social issue. Childcare remains primarily a family responsibility, despite repeated federal government promises to develop policy supporting a national childcare program (Doherty, et al., 1998). Proponents of such policy focus mainly on child development outcomes and/or on gender equity that recognizes that employed women more than men are affected by childcare policy (Baker, 1995). Additionally, proponents focus on reducing poverty through employment and strengthening the economy by

supporting women's participation in the Canadian workforce (Doherty, et al.). Childcare policy initiatives, however, have been hindered by on-going differences between family traditionalists and gender equity advocates. The former may support childcare policy to promote child development (for the sake of the child). This support is limited by their reluctance to promote maternal employment based on their belief that mothers' primary responsibility is to be at home with children (Baker). In contrast, gender equity advocates promote childcare policy as an important strategy that supports maternal employment as a means of improving circumstances for women. These two groups also differ in their respective support for family or social responsibility models of childcare. In the 1990's, the impact of these differences combined with the federal government reduction in funding transfers to provinces has contributed to a decline in the availability of regulated childcare in several provinces, including Alberta (Doherty, et al., 1998).

In 1993, Conway proposed the development of a national childcare system within an early child education framework. As an extension of the education system, childcare would be publicly funded, universally accessible, and quality ensured. More recently, The Early Years Study, a policy initiative supporting a national childcare program, was developed within an early child development framework (McCain & Mustard, 1999). The establishment of early child development and parenting centers was recommended. These centers could ensure optimal early child development, support responsive parenting and caregiving for employed and at home parents, and link families to needed services. The child development framework and inclusion of at home parents in this initiative could help prevent a backlash from family traditionalists who argue that childcare policy is discriminatory if at home parents do not receive benefits. Such a backlash was evident in media reports (National Post, June 6, 2000; National Post, June 8, 2000) following a recent announcement to create a provincially funded before and after school program for children of employed parents in British Columbia.

At the beginning of the 1990's, Tizzard (1991) voiced cautious optimism that the recognized link between quality childcare and child development might result in change for employed mothers and their children:

> All of us, including mothers with young children, have to balance our own needs and aspirations against our obligations to others...For forty years, in the West, women with young children who have chosen to work outside their homes have been made to feel guilty and have been viewed as inadequate and selfish mothers. However, there is now increasing recognition that if childcare of reasonable quality is available, the situation has potential benefit for children as well as for their parents (p. 192).

We have yet to see this optimism realized. Nonetheless, the issues remain relevant for employed mothers.

Health System: Access to Health Services

Most women in this study had limited demands for formal health services beyond consultation with individual care providers. A few women expressed general concern about the impact of on-going health system reform, but just one woman identified issues related to the timeliness of emergency services. Access to trusted providers and availability of medical or alternative care when needed were important resources in women's health decision making for themselves and their family members. In addition to the women with unconventional children, one other woman identified constraints on health decision making when either access or availability were limited.

Most women indicated that they had acceptable access to formal health services including medical and dental care, as well as alternative treatments such as massage and nutritional therapy. In addition to services available through the publicly funded health system, supplementary services and fee payment were available through the employer health benefit plan. Women expressed confidence in their access to needed services, considering this "background support" in dealing with personal and family health concerns. Kyla commented:

> I have two very good doctors for my boys. Me and my husband go too. They are very good doctors that I trust, I like, and they're good with the kids.

Kyla's comment illustrated women's primary focus on access to trusted providers for routine health care.

However, a few women voiced concerns about the timeliness and availability of health care services when needed. Daria recounted an episode in which she had waited many hours for emergency department care for her children:

> I am very disgruntled with the medical system the way it is right now. It saddens me to think that when you actually need something, there is nobody there. I am not one to use it all the time, but when it's there I want to be able to use it. I worry about new born babies and mothers. I worry about young children that sit for hours and hours. Like I've sat in emergency rooms for 8 hours waiting for my kids to be looked at.

Daria expressed worry about the impact of health system changes on families, having experienced inadequate services attributed to decreased health services.

In addition to immediate family caregiving work, four women provided care and support for elderly parents. Women monitored health concerns, arranged and attended medical appointments, and provided in-home support. Caregiving demands did not include the need for formal system supports such as home care. Rose oversaw care for both her partner's chronic cardiac disease and her father's failing health. She commented:

> I am really in the sandwich generation and I feel in all cases that my brothers have just gone elsewhere. I don't find my husband around willing or able to help.

Rose did not receive family support to care for her elderly father. Although she did not believe that formal services were needed to provide care for her father, Rose did not know of any available health system services that she could access unless her father became ill and in need of medical care.

The Canadian health care system has been undergoing reform primarily aimed at providing necessary services more efficiently and at decreased costs. Since the mid-80's, average lengths of hospital stays have shortened, numbers of hospital beds have decreased, and outpatient services have doubled (Canadian Institute for Health Information, 2000). The shift from institution-based to community-based care has been accompanied by concerns about the adequacy of community-based services to support family in-home care. Concerns also focus on the impact of increased reliance on volunteer services and unpaid care providers, typically family members, as well as off-loading costs from publicly funded health services to individuals and families (National

Forum on Health, 1997; Scott, Horne & Thurston, 2000). Family caregiving responsibilities have increased, particularly affecting women as the primary family caregiver in Canadian households (Avard, 1999).

The Workplace

Women in this study worked to meet expectations as a good worker and demands placed on them in the workplace. They recognized the potential conflict in concurrently dealing with high expectations and demands in the workplace and in the family. Women valued the informal support of good working relationships with supervisors and co-workers that contributed to needed flexibility in working conditions. Formal support provided by workplace benefits, policies, programs, and facilities was an important resource in women's everyday health decision making. Yet, women also felt constrained by perceived pressures from supervisors and co-workers to limit their use of provisions for paid leave. The expectations, demands, resources, and constraints associated with women's participation in the workplace were influential on women's health decision making. Available resources provided access to alternatives for care and supported women's health decision making. Yet, on-going expectations, demands, and constraints fostered women's stress, their sense of time pressure, and their tendency to sacrifice personal care to meet family care demands.

The Good Worker

In the workplace, women were aware of the need to be seen by co-workers and managers as good workers who were committed and productive. They saw themselves as good workers. Geri commented:

> Since I have to work with myself every day, my opinion of myself is pretty important. I expect to do a good job. I don't want my boss to think I don't care about that. I don't want my boss to think I am not doing a good job.

Geri, like the other women in this study, held high expectations for herself as a paid worker. Women faced challenges in concurrently fulfilling expectations to be a good worker and a good mother.

Women experienced time pressures to complete their work satisfactorily within

their regular work day in order to feel comfortable able leaving work promptly at the end of work hours. Jenna commented:

> If you are conscientious about it [your work] you'll make an effort of always trying to be on top of it. I guess you're just conscious of, you know this work has to be done in whatever time period and you just struggle on to get it done.

Jenna described herself as a conscientious worker. She prided herself on completing her assigned tasks efficiently and thoroughly. Since motherhood, she was under greater pressure to do her work without the previously unrecognized luxury of taking extra time at the end of the day when needed.

A "good worker" is characterised in Canadian and western cultures by attributes that include industriousness, productivity, efficiency, and loyalty in "commitment to one's job as all-encompassing" (Garey, 1999, p. 193). I concur with Baker's (1995) conclusion that the "structure of the labor force and the organizations in which most women work were originally designed by men for male workers. Women are still expected to adjust to an employment mentality which implies that work is the only important factor in employees' lives and that another family member is at home dealing with children and household responsibilities" (p. 367). Employed mothers, therefore are caught in the "cultural contradiction" (Hays, 1996) between the institutional ideals of the good worker and the good mother.

Informal and Formal Support

In this study, workplace support appeared to be specific to the type and timing of situations, the frequency of women's requests for support, and differences among supervisors who handled requests. None of the women described their workplace as either totally supportive or not supportive of their concurrent responsibilities for paid and family work. Sixteen women felt supported either by supervisors or co-workers in dealing with family demands that arose during the workday. Informal support was attributed to the women's history in the workplace, to the development of relationships with supervisors and co-workers over time, and to shared values among women as employed mothers. Leandra commented:

> I think the fact that I've been here 12 years, my boss truly does appreciate me and my skills so when I do have to leave early it's a matter of me saying, "I'm working through my lunch, I have to do this." She's fine with that. It's a very good environment to work in, they're all women. They're all very understanding.

Leandra believed that she had established a supportive working relationship with her supervisor, based on the length of employment in the office, as well as demonstrated skills and trustworthiness as an employee. Leandra believed these conditions created a work environment for her and her co-workers that was flexible regarding informal adjustments to hours of work.

Flexibility was an issue for all women in the study. Flexibility was secured by eight women: Two shifted hours of work, three worked part time, and three took and made up time informally with supervisor approval. In the focus group, women identified flexibility as the most important workplace characteristic that supported their ability to meet paid and family work demands, including caring for personal and family health:

> Flexibility is just huge. It answers almost everything. It shows there is support. And that can just be done on a personal basis. But, it has to be a mutual relationship. That's really important that there be the flexibility from the employer, but that there also be the understanding from the employee too that this is a place of business, that these things need to be done.

It was the women's experience that informal flexibility provided by supervisor support was essential to meeting paid and family work demands. Women's comments reflected the importance of establishing themselves as good workers and of developing positive relationships with supervisors as a basis for receiving informal support.

The importance of formal support provided by group benefits and policies, workplace wellness programs, health facilities, and the comparatively progressive reputation of their employer was recognized by all women in this study. Women who participated in the focus group agreed on the value of such support, focusing on the availability of benefits, policies, programs, and facilities whether or not they were used:

> It's kind of like the fact of living in Edmonton or living in Fort McMurray. In Fort McMurray you don't have the theatres, etc. that you have here. When you are here, you may not go but they are there, they're available. It feels better to live here. If you get a chance, you just might take advantage of it, it feels good.

Women especially relied on benefits and policy provisions for personal and family leave that helped them meet family caregiving demands. Health benefits included supplementary care for prescriptions, dental and vision care, physiotherapy, massage, and chiropractic treatments. Policy provisions for paid leave for medical appointments, personal illness, vacation, and family illness were important to all women. Most women found that they had limited practical access to wellness programs and health facilities because of inflexibility in the timing and length of work breaks and their need to begin and leave work promptly to meet family demands. This limitation did not diminish the support they felt from knowing that these programs and facilities were provided by the employer.

My review of the group benefits and policies, programs, and facilities provided by the employer concurs with women's perception of being employed in a comparatively supportive work environment. Group benefits include employer coverage for medical, dental, and vision care, as well as for psychological counselling, acupuncture, physiotherapy, massage, and chiropractic services. An employee and family assistance program provides confidential referral to resources and services to address personal, family, and work-related issues for employees. Extensive fitness and recreation facilities are available for employee use. Annual paid leave provisions include 3 to 5 weeks vacation year based on length of employment, up to 10 days for casual personal illness, up to 10 days compassionate leave for immediate family illness, and up to 6 months for maternity or adoption leave. All benefits and provisions apply to full time, and regular part time employees; technical employees are ineligible for compassionate leave.

During the past 5 years, the employer has established a workplace wellness initiative. Employee perspectives on issues in the workplace, compiled from a focus group study have guided subsequent initiatives to address priority issues, identified as managing better, improving communication/rebuilding community, and improving environment/safety. Issues related to managing better focused on ensuring flexible, but consistent leadership; reasonable priorities and workload with adequate staffing;

meaningful participation in decision making; clear performance review strategies; support for managing change; and support to recapture personal balance. Personal balance issues included the need for childcare services, flexibility in working conditions, and acceptance of demands and gender issues associated with work and family roles. Issues related to improving communication and rebuilding community emphasized workplace relationships and the need to improve mutual respect, recognition, and communication among co-workers and supervisors. Environment and safety issues focused on ensuring appropriate and safe physical work spaces, including ergonomics, technology, and office buildings.

Since the focus group report, priority initiatives primarily have been directed at addressing workplace relationship and environment/safety issues, as well as developing wellness strategies such as a Wellness Fair and a directory of available services. A program to promote informal recognition among employees and a supervisor management series were implemented to improve respect, recognition, communication, and leadership in the workplace. A report was prepared to detail the employer response to identified environment and safety concerns, including review of existing as well as development of selected new policies and strategies. The workplace wellness initiative has continued to develop processes and strategies intended to support on-going attention to priority issues.

In recent years, public and workplace policy attention in Canada has been directed to the development of "family friendly" workplaces, intended to support work-family balance and caregiving responsibilities (Alvi, 1994). Employers supporting family friendly policy development have done so in recognition of the consequences of work-family conflicts on absenteeism, productivity, and turnover that impact business productivity and competitiveness (Alvi). A Canadian study of strategies preferred by professional and nonprofessional employees to support work-family balance reported that flexible work hours, increased family leave, on-site daycare, and supervisor understanding were top priorities for employed mothers (Lee, Duxbury, Higgins & Mills, 1992). Employed fathers shared these priorities but included the option to work at home

as their first priority. The employed mothers' priorities are consistent with the reliance of women in the current study on workplace support. Women recognized that they needed both informal support, particularly from supervisors, and formal support from policies and benefits to balance paid work and family responsibilities.

Pressures in the Workplace

In this study, thirteen women, including seven who also experienced aspects of workplace support, identified workplace pressures from inflexible work hours and position requirements, limited relief from co-workers, lack of control over work demands, and difficulty in using personal or family leave. Leandra described the challenges of working in a small office where she provided clerical support to a large number of staff:

> It's a very busy office and I have a lot of responsibility. Basically, I am a one-person office. It is just me with 25 staff. That's a huge amount of people. Not that I'm constantly giving them clerical support, but they're all there and they all come to me whenever they need something.

Leandra's position provided limited options for relief if she needed time to deal with personal or family demands during the workday. Five women in this study described the difficulties resulting from lack of control over demands from unpredictable work load and hours of work. Dol observed:

> In the last 5 years we have had 4 different managers. That's been very difficult. The majority of them wanted you here when they're here which would mean it's very seldom I can afford to be late in the morning. And usually they also wanted me to stay until they were ready to go home, which wasn't always comfortable to make a home life.

Dol had experienced little predictability in her secretarial position since she was expected to be available as needed outside of regular office hours. Additional unpredictability occurred with the frequent changes in management.

Women described on-going pressures in the workplace, from supervisors and social expectations about good workers, to limit their use of personal and family leave policies. Women's strategies to deal with these pressures included arranging "back up" childcare with their partner or extended family if available, leaving not seriously ill adolescent children on their own at home, and using vacation leave to meet family

demands. Additionally, women typically worked while not feeling well themselves in order to "save" their leave for family demands, particularly with preschool and school age children. During focus group discussion, everyone agreed with the comment made by one woman:

> Well you kind of have to hope that when you start a new job nothing goes wrong at home for awhile. That the kid doesn't get sick or the school doesn't call so you have that time to prove yourself.

Women recognized that the pressure to limit intrusions of family demands in the workplace was most stressful before they felt they had established a good reputation and good working relationships, particularly with supervisors. Women also indicated that the pressure was on-going as part of workplace expectations of good workers.

Women voiced concern that their use of available leave policies was practically controlled by supervisor support in their immediate workplace, regardless of formal policy provisions. Women believed that unless they restricted their use of personal and family leave, as support staff they were vulnerable to loss of opportunity for advancement and potentially to job loss. They talked about perceived differences in expectations for support staff compared to administrative and professional staff who had greater flexibility in their use of leave. As Emily, mother of an adolescent and a school age child, reflected:

> I think it shouldn't matter whether you're a supervisor or clerical staff. If you need to have flexibility, I think those conditions should try to be met having a limited impact.

Emily felt that she had limited access to workplace flexibility and inconsistent support to use family leave according to her need and in the way that she chose. She believed that greater flexibility was given to management staff compared to support staff, even though similar leave provisions were applied.

Many of the most stressful workplace-related concerns for women in the current study were identified as part of the employer workplace wellness initiative, but do not appear to have been addressed as priorities. Although the employer workplace wellness initiative has dealt with several employee-identified issues, most of the issues related to flexibility in working conditions and promotion of work-family/personal balance have

not been included in update reports about the initiative. These issues may not have been included to date because they tend to be difficult to address. For example, flexible working conditions involve developing appropriate policy as well as promoting supervisor skills to creatively individualize solutions within policy provisions. Additionally, there are budget implications in addressing workload issues, staffing concerns, and childcare services. When and how the workplace wellness initiative in this institution will address these issues remains to be seen.

The issues and concerns identified by the women in this study are consistent with the generalized anxiety among Canadians about job insecurity and lack of confidence in economic prospects (Lowe, 2000). Work-family stresses have become major problems, particularly for employed mothers whose increased workforce participation coincided with "a time of declining real incomes and greater work intensity and insecurity" (Lowe, 2000, p. 166). A study of difficulties balancing family and paid work reported that difficulties were associated with concerns about job demands, interpersonal relations, and job control, as well as about family demands related to children, illness, and health behaviors (Canadian Fitness and Lifestyle Research Institute, 1998). Consistently, health practices were poorer for employees having difficulties balancing family and paid work.

Although the pattern of women's labor force participation has changed in recent decades, their relative concentration in white collar (clerical, service, and technical) occupations has persisted (Armstrong & Armstrong, 1994). These occupations typically represent support positions with low job control, fixed hours, and limited capacity for promotion. Technological advances have resulted in increasing requirements for a wide range of skills (Hughes, 1996). Yet, support skills are associated with women's work, the work remains often invisible and undervalued (Armstrong & Armstrong, 1994; Probert &Wilson, 1993), and "jobs are assumed to require little training and are structured in ways to make workers easy to replace" (Armstrong & Armstrong, 1994, p. 57).

The impact of work-family conflicts on productivity and absenteeism among employed mothers and the growing need for greater flexibility in work schedules have been documented (Lowe, 2000). Flexible schedules, a consistent recommendation to

address work-family issues (Canadian Fitness and Lifestyle Research Institute, 1998; Lowe, 2000), have been associated with reductions in absenteeism (Lipsett & Reesor, 1997). Yet, less than one-quarter of workers have flexible schedules and these are usually available to managers and professionals, not clerical and service workers (Lowe, 2000).

The movement in recent years toward the implementation of family friendly workplace policies has been hindered by controversy about the economic impact on organizations under continuing pressure to increase efficiency in a globally competitive market economy (Mitchell, 1997). Recent media coverage (National Post, May 20, 2000) provides evidence of controversy among paid workers within organizations about the relative merits and perceived "counter discrimination" of family friendly policies for workers without dependents or caregiving responsibilities. These controversies suggest that resolution of work-family balance issues will not be readily achieved on a broad social scale.

The women in this study identified the supervisor as a key person in the interpretation of formal workplace policies and the establishment of informal working relationships. A workplace environment of respectful working relationships contributed to informal support and flexibility in the workplace. This support and flexibility helped women meet family and paid work demands. Alternatively, supervisors could pressure women to limit their use of policy provisions and enforce inflexible working conditions. Effectively, supervisors controlled women's access to formal support from workplace policies, as well as to informal support from respectful relationships and flexible conditions. Current workplace wellness and work-family balance literature has emphasized the need for formal policy support to workers in meeting family and paid work demands. The experience of women in this study, however, indicates that access to such support may be limited informally by supervisor and workplace pressures.

Conclusion

My focus in this study on employed mothers' health decision making integrates a nursing orientation to health promotion, a sociological orientation to meaning and action in the social world, and a critical feminist orientation to explicating social institutional

influences on social interaction. I share with Bernard (1975) a concern that research about employed mothers' lives engage "an integrated approach that will help us see the lives of women as unitary wholes" (p. 242). As did Garey (1999), I attempt such an approach by examining employed mothers as mothers and as workers concurrently in order to understand "what it means to be *a worker with children* and *a mother at work*" (p. 19). Such examination challenges conflict-oriented constructions of paid and family work that conceptualize the institutions of motherhood and the family in opposition to the institution of the workplace. Garey cautions:

> If work commitment is understood as inherently conflicting with family responsibilities, then men, as breadwinner-fathers, will not be socially expected to share in family work as fathers, sons, and brothers. And women, as mothers, daughters, and sisters, will not be treated seriously in the workplace. ...If a commitment to job or career is conceptualized as being in conflict with participation in family life, then there is little reason to expect changes in the workplace that will accommodate *both* work *and* family needs (pp. 193-4).

I concur with Garey's contention that social and workplace policy intended to address work-family issues "should be based on concepts of motherhood, fatherhood, and parenthood that include the *relationships* of mothers and fathers to their children, rather than ones that reduce motherhood or fatherhood to the delegatable tasks of caring for children" (p. 197). Unfortunately, it is the accomplishment of the these tasks as well as the tasks assigned in the workplace that are the everyday challenge for employed parents, particularly employed mothers.

The current paradox of much of the focus of "family friendly" social and workplace policy is that the predominantly gendered use of such policy by women implicitly reinforces social ideals of family work as women's work. "Policies that appear to make life easier for women, and that may even be welcomed by a majority of women, may cement women's inequality" (Bergmann, 1997, p. 279). Even as employed mothers benefit from policies that support meeting their concurrent demands in paid and family work, such policy fails to address the need for change in the current social construction of

family work as women's work. The gender neutral language of policy, its application to parents, masks the current reality that a minority of men compared to women use policy provisions (Conway, 1993). I agree with Eichler's (1997) conclusion that family policy attention needs to incorporate consideration of labor justice, organizational structures, community action, and the interconnection between paid and family work.

Attention also needs to be directed to promoting informal relational support and ensuring access to formal policy support in the workplace. Current work-family balance literature has tended to focus on the development of formal policy provisions such as family leave, flexible work arrangements, and assistance programs (eg. Alvi, 1994). There has been limited attention to strategies to ensure the development of informal support from supervisors and co-workers, so that available formal supports are accessible. The experience of women in the current study suggests that formal support without informal support creates stress for women and constrains their choices in managing paid and family work.

In spite of the potential support from social and workplace policy and interpersonal relationships available to employed mothers, they remain ultimately constrained by the dominant motherhood ideal of the sacrificial, altruistic, and selfless good mother. The recognition of mothering as a moral, relational experience offers an alternative to this oppressive ideal, therefore a potential direction for change that would support all women as mothers. Bergum (1998) has challenged the view of mothering as inherently altruistic and self-sacrificial. Bergum advocated approaching mothering as a moral connection between persons that recognizes the "communal responsibilities inherent in these connections for all people" (p. 2). A relational notion of personhood, including motherhood, recognizes the necessity of commitment to both self and others concurrently. This commitment is mutual and intradependent, rather than hierarchical in relationship. This relationship places self with others instead of placing others over self or self over others. Bergum's approach challenges the dominant "belief in altruism and self-sacrifice as moral ideals for people (including mothers)" (p. 3). In contrast to emphasis on self-lessness in mothering, Bergum advanced the view that mothering should be "self-

full...[that] women, as mothers, are caught by the moral claim of the child, and through recognition of their responsibility to the child, they think about their own lives" (p. 5). From the view of self-fullness, good mothers care for themselves even as they care for their families.

My project in this chapter has been to describe women's everyday experiences and explicate the ways these experiences are socially organized and mediated. This project is consistent with Smith's (1987) analytic approach in taking "the everyday world as problematic". The point of reference is the organization of relations among and actions of people that are socially mediated by discourse. The social mediation of discourse is evident in conversations as well as written, filmed/videoed, and printed materials (Griffith, 1995). As described by Griffith:

> Smith's unique contribution to understanding everyday life has been to discover how ideas, legitimated through coordinated discourses, organize knowledge and action. Discourses have particular ideological force, shaping our knowledge of the everyday world to conform to interests outside our own. Smith's work illuminates how 'discourse' is an active relation of power between textually organized knowledge and the actions in everyday life it organizes (p. 110).

Smith (1993) contended that public institutions as well as family life are organized by the "standard North American family" as an ideological conception of the family. Nicholson (1997) also challenged the institutional ideal of the "traditional family" as a myth that was largely constructed during the past century and emerged as the 1950's idealized male breadwinner/female caregiver nuclear family. Nicholson concluded that the accompanying construction of all other family forms as "alternative" or "deviant", despite their dominance culturally, effectively prevents mobilization of political power to reform and increase the responsiveness of other social institutions. For example, the education, health, and social systems continue to reflect, however implicitly, dominant ideals that hold the family, particularly through motherhood, individually responsible for supporting the education, health care, childcare, and elder care of family members. Despite some progress toward "family friendly" environments, the workplace continues

to emphasise ideals oriented to workplace efficiency and productivity that may be inconsistent with social ideals oriented to family and community life. It is not surprising that women continue to embrace the motherhood and caregiving ideals so pervasive in Canadian society. Rather it may be surprising that any women are able to challenge the essentialist association of these ideals as natural to women and their embeddedness in the formal structures of Canadian social institutions.

CHAPTER 6

FINDING A BALANCE: THE PROCESS OF HEALTH DECISION MAKING

In this study, women described the everyday work of balancing personal and family health. In making health decisions for themselves and for their families, women went through a process of "finding a balance." In the process of finding a balance, women considered what met expectations and most pressing demands, fit with available resources and constraints, was acceptable to them, and was reasonable and practical at the time. Finding a balance was influenced by continuous changes in personal, family, workplace, and community demands. Concurrently, women's efforts to find a balance were influenced by frequent changes in available resources and situational constraints.

The process of finding a balance in decision making was framed within women's health meanings and health work (discussed in Chapter 4), as well as the complex social institutional influences on women's everyday lives (discussed in Chapter 5). Women in this study described health, for themselves and for their families, as the capacity for everyday living. Being healthy and having a healthy family were experienced as living fully in everyday life for individual family members and the family collectively. The personal and family health work women described was consistent with their meanings of health. Women's experiences of health decision making and health work reflected the effect of multiple social institutional influences. The social institutions of motherhood; the family; the health, education, and social systems; and the workplace shaped the expectations, demands, resources, and constraints women considered when making health decisions. Stress from inflexible expectations, multiple sometimes competing demands, time pressures, and inconsistent access to needed resources was a concern for many women. Stress threatened women's health, reinforced women's focus on family health over personal needs, and compromised decision making.

Discussion in this chapter focuses on the decision making process revealed in women's descriptions of everyday health decision making. This focus is necessarily located in the broader meanings, actions, and influences relevant to women's health decision making for themselves and their families. The concept of balance from women's

perspectives is presented, followed by in depth description of the process of finding a balance in decision making and discussion of relevant literature.

Balance

The language of balance and finding a balance was used spontaneously by many of the women during initial study interviews. In the follow-up interviews, women confirmed the fit of this language with their everyday health decision making experiences.

Balance describes a sense of compatibility or match for women among expectations, demands, resources, and constraints: They tried to meet expectations, deal with important demands, use available resources, and work within situational constraints. Women continuously attended to the challenges they faced in finding balance in decision making. They talked about balance as dynamic and constantly changing, rather than as static. The continuous, dynamic, and contextually situated nature of finding a balance was illustrated by Geri's reflection on balance in decision making:

> Balance is a big thing. It's in everything. It's how you deal with your children together, how you deal with them separately, how you handle the demands of the work place and the home and if you try to do something other than home and work, you know, if you have a life outside.

Geri's description emphasized the continuous nature of balance in everyday decision making. This characteristic as well as the dynamic nature of balance were illustrated by Lea's description of her everyday attempts to find balance:

> I try for the best balance I can and some days I hit it and some days I don't. If there's any problems, they're being dealt with relatively effectively most of the time. Overall what I am looking for is reasonability, balance, practicality.

Lea explicitly identified reasonability and practicality as important aspects of balance in decision making. Acceptability, as a third aspect of balance, was implicit in Lea's comments and explicit in Haley's reflection on balance as:

> Something I can live with, something that's OK with me, not necessarily you or my co-workers or anybody else. Something where I can still look myself in the mirror and know I am doing the best I can with what I have.

Haley could not imagine making a decision that was not acceptable to her, seeing acceptability as a personal concern.

All women in the study acknowledged the importance of reasonability, acceptability, and practicality as key aspects of balance in their everyday decision making. Reasonability focused on choices that made sense, given the situation at the time. The soundness of judgement was considered. Embedded in women's talk about reasonability, was a focus on the acceptability of actions to the women. Women's decisions reflected their values. Ensuing actions by women were consistent with their accepted values. Practicality focused on the feasibility of actions, considering what was do-able or workable for a given time and situation. Women tried to make choices that made sense, were acceptable, and were do-able. Women's efforts were illustrated by Scarlett's description of the challenge of making decisions that fit within ever-changing situations:

> That's probably one of the biggest challenges. The alternative that might work for today, ain't gonna work for tomorrow. You know, or what's happening as far as, if my work is crazy one day, I can't make those decisions...I can't get away if my child is sick at school. So I have to make sure I have some kind of back-up. Maybe my back-up isn't there the next day, maybe my work is different the next day. Maybe my husband can get there. That is not a minor thing, that is a major thing.

Scarlett identified circumstances related to family, workplace, and social support that reflected the influence of social context on their decision making.

Women in this study shared an awareness of how their circumstances influenced their decision making. Additionally, knowledge and the availability of needed information were also important influences on women's decision making. Haley identified this in her comment:

> I am always trying to find that balance and when I look back at things, I say I've made the best decision with the information I had at the time.

Haley focused on the practical aspects of making the best decision at the time. Similarly practical in her attitude toward decision making, Mora illustrated how women explicitly located their health decision making in their family and social context:

> I deal as a mom who has 3 kids, has to run the household and come home, come to work. You try to kind of balance your life.

Women's inclusive view of health as the capacity for everyday living, reflected

particularly in Mora's comment about "balancing your life", was evident in the way that each woman spoke about health decision making. In a practical sense, finding a balance in health decision making was equivalent to finding a balance in decision making in everyday life for women in this study.

The concept of balance has been popularized in women's and family health, as well as work-family or work-life literature in recent decades, however, there are important differences in how the concept is used and to what it refers. References relevant to the paid and family work focus of the current study include balance in organizing multiple roles (Marks & McDermid, 1996), balance in dealing with women's multiple responsibilities for family and paid work (Caproni, 1997; Crosby, 1991; Neal, Chapman, Ingersoll-Dayton & Emlen, 1993), and balance between physical, mental, social, and rest activities in daily life (Wilcock, et al., 1997). References to balance relevant to the health focus of this study include: balance in managing personal and family health problems in daily life (Kenney, 2000; Robinson, 1998; Schaefer, 1995) and balance in palliative care decisions (Bottorff, et al., 1998). Notably, balance has not been analyzed conceptually in current health and social science literature. Balance typically has been identified as an outcome or state in which comparative proportion has been achieved between relevant interests or component parts. This state-orientation contrasts with the focus of women in the current study on balance as dynamic and process-oriented, though the idea of comparative proportion is applicable. Although the phrases 'balanced decision' or 'balanced decision making' are used in everyday conversation, they do not appear central to decision making theory.

While the image of finding a balance in health decision making fit for all women in the current study, half of the women equated that image with an image of juggling in decision making. Among these women, most described juggling in the same way they described balancing solutions in the process of finding a balance. Jenna said:

> I think it's the juggling at first, trying to figure out what works, what can be done, then tying to keep that balance. So, it's kind of an experiment. It doesn't work, that juggling didn't work, so we'll try another part and then we try and balance the situations.

Jenna prefaced her description of juggling and balancing with a description of her adjustments to the birth of her second child and preparations to return to paid work. Juggling involved considering multiple demands from family and paid work, and her ability to identify and implement workable solutions to ensure family health. Balance was found when workable solutions were implemented to deal with the situation. This description is strikingly similar to that of balancing solutions, discussed later in this chapter as one phase of the process of finding a balance.

Whereas Jenna focused on juggling multiple demands to balance solutions, a few women identified with the overall image of themselves as jugglers trying to keep multiple balls in the air. The multiple balls represented individual family members, as well as women's multiple responsibilities for personal, family, and paid work. During the initial interview, Rose had described health decision making as being on a tight rope facing difficulties in going forward to a safe situation. In the follow up interview, she commented:

> You learn to juggle, you've got one [ball], which would be maybe yourself, your spouse or your partner. And then you've got two, that would the next child. And then you're still getting them to go around and around, but you've got to be able to catch each one. And it goes to show life is a circus!...And it is a constant moving. Not really on a tight-rope. I feel more that I am on a balance beam. I don't feel as far off the ground.

Rose talked about finding a balance and juggling as interchangeable images. She enjoyed the image of being a circus performer balancing on a tight rope or beam while juggling balls of responsibility. Women who globally equated balancing with juggling emphasized a sense of unpredictability in decision making. They described juggling as being active and partially in control, rather than out of control.

Crosby (1991) brought the image of juggling into popular women's health literature with her examination of the advantages and disadvantages of multiple roles for employed mothers. Juggling was described as:

> a special form of role combination. As the metaphor implies, juggling entails risks. Objects have weights and sizes of their own, and the juggler must contend

> with these and with the forces of gravity. Time is of the essence. A responsibility that is not caught in time can end in trouble, suddenly and dramatically (p. 7).

Crosby examined research on women's experiences of employed mothering, including the risks and doubts as well as the benefits of fulfilling multiple roles in family and paid work. She concluded that jugglers "derive a great deal of pleasure from life...they also feel stressed, stretched, and tired to the point of exhaustion" (pp. 202-203). Crosby's description of women's juggling in everyday life was comparable to the descriptions of juggling everyday health decision making by women in the current study.

In contrast, many of the women in this study distinguished between the images of finding a balance and juggling. For these women, the distinction centred on associations with action, control, and coping in decision making. Finding a balance was associated with taking action, feeling in control, and being able to cope with health decision making in everyday life. Juggling was associated with being reactive to unexpected demands, feeling out of control, and being uncertain about their ability to cope. Scarlett reflected:

> Juggling is you've got 8 different balls up in the air and at one point you are only dealing with one of those balls. You are grabbing onto it in your hands and the other ones are up in the air coming down towards you. But you are dealing with that one thing at a time. The balance means that I am able to deal with, basically, all the balls at the same time. I am balancing everyone's needs as well as my own.

Scarlett rejected the image of dealing with single responsibilities or balls, in favor of a focus on managing multiple responsibilities as a whole. Olivia also rejected the image of juggling:

> Juggling is having a hard time, this is a bad day. And on the day when you find the balance is the day you are doing all this but it's not stressing you out. You still are able to cook supper while you're talking to somebody and the phone is ringing and everything is still happening. But you're coping very, very well.

Olivia highlighted women's association of juggling with intense stress and inadequate coping. An extension from stress and coping to control was made by women. Emily commented:

> Balance is being in control. And the juggling being where you are starting to feel out of control. And not being able to cope or being that close that you're gonna say, "I can't cope with this any more."

Emily associated finding a balance with being in control, and by extension, being able to manage stress and cope with decision making situations. This description of finding a balance fit for all women to varying degrees, including those who allowed for the greater sense of unpredictability associated with juggling in decision making. Therefore, women concurred with the focus on the concept of balance, and the process of finding a balance in health decision making.

The Process of Finding a Balance

Women's descriptions of recent examples of making health decisions revealed a process of finding a balance that resembles conventional, rational decision making. They engaged in this process, whether making health decisions for themselves or their families. The process involved women's activities related to five phases of decision making: keeping track; cueing in; figuring out; balancing solutions; and assessing results. Keeping track involved women's efforts to monitor everyday conditions and activities. Women cued in to changes in usual conditions and patterns of activity, typically connecting changes to their knowledge and experience of previous situations. Figuring out involved the identification of presenting health concerns, including consideration of the severity and likely cause of the concern. In trying to balance solutions, women considered and selected alternative responses to deal with the identified concern. Women tried to devise solutions that balanced expectations and demands with resources and constraints. In most situations, balancing solutions was the most difficult and complex phase of finding a balance. However, in some situations figuring out was most difficult while balancing solutions was considered simple and self-evident. Women assessed results, particularly of their efforts to balance solutions, by considering the success of their efforts in dealing with and resolving health concerns.

In a now-classic work on decision making, Janis and Mann (1977) proposed a 5 stage model of decision making based on empirical research. The model applied to individuals and groups dealing with important life decisions such as lifestyle behaviors and medical treatment. The model was based on the empirical conclusion that a vigilant decision making pattern promoted high quality decisions. In an elaboration of the earlier

work, Janis (1993) characterized the pattern of vigilance as: "The decisionmaker searches painstakingly for relevant information, assimilates information in an unbiased manner, and appraises alternatives carefully before making a choice" (p. 60). The 5 stages in vigilant decision making were: (1) appraising the challenge or event requiring a decision; (2) surveying alternatives, including seeking information and advice to identify and eliminate alternatives; (3) weighing alternatives by deliberating about the advantages and disadvantages of the remaining alternatives; (4) deliberating about commitment by considering the implications of implementing the decided upon action; and (5) adhering to the decision despite negative feedback that could prompt a decision reversal (Janis & Mann, 1977). Although fluctuations or reversions between stages were recognized, particularly between stages 2 and 3 or 3 and 4, vigilant decision making presented a linear progression through stages. Only stage 4 was considered to be influenced by social conditions since deliberation focused on the anticipated response to the decision of affiliated persons and groups important to the decision maker. The other stages were considered mainly psychological, cognitive processes for the individual decision maker.

The 5 phase process of finding a balance in women's health decision making described in the current study generally resembles the 5 stage vigilant decision making model proposed by Janis and Mann (1977). In each, decision makers progress from identifying a concern, through selecting a solution among considered alternatives, to dealing with the results of the implemented decision. However, Janis and Mann emphasized an individual cognitive, rational, and linear approach to decision making with limited attention to social institutional influences. This emphasis distinctly contrasts with the decision making experiences described by women in the current study.

Despite the resemblance of the process of finding a balance to conventional decision making, women experienced finding a balance as recursive movement within a continuous process, rather than as linear progression through discrete stages. Figure 1, diagramming the apparently linear phases of the process of finding a balance contrasts with Figure 2, diagramming the recursive process described by women in this study.

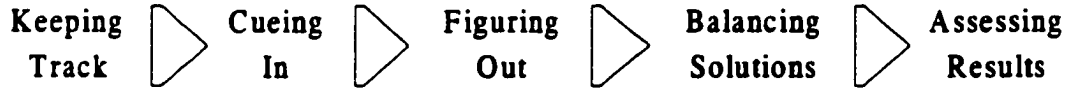

Figure 1. Linear phases of finding a balance.

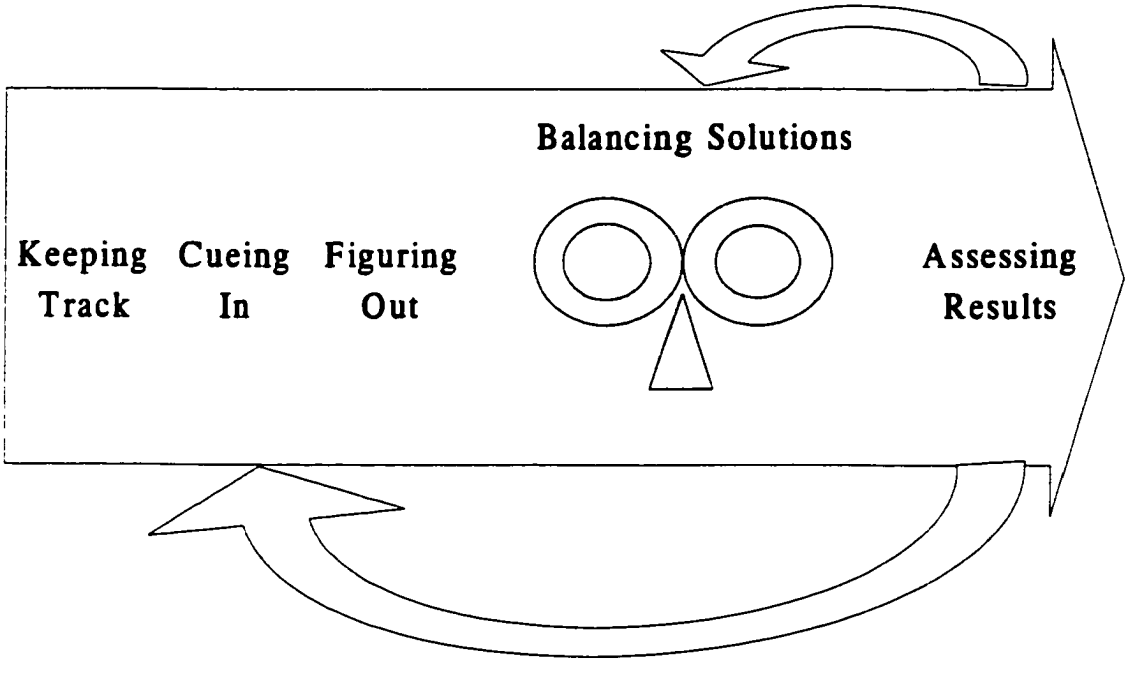

Figure 2. Recursive process of finding a balance.

In the following sections of this chapter, each phase of the process of finding a balance will be described in depth. Women's experiences will illustrate the difficulties and achievements associated with finding a balance in health decision making. Additionally, phases will be discussed in relation to current relevant literature.

Keeping Track

For women in this study, keeping track involved being sensitive to the usual patterns of daily life for themselves and their families. Women's focus on continually keeping track of everyday conditions and activities was discussed in Chapter 4 as an important aspect of women's health work for themselves and their family members.

Keeping track, as part of regular health work, frequently was the "bridge" or entry point for women into the process of health decision making. Women described keeping track of their own health as well as of their family's health, both individually and as a group. Keeping track was described as routinely "monitoring", "watching", "listening to", "keeping on top of", and "being in tune with" themselves and family members.

Women's focus on keeping track of their own health was described in somewhat introspective terms. In particular, women spoke of "knowing their bodies" and being sensitive to changes, for example in their usual energy and coping capacity, that could signal physical and social-emotional health concerns. Women made somewhat global statements about this sensitivity, as illustrated by Cass's description of keeping track of her own health: "I know what my body does. I can feel that a cold is coming on." Cass's sense of "knowing her body" was shared by women in this study. They relied on this sense of knowing in keeping track of their own health.

Even more than women did for themselves, they spoke of keeping track of their family's health. Women attended to the family group, as well as to individual members, both children and partners. Ilana succinctly described keeping track of her family's health: "I keep on top of things. I told you, I am like a hawk. I monitor them constantly." Ilana's statement captured women's focus on keeping track of overall family health. Additionally, women kept track of particular aspects of family member health. For example, Aryn noticed what her children ate from their school lunches as a means of keeping track of her children's nutrition:

> I am very lucky with the lunches 'cause they never throw anything out. If they eat half a sandwich, the other half comes home. So I always know.

Aryn felt able to maintain a high degree of involvement in keeping track of her children's

health because they were open about their activities. In contrast, Emily spoke of trying to keep track while recognizing that she could not be aware of everything in her adolescent children's lives:

> 'Cause as the children are getting older, this monitoring thing, you really have to be on top of it because you can't protect them anymore. They're being subjected to all different kinds of things, things that we can't even possibly think about or know about.

Emily felt a degree of uncertainty in being able to keep track of all important aspects of her children's lives. Similarly, Rose's comments about trying to keep track of her late adolescent son's health revealed this uncertainty:

> The kids being older, they're on their own more. I'm monitoring and watching from the sidelines, but I am biting my lip an awful lot.

Rose's sense of uncertainty was even stronger than Emily's, reflecting the older age and greater independence of Rose's children. Yet both women continued to keep track of their adolescent children's health on a regular basis.

Similarly, women tended to keep track of their partner's health, although women felt their partners were mainly responsible for their own health work. Women's attention to keeping track increased, however, when their partners had chronic health concerns. Cass talked about keeping track of her partner's health:

> I want him to quit smoking because he has been told on a number of occasions he has asthma and it bothers me to hear him wheeze as much as he does.

Cass, recognizing the relationship between the asthma and smoking, monitored her partner's condition for indications that his asthma was worsening. Her focus remained on monitoring even though she indicated that her partner controlled his own actions to quit smoking or attend to his symptoms. The few women who provided caregiving to elderly parents also described keeping track while respecting self-care responsibility. Rose, who provided regular caregiving to her ageing father and her chronically ill partner, described keeping track of their health:

> He [father] is very prone to respiratory, like he had pneumonia so that's why he has to be watched after. I have to be very listening to him, partly because of the age and I want to make sure that I don't miss something that he is trying to say to me. It is the same with my husband. I try to listen to him and I am really paying

attention to the fact that I don't want to miss any of the signals.

Rose spoke of "paying attention" to her father's and her partner's health. She described "watching" and "listening" for signals or indications of health changes for either her father or partner. The vigilance evident in Rose's description of keeping track was reflected in the comments of all women in this study. Women's vigilance in keeping track focused on attention to the patterns of daily activity in order to be sensitive to presenting cues that might indicate emerging health concerns.

Cueing In

Cueing in involved being sensitive to indications of changes in the usual patterns of daily life for women and their families. Women cued in to health concerns by connecting changes with their knowledge and previous experience of possibly similar or related concerns. Women relied heavily on observable behavioral cues, both for themselves and their family members. Additionally, women relied on an internal sense of awareness or "knowing" as a cue to potential concerns, particularly those related to social-emotional aspects of health. Emily's description of a concern about her own health reflected both types of cues:

> There were incidences that occurred to sort of say, "OK, wake up and let's think about yourself! Here you have put yourself in a position where it's time to look after you as a person, because you are always giving here, you are giving there, you are giving there, and it's just building and building and it is just becoming too much." I could say that I woke up. I could see how it was affecting those areas and the way it was affecting those areas was I wasn't in control any more of how they were being handled. It wasn't making me happy.

Emily cued in to a personal health concern by becoming aware of the impact on her daily life that was indicated by her inability to function as she expected, her reduced sense of control, and her unhappiness. Similarly describing cueing in to cumulative changes, Haley's comment reflected the interplay between keeping track and cueing in:

> It's sort of a checklist on myself and when I think I've hit that criteria, for you know, you let this go and you let this go and then all of a sudden you get to a point where you can't function the same way you used to. And THAT'S when my alarm bell goes off.

Haley's response to an "alarm bell" when cumulative changes led to interference in her

ability to manage daily life as expected was common to women in this study. In cueing in to their own health concerns, women relied on an internal sensitivity to their emotions, sense of coping, and behavior in managing everyday responsibilities.

In cueing in to children's health concerns, women relied heavily on behavioral cues to indicate changes in children's social emotional and physical health. Faith recounted her growing awareness of concerns about her infant daughter's child care situation:

> I'd come up and pick her up after work and she would be screaming and crying. She [child care provider] gave me the impression that it was because she was my first child. You don't know the first time around. I'd think, "well, maybe she's just having a hard time adjusting."

Faith cued in to her daughter's crying as an indication of her unhappiness in the child care situation. Faith's comments also suggest how her own inexperience with infant behavior contributed to her uncertainty about the cues. Her daughter's crying indicated distress that, as a general infant behavior, was difficult to associate with a single certain source or meaning. For women in this study, uncertainty arose from interpreting general or unclear cues and from lack of experience in interpreting particular cues. Such uncertainty presented a substantial challenge for women in cueing in to health concerns.

In contrast to this uncertainty, Emily described a situation in which the cues were seen to be clear and obvious:

> The few times that my children have been sick, you know that they're sick, 'cause they just hang all over you. So, it's those things, when they stop dead in their tracks and just want to hang around and lay around then I know that there is something wrong and that clues in, "Do I need to take them? Is there something serious here?"

Emily's expression of confidence in recognizing the cues in this situation was common to other women who described similar situations. Confidence seemed to relate to the perceived clarity of the cues and to women's knowledge and experience in recognizing cues appropriately. An interplay or fluidity between keeping track and cueing in was evident from women's descriptions of decision making. This fluidity carried over into women's focus on figuring out concerns once cues had been recognized.

Figuring Out

In the phase of figuring out, women focused on identifying or naming the presenting concerns. Concurrently, women tried to determine the soundness or legitimacy of the concerns presented to them. This determination was particularly important to women when dealing with concerns that affected women's paid work responsibilities. Additionally, women attended to figuring out the severity and possible causes of concerns. Consequently, women considered the immediacy of the need for a response to the identified concern. The various aspects of figuring out are illustrated in Daria's description of a recent experience with her preschool age son, who had previously been ill with a systemic herpes infection:

> My son has some sort of cut on his tongue, he's had it for about the last five days. And I'm trying to see what this cut is, whether or not it's a bite cut or he's got blisters again. So this is how the other one started, but it's different in a way. So, what I've done is I have sort of watched it and when he has said, "this bugs me," or "salt bugs me," or "water bugs me," or whatever, I sort of just watch that. He is eating, which he didn't do the other time. He complains about only one spot, so I kind of know that I'm starting to assess that I think he's probably bitten his tongue. So now I've gotten to about day five and I am starting to think, "Well, now how long does a tongue need to heal?"

Daria observed her son's behavior and physical signs of illness, comparing her observations to the previous episode of herpes infection and her own experience with tongue bites. Daria's description of her observations and analysis of her son's complaints and behavior illustrate how women in this study figured out health concerns. Daria's description suggests a predominantly rational, analytic approach to figuring out concerns.

While an analytic approach was emphasized by women, they also acknowledged reliance on an intuitive knowing. Faith, who described cueing in to concerns about her daughter's child care situation, talked about how she had concluded that a problem existed:

> We would drop her off in the morning, she would cry and cling to us. And we'd pick her up at the end of the night and she'd be crying and she'd be thrilled to see us again. So, you just have a sense that she is not happy. That's what we figured.

Faith also described her sense of "knowing" in another example with her daughter:

> I can sort of sense when she is getting over something or when she is coming down with it and when she is not. I guess it was just really knowing her...when you are with them 24 hours a day, you know, 7 days, yeah, it just seems natural.

Arguably in both examples, Faith's focus on knowing her daughter's condition could be interpreted as reflecting a sensitivity to subtle behaviors and an inability to articulate a more analytic approach to observation. Whether or not this was the case, many women spoke of knowing in figuring out, just as they had in keeping track and cueing in.

Faith went on to describe how she finally figured out that the child care situation was problematic, by comparing the provider's description of her daughter as unsociable to her daughter's behavior in other social situations. Faith questioned her own sense of the problem given the child care provider's explanation of her daughter's crying as normal separation anxiety and an unsociable temperament. For Faith, figuring out what the concern was, whether or not it was a serious problem, and what contributed to the problem was difficult because of her limited experience with normal infant development.

Faith was challenged to figure out concerns when her infant daughter was too young to provide more than behavioral cues; however, older children's verbal ability did not necessarily make the task of figuring out any easier. Women talked about trying to assess the legitimacy or soundness of children's complaints. Dol described figuring out whether or not her adolescent daughter's complaints were sound, and what form of response was appropriate:

> There are times when I am booked into meetings from here, when my daughter will phone from school and say, "I am not feeling well." But on the other hand, I also know she's a kid and she's played and cried wolf once too many and so I have to sit there and try to judge from this 35 second phone call how serious this is. Should she go home? And I guess what I am starting to do is ask questions, as in "Are you feeling well enough to take the bus home or shall I phone grandpa?" And we both know that grandpa shouldn't be driving around the school yard with children. So she will say, "Is there any way you can pick me up?" Then I know she's serious. And if she says, "I can take the bus home," I will say, "Well, you just hang in there."

Dol described listening to her daughter's tone of voice, testing her response to an unattractive solution, and considering her daughter's previous requests to leave school. Women's awareness of their children's ability to exaggerate complaints further

complicated attempts to figure out children's health concerns. Dol's description also illustrates women's awareness of their concurrent responsibilities to care for their children and to finish their paid work day.

Compared to figuring out children's health concerns, women's descriptions of figuring out personal health concerns tended to reflect an even more analytic approach and a greater sense of confidence in interpreting cues. This was most evident in Ilana's account of how she figured out health concerns, both for herself and for her children:

> There are times because of maybe added stress or whatever that I can notice that my condition is deteriorating badly, overall my physical condition. So when that starts happening then I start evaluating the situation, kind of figuring out what is causing this. Too much work? Not enough time for myself? Too much allergens in the air? Too dry air? Whatever it would be. Well, at that point, I notice that my condition is starting to deteriorate more than usual, I start making this kind of analysing. If I notice some changes happening, I start asking questions and trying to pinpoint what's happening. I basically go through the same kind of process with my children. If I notice some changes happening, I start asking questions and trying to pinpoint what's happening.

Ilana used the language of questioning and analyzing in her description of figuring out health concerns. Ilana's questions illustrate women's recognition of different possible interpretations of presenting cues. In a dramatic example of trying to figure out a cue that could be interpreted in different ways, Lea recalled:

> I started with the chest pain. And it was a bad pain. I figured it was probably stress because I've heard this before, so I didn't panic. Took some Tylenol. By this time I am a little concerned but still thinking it is probably stress related. Looked it up in the books that I've got, figured I was running 'fifty-fifty' possible myocardial infarction and acute stress. Figured that based on my past history of stress reactions and current situation, it was probably acute stress.

Lea considered the response to her attempts at pain reduction, the medical information she read, and knowledge of her previous stress reactions. Lea's approach to figuring out health concerns reflected what she later described as "making an educated guess".

Women drew on lay knowledge, specialized information, previous experience, and intuitive knowing in figuring out health concerns for themselves and their family members. At issue for women, was their ability to determine with some confidence what concern was presented, how legitimate and serious it was, and how immediate the

response needed to be. Even as women were making this determination, they were already engaged in the phase of balancing solutions as they recursively anticipated the implications of possible solutions to differently identified concerns.

Balancing Solutions

For women in this study, balancing solutions usually was the most difficult and complex part of the process of finding a balance in health decision making. Women tried to develop balanced solutions that effectively responded to the particular situation, that accounted for women's multiple responsibilities, and that were sustainable over time as needed. The process of balancing solutions was continuous and recursive.

In balancing solutions, expectations had to be balanced with current demands, available resources, and identified constraints that changed from situation to situation over time. For women in this study, balancing solutions involved considering both what should be done and what could be done. Figure 3 diagrams women's view of balancing solutions in decision making. The diagram illustrates the multiple influences on women's experiences in balancing solutions that are integrated within women's decision making.

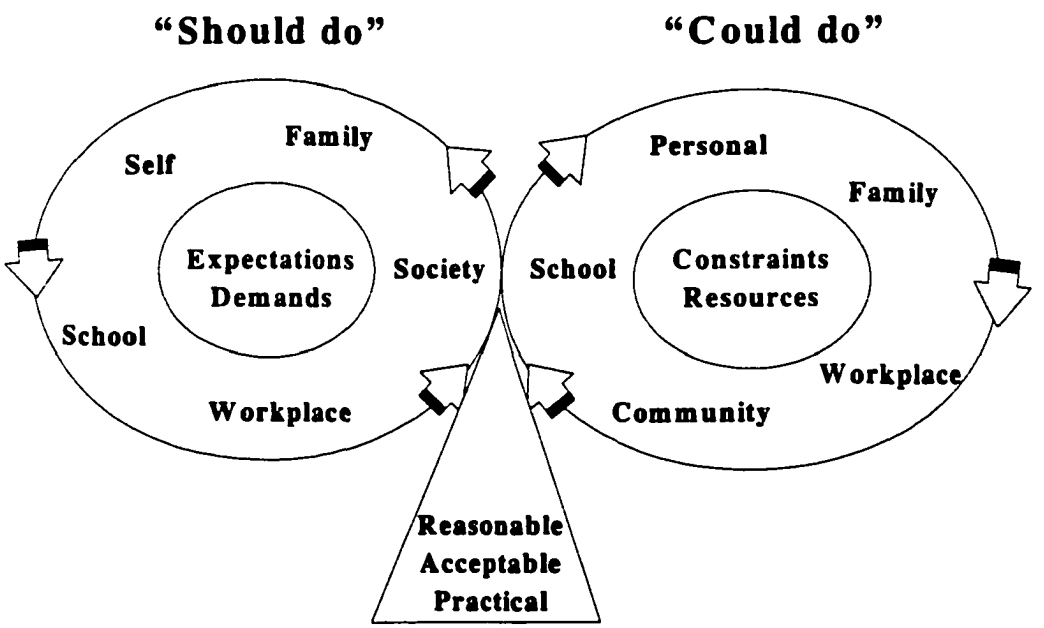

Figure 3. Balancing solutions.

To achieve balance, women used three approaches that enabled them to meet expectations and demands. Women tried to meet expectations and demands directly by strategically focusing on identified priorities, by being fair in their consideration of others, and by letting go of inflexibly high expectations and demands. A second approach that helped women meet expectations and demands involved using available resources. This approach included a wide variety of strategies: accepting support; asking for help; sharing decision making; recognizing self rewards; using time out; using spiritual support; choosing paid work with flexibility; and valuing available benefits and services. Women also used a third approach of working around situational constraints to meet expectations and demands. This approach included the strategies of delaying demands when possible, planning for contingencies, using alternatives when access was limited to resources or services, and persisting in their efforts to resolve problems. The three approaches were focused primarily on enabling women to meet expectations and demands while working within or around resources and constraints, although each approach was mutually supportive of women's capacities to balance solutions. Women's use of these three approaches and the various strategies in balancing solutions is diagrammed in Figure 4 and is discussed in the following sections.

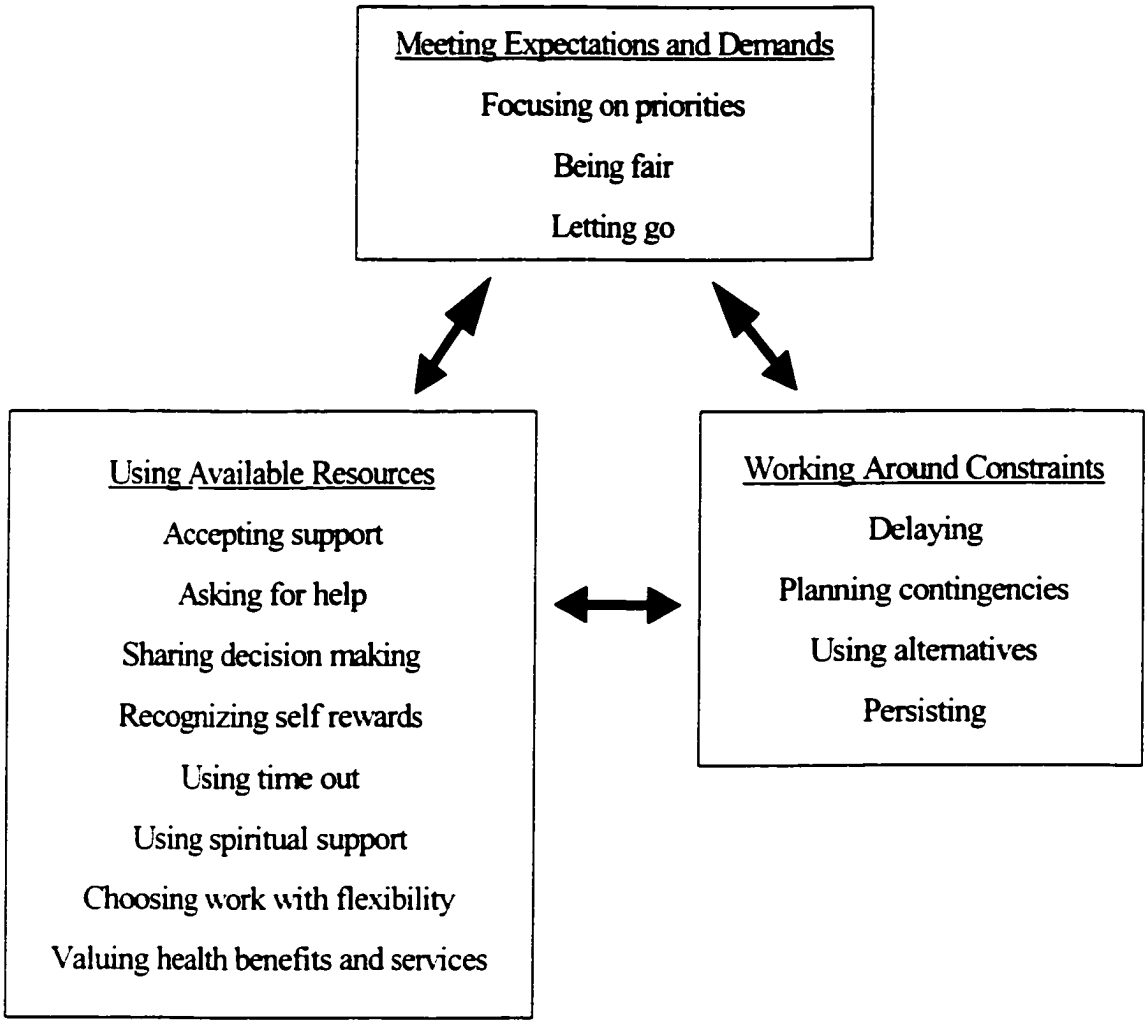

Figure 4. Approaches and related strategies used to balance solutions.

Meeting Expectations and Demands

Women's expectations for themselves reflected their embodiment of family and social expectations of the good mother caring for others and the good worker producing for others. Women integrated these expectations within their sense of self and did not see them as inherently conflicting. Balanced solutions for women included meeting these expectations.

Women felt challenged to balance expectations with the multiple demands placed on them in their everyday circumstances. At issue for women was the intensity, frequency, and timing of health-related demands concurrent with daily demands arising from their responsibilities for personal and family caregiving as well as for paid work. Family demands tended to vary for women according to the age and abilities of their children. Workplace demands tended to vary with women's sense of control over working conditions.

Focusing on priorities. Women in this study frequently talked about focusing on priorities to guide their decisions in balancing solutions. Family responsibilities, particularly caring for their children, were an explicit priority for all women. Paid work responsibilities also held priority for women as individuals and as part of providing for their family.

Women were aware of the potential for conflict between family, paid work, and personal responsibilities in their everyday lives. For most women, this awareness was mitigated by their experience that direct conflict between priorities, for example between family and paid work, was not an everyday occurrence. Dol reflected on her general approach to decision making and her recent experience of intense family caregiving:

> The whole thing comes down to priorities. All of us have a wallet with 24 hours a day in it and how are you going to spend your 24 hours? So your goals, you have to keep those goals in mind. And when you are looking at it, I think you have to decide what I'm doing next, is this going to help me toward my goals or is this taking me off track? But you also have to balance the fact that those goals are there but you need...time with my daughter, time with my family is so important and yet I need time for my goals. The immediate family situation took precedence over any personal goals at that point. It was just a matter of keeping this alive through this family situation.

Dol talked about the importance to her of knowing her personal priorities and goals in everyday life, while locating these in the context of everyday and extraordinary circumstances. She advocated a "big picture" perspective on balancing solutions that supported her through more difficult circumstances. Many of the women in this study shared and were supported by a big picture perspective.

Although being good mothers and good workers as well as individual women

were not considered inherently conflicting goals, women recognized that they experienced decision making situations in which the expectations and demands of one goal took priority over the other. Lea recounted a conversation with a neighbour who was a lone father:

> He was talking about 'well he guessed he had to give up his life to raise his kids'. And I said, "You know something, I thought that too until I had this whole crisis deal and realized that if I don't start putting in some of my own needs forward I am going to get lost in the shuffle and I am going to end up resenting this child and taking it out on him.

Lea, through the experience of a personal crisis, had come to believe that parents could not achieve balanced decision making if they expected themselves to focus only on their responsibilities to care and provide for their families.

Women in this study tried to achieve balanced solutions that addressed immediate health demands without persistently subverting any single aspect of their multiple responsibilities. They achieved balance by maintaining focus on priorities in personal as well as family responsibilities. Within their family, priority was given to younger and unconventional children who were considered more dependent on women's caregiving and attention. As children matured into adolescence, women gained flexibility from decreased demands and less need for immediate responses to demands.

Not surprisingly, mothers of young children dealt with high demands in daily mothering work and maintaining satisfactory child care. Naomi, whose son was a toddler, commented:

> There's always demands, you always want to allow them to grow and to learn and to do things like that. And usually that's somewhat at your expense, either financially, time wise, or driving them there.

Focusing even more concretely than Naomi on the demands of daily caregiving, Ilana, whose children were now adolescents, recalled:

> When they are young they need you physically there helping them put the clothes on and take them off and giving them a bath and all those kinds of things. The actual physical energy that you need, just with the younger children...

As Naomi and Ilana indicated, the continuous nature of demands with young children had to be considered in making health decisions. Decision making for children's care was

continuous, and the energy and time necessarily spent in caring for young children was a recognized priority.

Mothers who cared for an unconventional child with developmental or behavioral concerns faced sometimes intense demands to deal with family, school and social difficulties. Lea reflected on how her priorities had shifted recently to increase needed attention to her son and decrease attention to a continuing education program in which she was enrolled:

> I have become a little more aggressive with getting his own needs met. And things like this class, I think this might have actually been more important to me last term. It just doesn't have the same level of importance. It's like the grid slid over and what I am measuring it against isn't the same any more.

Lea had reinforced the priority placed on her son's wellbeing when he developed health problems that required additional medical treatment. Her focus on him as her priority let her accept reducing her commitment to the continuing education program for as along as her son's health problem required more intense attention.

All mothers of school age children tried to give priority to seemingly continuous demands from their children and from the school system to volunteer in school activities, usually scheduled during the regular working day. Women also described the need to volunteer in children's extracurricular activities. Geri recalled:

> For about 7 or 8 years I did a lot of volunteer work with a non-profit organization, in addition to doing a lot of volunteer work with the schools that my children were attending.

In addition to on-going priority to volunteer demands, Geri and other women with school age children dealt with everyday demands in ensuring that their children's physical and social emotional needs were being met. Each seemingly routine aspect of children's care required multiple decisions that also needed to be balanced with demands in women's others areas of responsibility.

Mothers of adolescent children described decreasing demands for volunteer work in children's activities and in family work as children became increasingly responsible for their own health decision making and health work. Olivia, whose daughters were mid-adolescents, talked about the relief that she no longer had "to worry about school support

any more or anything about better daycare". She also felt decreased pressure when dealing with the multiple everyday demands of caring for her daughters:

> Some days nothing works. And this is MacDonald's day and I think that is why not having the small kids, I don't worry so much about it, because if you have to have MacDonald's tonight I don't have any guilt over it. When you have little kids this is such horrible food that you can't help but feeling bad. And I don't anymore, they're big enough everything is OK...My kids are teenagers. It makes a big, big difference.

Olivia contrasted her current demands in caring for adolescents to the greater demands and guilt with young children. Olivia's sense of reduced demands was shared by women with adolescent children.

Beth, whose older children were young adults, described relative freedom from everyday caregiving demands yet continued to experience a demand for involvement from her children:

> [My daughter] is still wanting to talk everything through with me and you sort of think that they are not requiring that of you. And so I sort of still feel that I really need to be there for the discussion of the homework and stuff still.

Beth, although surprised by the recurring demands from her older children to be involved in their everyday lives, continued to make herself available to them and to facilitate their health decision making. As Olivia's and Beth's comments illustrate, women retained a core sense of responsibility for family health decision making and health work with adolescent children. Similarly, although seldom discussed explicitly, women retained some sense of responsibility for facilitating health decision making with their partners. The priority women gave to family responsibilities was accepted as part of their expectations to be good mothers.

Women included their own health as a priority by considering their value as mothers caring for their families and as paid workers providing for their families. Scarlett, who described herself as an overachiever, talked about recognizing the need to care for her own health:

> So that's a really hard challenge for me personally. It's learning to take that time for your own health. Because if you don't have that, you haven't got...you can't do it with everyone else.

Scarlett connected giving priority to self-care with priority to fulfilling her family and paid work responsibilities. Making this connection helped women focus on themselves along with their other responsibilities, supporting them to achieve greater balance among personal, family, and paid work responsibilities.

Another aspect of focusing on priorities, identified by some women, was the challenge presented by major decisions. Geri described the intensity of trying to balance solutions in making major decisions:

> I am always trying to, well, 'If I do this, what could happen?' Well, this could happen or it could play out this way, or it could be this other way. Or, heaven forbid, something I haven't even thought of could happen. And then what will I do? It takes me a very long time to make decisions, major ones.

Geri tried to anticipate and account for all possible eventualities in making major decisions. To a lesser extent, women also tried to do so in balancing solutions in everyday decisions as well.

Focusing on the priorities given to maintaining family and personal health, as well as to major decisions helped women achieve balanced solutions consistent with identified priorities. Implicit in women's focus on priorities was an expectation of fairness in attention to priorities.

Being fair. Women tried to be fair in simultaneously balancing solutions for themselves and for their families. Naomi reflected:

> Sometimes when you're doing the balancing stuff it's not so much about you. Sometimes it's about the other person. So I can make all the decisions I want about time and all these other things, but the other person's situation has to come into play there somewhere too. In order to sort of balance it you have to know what's going on with the other person's scenario. Yeah, your spouse and your child. He's doing a balancing thing just as I'm dong a balancing thing and so then somewhere together, somewhere in there you have to work together. You have this whole thing going around about yourself, your time, your work, your schedule, your kids, your husband, but then he has this whole other circle that he has to do that includes everything that you're doing but in sort of a different world.

Naomi tried to be fair in balancing solutions that considered both personal and family perspectives. She highlighted women's recognition of the need to consider not only their

own responsibilities and pressures, but also those of other family members.

Women emphasized being fair within their families, particularly in dealing with their children. Olivia voiced comfort in her sense of fairness in dealing with children's demands over time:

> I have a friend who has three [children]. And it's always about did she spend the right amount of time with everybody. Is she being fair? And it's always about being fair. And it's not true, being fair is not that, being fair is whoever needs me now.

In balancing decision making for twins, Olivia had faced the issue of fairness from their birth. For her and other women, being fair reflected their expectations of themselves as good mothers. These expectations, also reflected in women's priorities, guided women's decision making.

Letting go. Women needed to be able to let go of inflexibly high expectations or demands that prevented them from balancing solutions. Geri said:

> I have consciously taken myself off those [volunteer] committees until I feel that I can once again contribute something to those organizations without that contribution being detrimental to my family. I really try to strike a balance.

Geri's withdrawal from extensive volunteer commitments reduced demands on her, helping her to achieve a better sense of balance in family health decision making.

Letting go, for many women, meant moderating self-expectations, particularly about selected areas of family work such as house work. Olivia described a gradual change in her expectations:

> It's over time, it's...the first is always toughest and then afterwards it just becomes easier to just let go of some things.

Olivia had learned to moderate her expectations over her years of meeting family and paid work demands.

In addition to time to let go of their expectations, women needed to be able to connect self-expectations with their actions. Scarlett commented:

> I still firmly believe that as a mother I am doing the best job that I can do. I've changed my expectations and as a result I've changed the way I react to situations.

Implicit in Olivia's and Scarlett's comments was a growing acceptance of moderated

expectations of themselves. Mora expressed her acceptance more tentatively:

> So, I am trying, I don't know if I'm...I'm doing the best I can. What can I say? I can't say I am perfect, no.

Mora's and Scarlett's focus on an acceptance of "doing the best they can" was shared by many of the women in this study. This acceptance, however, was a recurrent tension for most women and remained a persistent issue for some. Geri commented:

> And ideally, I would still think, I would still expect myself to be able to handle everything and I just have to bite my tongue sometimes and, or grit my teeth or something, and recognize that I can't.

Geri had talked about letting go of expectations and accepting limits on her abilities to resolve concerns independently, recognizing this was necessary to achieving balance as a lone mother.

Women's ability to let go of self-expectations varied within individual women from situation to situation. Some women like Olivia and Scarlett voiced comfort in letting go of self-expectations. Other women like Mora varied their self-expectations with higher expectations in situations, such as dealing with ill children or working with a new supervisor, where social pressures were felt more intensely. A few women like Geri very reluctantly let go of expectations even though they understood the need to do so.

Using Available Resources

As a second approach to balancing solutions, women used a variety of available personal, family, workplace, and social resources. Geri reflected:

> There are a lot of things in my life that contribute to the health of this family: an understanding boss, and a loving supportive family, and good friends.

Geri felt generally supported in her workplace, in her family, and in her social network. Flexibility in expectations and demands, as well as in available resources was critical to women's ability to balance solutions. Women also found it easier to achieve a balance if they were comfortable with their personal abilities and priorities and could moderate their own expectations. Scarlett advised "trusting your instincts" and Kyla talked about trusting "common sense" in balancing solutions in decision making.

The workplace was an important resource to women in their efforts to balance

solutions in health decisions. Women identified flexibility in demands imposed by working conditions, in informal support from supervisors and co-workers, and in formal support provided by employer benefits and policies as important elements of workplace support in health decision making.

A challenge for all women was securing and using a variety of resources personally, in their families and social networks, in the workplace, and in the health and social system. Women who felt more able to balance solutions typically had consistent access to a wider variety of resources compared to women who had more difficulty achieving balance. Women's strategies to use available resources included accepting support, asking for help, sharing decision making, recognizing self rewards, using time out, using spiritual support, choosing work with flexibility, and valuing available health benefits and services.

Accepting support. Partners, other family members, and members of women's support networks who willingly shared family responsibility and offered additional support as needed were a valuable resource for women in balancing solutions. For most women support came from their partners and some women also shared responsibilities with adolescent children. Naomi talked about what helped her make family health decisions:

> Flexibility and mostly spousal support comes in. If something happens that it looks like I'm going to have a conflict then what I do is usually try and assess what is the most important and if there's any way...if it really has to be me doing the chore at any specific spot, either at home or with my son or at work, well can somebody else cover for me or can my husband go and be with the child if he's sick?

Naomi relied on her partner's participation in sharing family responsibilities and identified her partner as her primary support in health decision making. She went on to add that "If it wasn't for him, a lot of the help, a lot of things wouldn't be done". Naomi also relied on his perceptiveness in cueing in to her need for his support:

> My husband's very perceptive and he's very supportive. So if there's times that I am not feeling so confident, or that I am not feeling so good about things and I want to take time out and think about it, he's usually very perceptive and helpful. Even the confidence and knowing that that's there is helpful.

Naomi, as did all women, preferred not having to ask for support in decision making.

Both of the women who moved from support staff to management positions during the study talked about securing family support in making that decision. Scarlett said:

> The only way that I was able to make this decision was with the support of my family, was with my kids knowing, my husband...and we just said, 'we're gonna do it.' Because we all have to buy into it. It's going to affect all of us.

Scarlett felt able to draw on family support when conflict developed between workplace and family demands because this had been discussed and agreed upon before she accepted the promotion to a management position. Both women felt strongly that they could only succeed in balancing the increased workplace demands if their family committed to supporting them.

Support from extended family and from social networks were identified by all women as valued resources in balancing solutions. Among the majority of women who described the availability of supportive networks, Dol's comment was typical:

> If you have the right network, they will help you, keep you focused and they will support you in your decision. Whether they agree or disagree but they will support you and that's a big difference, a big, big difference.

Dol relied on her extended family network to be available when she needed them and to provide support that conveyed acceptance of her decisions and actions. Scarlett, who had been a lone mother for a period of time, also talked about the support she received from her network:

> The biggest help for me is sharing the raising the children. My best friend stepped in, my mother stepped in. That's the biggest help for me is that support system, so that if something does go wrong, I am not standing there on my own.

Scarlett, as did Dol and other women, appreciated being able to use a support network of family and friends who made themselves available, relieving the women of the stress of feeling solely responsible for decision making.

In their discussions of support in decision making, many women described their comfort in using support within individual reciprocal relationships. Rose said:

> I have a good friend I think I can always tap out to her and her to me. I would like

> to be able to give as well as receive and I am hoping that I can, same as the people at work.

Rose's comfort in accepting support from her friend was framed within an expectation of being able to return support to her friend when needed. Women expected such individual reciprocity in supportive relationships.

Alternatively, a global view of reciprocity in social support was helpful to several women as it broadened their ability to accept support without an immediate sense of obligation to reciprocate. This view was evident in the focus group discussion of social support and reciprocity in supportive relationships:

> S: That's very important that balance.
> I: Yes, it is and I think it's always a mutual thing, because you do pay back one way or the other. There is always something that the other person also needs. Sometimes it's simply the company and the friendship.
> S: And, maybe it's not always right away.
> B: Yeah, someday they'll need something.
> D: It feels good to be able to do something back.

Women in the focus group acknowledged that "give and take" in supportive relationships could occur over time and through diverse actions. The focus group exchange and Rose's comment illustrate the importance to women of reciprocity in social support. Additionally, women in the focus group explicitly discussed the importance of accepting a more global or long-term view of reciprocity. This view promoted women's comfort in accepting support, thereby sustaining access to support as a resource in balancing solutions.

Asking for help. When family or social support was not offered to women, asking for help became an important strategy in balancing solutions. Geri said:

> I ask for help. But it's not, I don't like asking for help. And it's neither pleasant nor easy.

Geri recognized there were situations when she needed to ask for help. These were situations in which she needed another adult in order to balance demands on her as a lone mother. Being able to ask for help required that women let go of inflexibly high expectations, accept their own abilities, and recognize when additional support was needed.

Sharing decision making. An extension of women's strategy of using available family support was the strategy of sharing decision making responsibilities with their partner. Most women did not explicitly talk about the influence of power in the partner relationship on health decision making, although this influence was evident in the situations described by several women.

The women who characterized their partners as committed to sharing family and paid work responsibilities described a comparative balance in decision making power. Aryn commented:

> I have always said to my husband, 'My job is as important as your job' and that's important to me. We are both in this together, so both of us have to take whatever works.

Aryn described her partner as similarly committed to shared power in family health decision making and subsequent health work.

In contrast to other women in this study, Haley talked forcefully about power in the partner relationship:

> The financial security also means there's power in the relationship. That's my anchor. That's why I can command and do what I want to do because I yank in enough money to have a say.

Haley emphasized her financial contribution to the family as a basis for her comparative power in dealing with her partner. She also reflected on her ambivalence about sharing decision making control:

> You have to start to delegate more to your spouse, but that means you have to let your spouse in and you have to give your spouse information and that opens up another whole can of worms and you don't really want his opinion. You let them into the delivery room and they think they can make decisions with the children!

Haley described her partner as selectively involved in family health issues and decision making. She identified his support in family responsibilities and decision making as a resource qualified by tensions about control in decision making.

Women who shared decision making control with their partners identified them as a primary resource in balancing solutions. Women who characterized their partners as selectively or inconsistently involved in family responsibilities and decision making saw

their partners as an occasional resource in health decision making.

Recognizing self rewards. Many women recognized rewards they derived for themselves from their multiple activities. These rewards contributed to women's sense of balanced solutions. Women talked about the non-material personal rewards they derived from their paid work role. Diana commented:

> I've always felt that work has actually been healthy for me. I think it's good to actually get out of the house, get away from the kids, the husband and the housework.

Reflecting a similar sentiment about paid work providing time for herself, Aryn said:

> I think the big thing is I want to be at work. And I think that is half the battle.

Women recognized that paid work complicated their everyday demands. Yet, they found that their paid work provided them with time for themselves as an adult woman independent of their family obligations. The "change of pace" during the paid work day provided a relief from otherwise continuous family demands. This relief was an additional personal resource for women when they faced multiple demands in family work and needed to balance their health decision making.

Using time out. Women used time out from daily demands to reduce stress and to allow reflection outside of the immediate pressure to resolve decisions or deal with family and paid work demands. Many women deliberately made time for themselves outside of their paid work. Aryn commented:

> I love reading and it's very relaxing to me, sort of going into your own little world and forgetting about everything that's going on. I always have time to read.

Aryn and several other women read to remove themselves from daily demands.

In addition to making personal time, some women used social time with friends or family as a form of time out. Diana reflected:

> I think this is really important for us [employed mothers] to be able to disengage from the everyday happenings in your house and in your life and say, "OK, this 2 hours is MY time and I am gonna do with it what I want to do." Whether it be go for lunch on a weekend with my friends or go out to a movie or sit in my computer room on a Saturday or Sunday afternoon, all afternoon if I want to, and do nothing but do what I what to do on that computer.

Diana used both individual time on her computer and social time with friends as time out

from daily demands. Scarlett emphasized time out with her partner:

> We sit down on the couch and we have a cup of tea. We have time together. We just talk and figure out what we're doing and have some time together and relax.

Scarlett and her partner used time together each evening after the children were in bed to talk about what was important in their lives. Time out allowed women to remove themselves from the stress of continuous demands and maintain a sense of personal balance that helped them deal with family and paid work demands.

Using spiritual support. Only a few women explicitly talked about the support they gained from their spiritual beliefs. Dol described times when she consciously drew on her beliefs:

> There are some days you just feel overwhelmed and you just sort of say, "It's time to pull in the big guy, I need help, this is up to you. Let me go on living, but you do the decisions and I'll do what I am supposed to do." And it relieves, it seems to take the monkey off your back, it seems to take the load off your shoulders.

The relief Dol felt from the pressures of everyday demands, was more broadly described by Mora:

> It is just so wonderful, like this keeps me going. I see the joy in life, I see the purpose.

Mora and Dol, as did other women, gained a sense of personal support through their spiritual beliefs. The sense of connection to life beyond their particular experience supported them through the extremely difficult decisions each of them had faced. Other women may have also used spiritual support without including this in their conversations with me. Support from spiritual beliefs may have been considered a private matter for some women, or such support may not be consciously used except when facing extremely difficult situations.

Choosing work with flexibility. When they could, women chose paid work that provided the flexibility they needed to be able to balance solutions, particularly in dealing with family health demands. Flexibility in paid work conditions was available to women in a variety of ways, including through part time employment, negotiating flexible hours, and completing work at home.

Women chose part time employment for the greater flexibility in hours, and

subsequent support to them in balancing decisions related to family and paid work responsibilities. Rose reflected:

> I have always been part time and that's the reason I took the job. The hours I had been given allowed me to be part time at those field trips and to work 8 months of the year. I was extremely lucky.

Rose, like other women in this study, had relied on the flexibility afforded by part time work to help her meet family demands. Part time employment helped women limit intrusions of family demands into paid work time and left sufficient time for family and volunteer work.

Several women were also able to secure flexibility in hours of work and maintain full time employment. A few women did so formally through altered hours for their work day, typically starting and finishing earlier than standard office hours. Diana commented:

> I do work 7 to 3 [pm]. My kids come home after 3 and we're home in the evening together. So there always seems to be that time to be able to deal with our family matters.

The earlier work hours allowed Diana and other women to be home with their children after school, thereby alleviating the need for child care or concerns about children left alone.

Alternatively, a few women also secured needed flexibility informally by "making up time" that had been taken to attend to family work or by completing paid work tasks while at home. Aryn said:

> Where I work it is really also based on how much trust they have in you because they know that even if I am at home and my child is sick, my work gets done and I am worried that I am not there. You know, maybe I will take some stuff home at night or this kind of thing.

Aryn was one of a very few women in this study who was able to secure flexibility in both hours of work and in occasionally working at home. Aryn was aware of the importance of balancing her use of this flexibility by working within the standard office hours most of the time. Women in this study shared this awareness in their decision making.

Less flexible paid work demands could be offset by flexibility in hours of work.

In the workplace, all women faced demands to fulfill expectations as committed, productive workers. Some women had little control over demands from unpredictable work load, hours of work, or how their work was structured. Olivia commented:

> When the kids were in kindergarten, I went to all the outings. They [supervisors] don't ask me to make up for it, but this is part of the deal, that I have a lot of flexibility. When all hell breaks loose, I am flexible enough to stay until it's fixed. I have been here on holidays and on weekends when I have to.

Olivia described the demand for her to be available as needed in her paid work. She had also described the relief provided by a degree of time flexibility, so that she usually felt able to meet family and volunteer demands as they arose.

Women valued flexibility in relationships with supervisors and co-workers that provided both formal support for the use of family leave policies and informal support through a sense of understanding and willingness to help. This support was illustrated by Geri's comments:

> A big help is knowing that the other people in the office that would be called upon to do my work if I were not there to do it, are themselves moms, and they know what it's like if for some reason you need to be home with your kids. ...It's an unusual workplace because the manager is more than willing to accommodate just about everybody.

Geri felt supported by her supervisor and co-workers in dealing with family responsibilities that arose during her paid work time. Geri, as did other women, attributed this support to their good relationships in the workplace, as well as to their ability to establish a reputation as a good worker.

Flexible paid work conditions supported women in balancing solutions to both personal and family health decisions. Flexibility was important to women, whether it was formally provided through part time and shifted hours of work, or informally through making up time with supervisor support.

Valuing health benefits and services. Women valued available health benefits and services provided in the workplace, as well as the health and social systems that provided resources to meet health and caregiving demands. Employer provided benefits and policies were important workplace resources for women. Additionally, women

valued access to trusted health care providers and services including medical and alternative care and quality child care.

All women valued having family benefits and policies that formalized women's access to family or personal leave and health-related benefits, even if they did not use them regularly. In several families, it was the woman's employment that provided for health benefit coverage. Leandra commented:

> We have several friends who are self-employed who don't have benefits and they think twice before they take their kids to the doctor. I can't imagine having to do that. You want to be able to take them in without thinking about it and just the cost of medicines.

Leandra recognized the potential impact of access to health benefits through her employment on decisions she could make to resolve children's health problems. Similarly, Lea talked about how health benefits influenced her health decision making:

> I am very grateful for all the different health care coverage because I have options without worrying about, "How can I afford this?" We didn't always have prepaid prescriptions. It made a big difference to me, I used to have to wait on some things, like I would go without some medication that I needed on occasion until the end of the month.

Lea's decision whether or not to delay filling a medical prescription was influenced by the type of health benefits provided through her employment. Lea, as did all women, considered the availability of benefits and specific types of benefits in making decisions about medical concerns. Women's access to employment benefits, particularly health benefits, was an important resource to them in balancing solutions in decision making for themselves and their families.

Women valued established relationships with trusted and supportive medical and alternative health providers as an important resource that enabled them more comfortably to balance solutions in decision making. Scarlett described her decision making between medical and alternative treatments for a serious illness:

> Because once I got the diagnosis, my doctor said, "We got two ways of treating this." And we did start to treat it with meds and I got very, very sick. I lost a lot of weight. I was sick with it, and I said, "I am not doing this." I said, "If I am gonna do this, I am gonna do this holistically and I am going to take a look at fixing me." And, 'cause I knew in my heart something was wrong with me, with my life.

And we started doing that, and the children worked through that with me.

Scarlett was supported in both medical and alternative approaches to the health concern. The support provided by the physician who willingly considered both medical and alternative therapies and the availability of both therapies to her enabled her to achieved a balanced solution that included her preferences for various therapies.

Women in this study valued access to quality child care as an essential resource for employed mothers in supporting decision making to meet multiple responsibilities. Aryn recalled:

> When I am at work I am not thinking about my children because I have always been very fortunate that I have had the care for them. I had a wonderful babysitter for 5 years and I never, ever thought about that and worried. If you've got really good care, which is the luck of the draw, that's great. And if you have a back-up. If you have a job where you are able, and if you have a husband who knows it's both of you that are trying to make it work, not just one then it really makes a difference.

Aryn had relied on the child care provider to maintain a caring, stimulating, and safe environment for her children. This care had reduced Aryn's stress about concurrent family and paid work responsibilities. The care combined with the additional support provided by Aryn's partner and support network enabled her to make decisions more easily to balance her multiple responsibilities.

Although women understood that employer policies provided for personal and family leave to deal with family health concerns, such as ill children, women also recognized that their use of these policies reflected on their reputation in the workplace. Women consciously tried to maintain a balance between family and workplace concerns in making health decisions.

Working Around Constraints

The third approach to balancing solutions, working around constraints, was used when women experienced situations in which their ability to balance solutions was constrained by their situations. Women talked about constraints imposed by competing or conflicting demands between personal and family responsibilities or, more often, between family and paid work responsibilities. Women also talked about situational constraints

imposed by time pressures, inadequate available support from their family and their support network, and limited access to existing health and social resources. Emily reflected:

> Whatever choice or decision you make at that moment has so many more impacts on people around you. And your choice may not have been that choice if your situation was different, if you were just a mom staying at home. It's funny because some of the decisions or choices I've had to make would have been very easy choices if I didn't have, if I wasn't at work. But because I'm at work, then those choices become, you have to be more creative in how you're going to go with it.

Emily recognized the need to consider the impact of her decision making on others, particularly her family, as well as on herself. She believed, as did all women in this study, that this consideration was further complicated by the need to consider the impact on her paid workplace. Additionally, women recognized the need to consider the impact of available health and social resources on their decision making. Women described four strategies they used to work around situational constraints in order to achieve balanced solutions: delaying, planning contingencies, using alternatives, and persisting.

Delaying. Some women delayed responding to family demands in order to work around constraints imposed by inflexible paid work conditions. These women held positions that required them to be at their workstation during fixed hours. The inflexibility of fixed hours created problems for them when family demands arose during the workday. Emily commented:

> We have a rule in our house that you do not phone me at work unless you're dying. And I have to say that 99% of the time they will not call. The 1% of the time they do call is usually, very calmly I'll say, "I can't deal with this right now, we'll discuss it when I get home."

Emily went on to talk about the difficulty she faced when her children's demands could not be postponed until after work hours. She then had to request family or person leave and rely on supervisor and co-worker understanding of her decision. She tried to delay and limit these requests because she felt she had inconsistent supervisor support despite good formal support from workplace policy provisions. When women faced concurrent demands from family and paid work, their limited control over workplace demands made

balancing solutions more difficult.

Planning contingencies. Women, recognizing the limitations of potential support provided by others, developed contingency plans that relied on their own resources or additional sources of support as a back-up to expected support. Geri commented:

> There are times when my son is the one that actually handles the situation best. And there are other times when my daughter is the one that handles things. And there are times when neither one of them handles it and I just try to not expect too much of them. Because maybe they just don't know how to handle it. And I try to handle things most of the time.

Geri and other women in similar circumstances basically accepted that available support from their partners, older children, and support network was frequently less than needed. The contingency plan for many women relied first on their own ability to act as back-up when other arrangements did not work.

Women in the focus group identified having "back-up plans" and workplace flexibility as equally important to being able to balance solutions when family demands intruded into paid work:

> That's the number one with small children, you have to have the flexibility or some other back-up to look after the children if you can't.

Back-up or contingency plans that resolved family and paid work conflicts were seen as necessary for women dealing with situations such as when children became ill or childcare arrangements changed. Women emphasized the importance of having contingency plans to deal with conflicting demands, as well as to relieve stress from continuous family caregiving demands.

Using alternatives. When women recognized that their access to needed resources or services was limited, they found and used acceptable alternatives. Alternatives represented compromised choices that addressed most important concerns and provided acceptable, rather than preferred solutions. Ilana reflected:

> Unfortunately, under the circumstances your choices are kind of limited. You can't often just take time off from work even if you are sick. So, then it leaves me the options that I go back to the doctor and see if he can suggest something, either different medication or something else. And I also try to improve in the other areas, like more rest or whatever.

In dealing with her chronic asthma, Ilana pursued alternatives to taking time off work because she did not have supervisor support for potentially recurrent use of personal leave. Medical care and self-care were acceptable alternatives for her, although they were not her first choice. Alternatives helped her achieve a measure of relief from symptoms, but did not provide the more extended rest that she believed helped her resolve symptoms long term. Women used alternatives to work around situational constraints in dealing with family as well as personal health decisions.

Persisting. Being persistent to get what they sought helped women work around situational constraints imposed by difficulties accessing needed resources and services or by stressful family circumstances. Geri, whose unconventional child was in late adolescence, spoke from the perspective of her experience over several years:

> Some things are easy to access and others are not. But I haven't ever come across something that I couldn't access. You know, whether it's educational services or health care services or whatever. I've been able to get access to what I need.

Geri's persistence in dealing with decisions about her unconventional son's care had resulted in a sense of relative success despite diverse barriers to securing needed services and resources. She made a priority of working around difficulties in accessing services. She identified needed services and persisted in presenting her requests for access until she received what she sought. She described her approach as "putting on armour and doing battle."

For some women, everyday life presented difficult issues that required persistent attention to balancing solutions for even ordinary decisions about family nutrition or personal time. For example, Lea commented:

> One of the biggest balancing acts for me is find a balance between what I need and what I want. Because what I may want is to go to a movie. And what I may need is to stay home and do laundry. And what I may want is to pay a sitter so I can get out of the house and what I may need is to not spend any money because we are really broke. The need and want thing gets balanced every day we go to Safeway. We need cereal. I want some fancy box of cereal, don't need that, need this.

Women like Lea who regularly faced difficult circumstances in their everyday lives found

it harder to maintain a focus on the big picture of overall priorities and goals in everyday life. Persistent attention to balancing solutions was stressful for these women, even when they were able to maintain a relative sense of balance.

Women who were able to meet important expectations and demands, using available resources and working around situational constraints were able to balance solutions in decision making. Women used a variety of strategies to help them achieve balanced solutions, including strategies that relied on their own resources and on available family, workplace, and social resources. For most women, using a greater variety of strategies increased the potential for achieving balance. Using a greater variety of strategies also helped women avoid the stress associated with over-reliance on a few strategies and the accompanying vulnerability about possible withdrawal of support or strategy failure.

As women decided on a balanced solution to a particular health issue, they took action to resolve or manage the issue. At times, action followed decision. More often, action and decision were recursive until a satisfactory and workable solution was achieved. Similarly, assessment of the results of decision and action occurred somewhat recursively as women reflected on the process during and following decision making.

Assessing Results

Women assessed the results of the decisions and subsequent actions they had taken in trying to balance solutions. This assessment involved reflection during each phase of the decision making process, as well as following management of the concern. Women considered their consistency in keeping track of personal and family health, their timeliness in cueing in to concerns, and their accuracy in figuring out important aspects of the concerns. Ultimately, women considered the success of the response they had used to deal with the particular concern. Scarlett captured the focus of assessing results:

> I think that's the most important thing, is to keep re-evaluating that stuff. To learn what works and what doesn't work.

Scarlett's comment illustrates women's emphasis on learning from their on-going assessment of results. This on-going assessment was evident in Olivia's description of

trying various ways to manage her daily family work while caring for twin daughters:

> I would have never dreamed of buying anything that was canned before the girls and all of a sudden nobody died. We ate frozen vegetables and nobody died. It just becomes easier to just let go of some things. And it is by trial and error, I find, is you let something go and you go, "Oh, I can't stand this." The kitchen has to be clean, but it can be messy. I still notice it but it doesn't bother me and there's a big difference.

Olivia, as did other women, illustrated the fluidity between balancing solutions and assessing results, describing this as "trial and error".

Women engaged in an on-going process of trying solutions and assessing results as they looked for satisfactory, balanced solutions that were sustainable and successful. The need for sustainable and successful solutions to on-going health concerns is also illustrated in Faith's description of assessing the results of changing childcare arrangements for her infant daughter:

> We switched to this other woman and it was like night and day. Like she wants us to go in the morning, she waves good-bye to us. It is a good feeling. I need that to be able to go to work. I need to know that she is happy, and you can see it on her face, too.

Faith had struggled with the decision to change childcare arrangements, describing conflicting interpretations of her daughter's behavior in the initial childcare situation. Once action was taken, Faith used the same behavioral cues to assess the results of the new childcare situation. She concluded that the change had been warranted and had been a good one both for her and her daughter.

In managing on-going concerns, women tended to maintain successful responses and modify them as needed over time. Leandra, who described an initial hesitance to try massage therapy, reflected on her current use of massage to manage stress and perimenstrual symptoms:

> I know there are still times, you know, at work with the stress level that I, you know, it's just really hard. And then I might go in for an extra massage. Now there are times when I don't get back there for 2 or 3 months and I am a wreck by the time I get back there, and, you know, it is something I have decided that I need to have every month. I have actually timed it so it comes just about a week before I get my period so that I can sort of try to get rid of that PMS or help it anyways.

Leandra's initial hesitance to use massage had been overcome by her assessment of its positive effect in helping her manage on-going stress in her life. Based on this assessment, she not only had continued the treatments but also had modified their timing in relation to recurrent perimenstrual stress as well as to extraordinary stress.

Women incorporated the learning from their assessment of results into each phase of decision making, increasing their sense of confidence in their ability to keep track, accurately cue in and figure out, then appropriately balance solutions. Daria described how her previous experience with a particular concern had influenced her subsequent decision making:

> Sometimes, it's worse to leave it. Well, I did it with my back. I continued to push and day after day it was getting worse. I finally went in and had something done. It took me a year of physio to try and work it out. Whereas I think if I would have went earlier...so now I am more in tune for that kind of feeling, that kind of problem. Then I sort of know, "OK, I can do this, I can do this. But if it gets really bad, off to physio you go."

Daria assessed that she had been insufficiently sensitive to cues and had not dealt with the problem as well as she might have. She also assessed that her experience had resulted in an increase in her ability to keep track, cue into, figure out, and resolve the problem if it recurred. Daria's description of dealing with the problems with her back illustrated how women reviewed their decision making process and the results of actions taken. Experiential learning from assessing the results of actions was incorporated into the phases of finding a balance with subsequent decisions.

Unbalanced Solutions

For most women, unbalanced solutions occurred when they faced unworkable combinations of expectations, demands, resources, and constraints. Many women in the study recalled circumstances in which they had not been able to balance decision making because of inflexible expectations on themselves, subsequent guilt, conflicting demands between their multiple responsibilities, and time pressures. Women also found they could not balance solutions when available resources were insufficient to deal with presenting demands. Ultimately, each of these circumstances acted as a situational constraint on women's ability to balance solutions.

Women were not always able to make decisions that fit within the constraints of their situations. These constraints included time pressures, inflexible expectations, conflicting or competing demands, compromised personal resources, and difficulty accessing support from family, workplace, health, and social resources. Figure 5 diagrams women's view of unbalanced solutions in decision making.

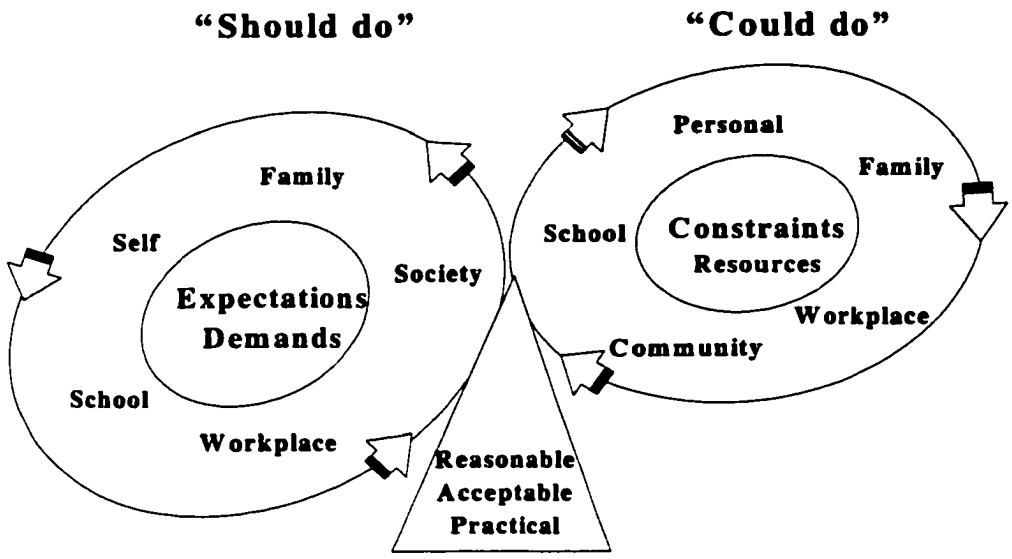

Figure 5. Unbalanced solutions.

The static diagram cannot capture the dynamic, recursive process women experienced in trying to overcome inflexible expectations, conflicting demands, inadequate resources, and situational constraints. The potential imbalance, however, among the multiple influences on women's efforts to balance solutions in decision making is illustrated. The relative disproportion or imbalance is shown between what women believed they should do and what they found they could do in any given situation.

Unbalanced solutions typically reflected a potentially health damaging pattern in which women sacrificed self-care in favor of family caregiving and paid work responsibilities. Women became stressed by time constraints, inflexible expectations, conflicting demands, and inadequate resources. Under time constraints, women made compromised decisions that were not acceptable or sustainable long term. Under pressure from inflexible expectations and subsequent guilt, women tried to manage demands by themselves and minimized personal health practices. Women who dealt with chronic illness faced conflicting demands between self-care and family care. When illness compromised their ability to meet family and paid work responsibilities, women felt guilty and minimized self-care when able. Inadequate family and social support reinforced women's tendency to manage demands by themselves, increasing their stress and minimizing self-care. Inadequate workplace support decreased informal inflexibility, limited access to entitled policy provisions, contributed to job vulnerability, and increased women's stress. Inadequate access to health and social system services limited women's alternatives, reinforced their efforts to manage without needed support, and increased their stress.

Time Pressures

Under time pressure, women felt they made poorly considered decisions that satisfied immediate demands without balancing women's multiple demands. All women acknowledged pressures imposed by time constraints: inadequate time to deal with situations and time conflicts between concurrent demands. Scarlett commented:

> I think sometimes that for me personally I make not the greatest decisions for the kids' health sometimes because there is no time to think it through. OK, I need half an hour to just run through my options and find out what's gonna work but it's when you get a call from the school, "Your daughter's throwing up. Come and get her!"

Scarlett concluded that pressure to respond immediately to a situation imposed constraints on her ability to consider alternatives and create balanced solutions.

Time constraints were also experienced by women in less intense situations than those requiring an immediate response. Lea reflected:

> Time constraints are a major factor in decisions to when to take care of things and

> how to take care of them. Whether or not I will drive across town to the doctor that we'd normally see or go to the medi-centre behind our place where I don't like the doctors and don't trust the diagnosis, but I need to see a doctor. I would like to not have to have everything compressed in such a tiny ball where you have to make decisions based on the clock, rather than practicality or necessity.

Lea was frustrated that time pressures constrained her ability to make acceptable alternative choices. Her preference to consult the family physician was countered by the travel time to reach his office, the wait for an appointment, and the comparatively shorter time to consult physicians available at local walk-in clinics. Coupled with the pressure of multiple demands from family and paid work, Lea was frustrated with choosing a less preferred solution because of time constraints. Frustration centred on her concern that she was not providing her son with the comprehensive medical care he needed.

To a lesser degree, most women identified similar concerns about time pressures. Jenna concluded:

> I don't think there's time enough in the day for all the things you want to do, plus all the things that need to be done, so I guess you always have to decide what is important and what is not important.

Jenna, as did Lea and all women in the study, tried to manage time constraints on decision making that were imposed by meeting the multiple demands of daily responsibilities. Women who relied on their attention to priority family rather than personal demands mitigated time constraints at their own expense.

Inflexible Expectations

Women who felt guilty about not meeting inflexibly high expectations of themselves compensated by reducing personal health activities in order to attend to family and paid work responsibilities. Many women felt pressured to live up to inflexibly high expectations of themselves, particularly as mothers and paid workers. Subsequent guilt when they did not meet these expectations constrained women's choices in balancing solutions. Kyla commented:

> I really changed when I had kids. I had a nice childhood and I just thought how nice it would be to do that and have the kids and I really enjoyed it and maybe I just got too busy and just too caught up with the kids. Of course, it's always an excuse. I feel very guilty going to work.

Kyla's expectations of herself as a mother and family caregiver constrained her decisions to attend to personal health promotion. Kyla was aware of this constraint, but accepted it because of her guilt about being employed and her inability to devote full time attention to her family.

In contrast, Haley's guilt about paid work arose from expectations of herself as a paid worker:

> I feel guilty when I am not doing the job that I am supposed to be doing. I am gonna have to work overtime or through lunches, where I should be going for a walk every lunch to take care of my health and reduce my stress, I am gonna cheat.

Haley limited her attention to personal care as a means of decreasing guilt about not fulfilling her expectations as a paid worker.

Like most women in this study, Emily's guilt related to both family and paid work responsibilities:

> I feel guilty because I am not at work and I feel guilty because I am not at home. So where does that balance out?

Emily felt about her difficulty balancing constraints related to her expectations to be a good mother and a good worker. Guilt increased the likelihood that women would balance solutions in family health decision making at the expense of balancing solutions for their own health.

Conflicting Demands

When it arose, conflict between family and paid work responsibilities not only constrained women's options in balancing solutions, but also increased the stress and guilt of being an employed mother. Conflict between family and paid work responsibilities was acknowledged as a constraint on decision making by all women. Most often, this conflict related to children's demands. Whereas women in the study did not hesitate to respond to emergency situations with their children if these arose during the work day, women felt constrained when dealing with demands that were considered less serious. Women's awareness that such demands might be dealt with outside of paid work time was countered by their belief that they should be available to their children when needed.

Women placed high priority on being available to care for their children when they were ill. Understandably, children's illness during the paid work day created intense stress for many women. Emily described trying to address concerns with her school age daughter:

> You say, "It's gonna be OK. If you get upset during the day you know you can phone me at work." You can lay out all these options, but when they do call you, it may not be the right time. She calls me and, "Oh, honey, I can't talk to you right now. I'm right in the middle of this and..." So I find that really frustrating.

Emily's attempts to create alternatives to deal with her daughter's concerns were constrained by concurrent paid work demands.

Additionally, women felt pressured to attend children's activities not only because this was seen as fulfilling personal and social expectations as a good mother, but also because women believed that their attendance contributed to their children's social emotional well-being. Ilana recalled:

> When the children are young, they have all these things at school that parents are supposed to attend. You just cannot do it, at least not the way the workplace is at the moment.

As Ilana had found, many school activities at which mothers were expected to volunteer occurred during the school day which coincided with the paid work day. Many women were unable to work around this direct conflict, resulting in guilt from unmet expectations.

Competing demands and inflexible personal expectations compounded women's sense of guilt over unmet expectations. Daria said:

> There's a lot of guilt in not getting things done to a certain specification. I am very self-conscious of getting things done and they have to be a certain way. I don't want anybody else to pick up my job partway through. There's guilt when it comes to the pressures of everyday life and being tired and wanting to be by yourself. There's guilt in wishing I could be more involved with my kids' school. I wish I could volunteer and help kids with the reading programs. There's guilt in every single area of my life. I should maybe be doing more things for my grandmother. I should be maybe visiting my parents more often. I am feeling really pressured that I should be doing more around the house. My biggest guilt is from falling asleep. And there's guilt that you don't spend enough time with your husband.

Daria's catalogue of guilt reflected her sense of continuous pressure to do more, to carry even more responsibility in each aspect of her life, including attention to paid, personal, family, and volunteer work. This pressure combined with the demands and constraints arising from her extended recovery from an injury contributed to Daria's stated inability to find balance in health decision making and subsequently in her everyday life.

Demands from paid and family work typically took precedence over personal care for women, creating difficulties for women in attending to self-care even when they acknowledged the importance of trying to make decisions that balanced these multiple demands. Leandra said:

> Until I left my husband, I was a wife and a mother. Now through counselling, I am realizing that I also have to be a woman and I haven't been that for so many years, it's very difficult to try to find that person. I think the work and the children are going to come first and what little time there is left at the end of the day...you know, there's not going to be a whole lot of time for me personally. It's been a struggle and it's going to be a struggle for a long time, I think, to give myself permission to sometimes put that person first.

Leandra struggled with refocusing on herself as a person, while continuing to place priority on her responsibilities as a mother and a paid worker. Leandra also talked about her sense of imbalance as a lone parent:

> My children are living with me and it's just a whole different scenario now. Right now I don't seem to have that balance anymore. I know that there are tons of women out there who work and are single parents, but for me to start that now it's just a huge change. I don't have time to worry about what it could be. I have to just deal with it as to.

Leandra felt unable to balance solutions in decision making while she tried to establish different strategies for coping with her changed family situation. The guilt Leandra associated with being an employed mother was somewhat mitigated by her sense of necessity, yet that also raised guilt related to her discomfort with "going with" rather than orderly management of decision making. She also believed she made decisions too quickly, with insufficient consideration of possible alternatives because she felt intense time pressure and was unfamiliar with resources to replace her former partner's contributions to family work. Leandra's experience of the struggle of addressing personal, family, and paid work demands in balancing solutions was common to many of the

women in this study.

The stress of conflicting demands between family and paid work could be compounded by inflexibility in demands generally. Scarlett described what hindered her in making health decisions:

> Inflexibility, that does not help at all, be it the health care system, be it a physician, be it my work place, be it the schools.

Scarlett had dealt with a past health crisis in which she had been initially unable to balance treatment for her diagnosed problem with her personal preferences for non-medical care and her family problems. Scarlett identified difficulties from inflexible health system and provider demands, in addition to constraints imposed by inflexible workplace and children's school demands described by many women.

Compromised Personal Resources

Some women experienced compromised personal resources that constrained their ability to meet family caregiving demands and increased the guilt of not managing family responsibilities as they expected. Women needed to consider their energy level and issues related to chronic health concerns. Perimenstrual symptoms were disruptive for several women. Leandra felt that perimenstrual symptoms affected her decision making:

> And definitely during my PMS time, things are totally blown out of proportion. So I really have to watch myself then.

Leandra and other women who experienced intense symptoms found that their need to conserve energy to deal with symptoms limited their capacity for meeting family caregiving demands. This limitation was equally important to the women who were affected by chronic health concerns such as asthma and arthritis or recovery from physical trauma.

Women also found that necessary attention to personal health demands limited their choices in meeting family health demands. Daria talked about the constraints imposed by her extended recovery from an accident:

> My medical time and my sick time for my kids gets eaten up with two kids and it's very, very hard for me right now because I am doing so many medical things within myself that I don't have the time for medical things for them also unless they are sick-sick. Then I will make the time, but for minor things I just kind of

wait until I can see if there is something really wrong with them to take them in. Daria had always "saved" her sick time for dealing with family health issues. Her current inability to do so limited her capacity to balance solutions when family issues arose that carried over into paid work time. She felt pressured to delay dealing with less serious children's health concerns. This pressure was intensely uncomfortable for Daria and the other women who talked about how compromised personal resources contributed to unbalanced decisions.

Inadequate Support

Women responded to limited support by relying on their own capacities to balance solutions, as they either limited requests for support or made contingency plans in case support was not provided as expected. Consequently, women experienced increased stress from trying to manage without support and from continuously developing contingency plans. This stress reinforced women's inattention to self-care in favor of family caregiving and paid work responsibilities.

Several women had limited or inconsistent support from their family and social network. Limited support resulted when partners were absent from family activities because of travel requirements in their own paid work situations. Cass commented:

> My husband is not working at home, so he is gone for days at a time. So he is home every other weekend for 4 days. So that really limits what I do with myself, with the kids.

Cass described her partner as supportive when home, but simply unavailable when he worked out of town. Additionally, several women could not draw on extended family for support because they did not live in the area. Ilana identified unavailability of extended family support as something that did not help her make health decisions:

> We don't really have any extended family here because it is just our own little family. Everybody else is far out and abroad. So that makes things a little bit complicated because we don't have that many outside resources to fall back. We have to basically rely on our little family to cope with and make things good one way or the other.

Even as she talked about relying on her immediate family for support, Ilana acknowledged the stress this created when her partner or adolescent children did not

provide support. Ilana's partner was frequently unavailable due to work requirements and her children were inconsistent in providing requested support.

Alternatively, some women identified limited partner support related to their partner's expectations about women's responsibility for family work. Rose said:

> We have a husband and father who is definitely not there. He's there physically and he's there for the bills.

Rose described her partner as traditional in his views about men's and women's family roles. As such, he believed that she would manage family work without need of his support.

Whereas several women reported limited support from their partners, Haley described her partner as selectively supportive. He tended to pass off her attempts to delegate responsibility to him by then delegating to their adolescent son:

> So he [partner] is still out of the loop. It's cooperation as long as it's not interfering with anything he needs to do.

Haley could not rely on her partner's support, even though he indicated his intentions to be supportive to her in meeting family and paid work demands. The inconsistency of his support resulted in her trying to manage demands by herself.

The constraints for women with limited or inconsistent family support were compounded for a few women by non-support, negative actions and comments, from family members. Diana, whose adolescent daughter presented recurrent behavior problems, described her situation:

> I find it's harder for me to deal with a situation when he's saying, 'well, it's your fault'. That's not what you should be doing, you should support me saying, we're working hard on this, we're trying, we're doing our best and it's not working. And not saying, 'it's you.'

Diana partially excused her partner's non-support because she considered it an expression of his frustration at their inability as parents to resolve the problems with their daughter. Nonetheless, Diana felt both blamed and betrayed by her partner when he made these comments. Leandra also struggled with feelings of blame and betrayal even as she acknowledged the reasons for non-support:

> And I am also struggling with the fact that there are times when I am going to have to call my husband and ask for help and that for me is kind of a problem because I was the one that wanted to leave and he keeps reminding me that it was my choice. So kind of, 'Live with what you're living with because you wanted me to leave.'

Leandra knew that her partner's non-support related to her initiation of a marital separation, so she tried to avoid asking for support from him. She limited her requests to extraordinary circumstances where no other support was available. For both Diana and Leandra, non-support effectively increased the stress of balancing solutions and limited choices in securing needed support.

Workplace support was limited by lack of relief from co-workers, inflexible work hours, and difficulty in using personal or family leave to deal with family issues. Women identified limited workplace support as an important constraint on their ability to balance solutions. Women frequently reflected the tension of meeting expectations as mothers and paid workers when dealing with intrusions of family demands into the workplace. Rose described her work situation:

> We've got people away at work, we've got people ill at work, we've got one less supervisor than we did last year, we've got people retiring.

Rose felt that continuing staff shortages limited her ability to secure workplace support to attend to presenting personal and family health concerns.

Similarly, women in positions with inflexible work hours and conditions felt constrained when having to deal with health decisions during the work day. Faith commented:

> My position is quite rigid. We've got our set lunch hour. As far as work issues go, you have to be at your desk if somebody is calling you. It's very rigid in the sense that you can't be taking off and go someplace for half an hour without letting somebody know where you are because they need you. It impacts on the other people that you work with. If there is guilt, that's when it comes in because you think, here I am at home and other people are going to be stuck doing your stuff. And you never really know how they feel.

Faith's support position was not flexible in hours of work, demands, or potential to work away from her desk. Her tension arose from knowing that if she took time away from work to attend to family demands, her co-workers were having to do both her work and

theirs. She, as did other women in similar positions, limited their use of available personal and family leave. Women frequently felt guilty regardless of their decision about using available leave.

Difficulty in using personal or family leave to deal with family concerns was an issue for several women, not only because of their guilt at the implications for co-workers, but also because they experienced non-support from supervisors and co-workers. Women distinguished between formal workplace recognition of issues related to family demands and provision of support to deal with family demands during the workday.

Whereas employer policies provided support through personal and family leave and group health benefit entitlements, women found their access to entitlements was practically limited by the attitude of supervisors or co-workers. Women implicitly expected supervisors and co-workers who were also employed mothers to be more understanding and supportive of their need to respond to family demands during the workday. However, this was not the case for some women, as Cass had found:

> The supervisor, she's got kids herself, but she has a way of saying things...that you would come back and you would feel guilty that you left because your child was sick.

Cass tried to limit her use of family leave, despite her awareness of entitlement, because she believed her supervisor was non-supportive. Emily also described tensions related to securing supervisor support for family leave requests:

> I almost look at the support as sort of an extra gift. It isn't something that I'm looking for, although on the same side, I don't want them to judge me. The part that I get frustrated with is always having to explain. As a mom I need to be there for her and I don't think there should be any question. We're all aware of our responsibilities, we have a full time job, and we need to be there and I think 99% of the time we do the work that needs to be done. But the 1%, I think, needs to be left for things that you as a parent, whether it's a father or a mother, you need to be there.

Emily tried to limit her expectations for support in the workplace to counter her frustrations about not receiving support. She linked these frustrations to personal health concerns and her limited ability to resolve both personal and family health issues as she preferred. For Emily, available options were limited by the feeling that her status in the

workplace could be jeopardized unless she made decisions more closely aligned with her supervisor's views.

Several women believed that as support staff, they were vulnerable to non-support from management that could threaten their job unless they restricted their use of personal and family leave. Mora expressed her concern:

> I deal as a mom who has 3 kids, has to run the household, come home, come to work. I like to know that I'm not gonna be penalized because I am a working mom and have 3 kids.

Mora's concern about being penalized in the workplace because of family responsibilities created stress for her when she needed to request family leave. Additionally, Mora tried not to use personal leave, sometimes delaying personal care until she became very ill. She recognized the complications from her actions, but felt this a necessary balance to expectations in the workplace.

Women worried that they risked compromising their children's health by discouraging their requests during the workday, and found that their personal health suffered because of the continuing stress. Cass talked about the impact of supervisor non-support on her response to family demands:

> I felt that anything I did, whether it was family related, whether it was work related, I would get crucified at work for it. You know, so it is like, 'Kids, you cannot demand anything from me from 8-4 because she'll just hang it over my head.'

Cass felt stressed and guilty about discouraging her children's demands during the workday. She felt, however, that she had no alternative that might not threaten her continuing employment.

Some women considered lack of support in the workplace to be a gendered issue. Male supervisors, co-workers, and written policies were seen as reflecting a male orientation of relative freedom in the workplace from family responsibilities. Haley, one of the minority of women who dealt with a male supervisor, commented:

> The policies are not flexible. I think they were written by men who never had to stay home with their children. I never had a woman boss ever haul me up on those kinds of things. The policies have to be changed, the flexibility has to be there.

Haley took issue with supervisor non-support and employer policies, believing that both

reflected traditional workplace expectations for relative separation of workplace and family responsibilities.

While Haley was one of only a few women who believed that workplace policies were inadequate, her experience with lack of support from male supervisors was shared by other women. Naomi said:

> Both my supervisors are males and don't have children themselves. I believe they truly don't understand the entire involvement of that. They don't want to give me extra responsibility.

Naomi was concerned that acknowledging family responsibilities and using family leave affected how her supervisors thought of her as a worker and compromised her potential for promotion. As such, she felt pressured to limit her use of both personal and family leave to situations where no other alternative could be identified.

In contrast to most women's experience in this study, Olivia found women less supportive than men in her workplace:

> If for some reason I have had to leave work, if for some reason they have had to take a message for me from the school, they are not against it but they are not supportive. I think it is quite strange because I would say women are worse than men when it comes to things like that.

Olivia was employed in a traditionally male-dominated field where she had dealt with gender issues throughout her paid work experience. She, like other women, expected employed mothers to be supportive in the workplace. She, like other women, had found that this was not always the situation.

Inadequate Access to Services

The difficulty of securing health and social services and resources increased women's stress, frequently contributed to time pressures, and created additional strain on women's personal resources to cope with demands. Women's choices in addressing children's health concerns, as well as their choices in the broader responsibilities for personal and family health were constrained by limited access to needed services and resources.

Women who cared for unconventional children were frequently frustrated by difficulties in securing needed services and in connecting with professionals responsive to

their concerns. A year after moving to the region and initiating contact with local health providers and services for her daughter, Haley commented:

> Information is not easy to get. I've learned more by talking to some of the special needs counsellors that come in with their volunteers about agencies. I don't think the health care system is ready for people like me. We're very complicated. So that's a failing.

In addition to difficulties in obtaining needed information about available resources and services for her daughter, Haley had been only partially successful in securing resources, including trusted health care providers. Haley remained frustrated by her lack of success and felt that potential alternatives to deal with her daughter's health concerns had been unnecessarily limited.

Some women were frustrated with difficulties in identifying resources, accessing information about issues, and dealing with non-supportive professionals or agency personnel. Leandra recalled her frustrations when trying to identify additional childcare alternatives:

> I phoned the City to see if I could qualify for some type of subsidy for daycare and I phoned 4 days in a row and left messages every day and I've never ever heard from anybody. I kind of gave up. So I am thinking what kind of system is this?

Leandra had been unable to access needed information that might have provided additional alternatives for her in securing satisfactory childcare within her current financial circumstances. Without this information, she had spent considerable time resolving the childcare demands. In addition to increasing her own stress, the time had conflicted with her paid work day and raised tensions with her supervisor about the need for time to deal with family issues.

In summary, women's inability to work around situational constraints to balance solutions was a reflection of combined constraints that exceeded women's personal capacities and family, workplace, and social resources. These constraints arose from inflexible expectations on women as mothers and paid workers, conflicting demands among multiple responsibilities, and inadequate resources to provide needed support in fulfilling responsibilities. All women had dealt with situations in which they were unable to balance solutions. Most women described a sense of balance more often than not,

although they acknowledged situations in which they had needed to work hard to find balance. A few women, however, dealt with difficult everyday family and paid work situations that continuously stressed their ability to balance solutions. These women felt unbalanced in their health decision making and their daily lives. All women saw balance as their goal and believed that they would be able to achieve balance if they had adequate support from family, workplace, and social resources that would enable them to work around constraints.

Routine Decision Making

Women identified patterns in their decision making that remained consistent over time and supported routine decisions and subsequent health activities. Leandra commented:

> I tend to follow a pattern. And while my pattern might have to change, I would still tend to follow a pattern.

Leandra's decision making pattern was based on her expectations, values, and skills in organizing priorities. Leandra and most women reflected that their pattern had developed in complexity with their knowledge, skills, and experiences in health decision making. Their repertoire of strategies used to make decisions and take action developed, but their routine approach to deciding which strategies to use tended to remain consistent in everyday circumstances.

Health Activity Routines

The consistency in decision making approach supported routine decisions that became established in everyday health activity routines, providing relief for women from otherwise continuous attention to recurrent daily demands. For example, women made routine decisions about family nutrition and social interaction that resulted in family meal routines. These routines involved food choices that were appealing to children, conversation to explore children's social emotional well-being, and regular meal times that accommodated family activities. Emily described family meals:

> Every day at suppertime we talk about something positive that happened in our day. And it doesn't have to be anything huge. Sometimes we just sit there and laugh and laugh. It's such a good feeling, and then we look at both our children,

> because we're not singling them out. We go, "I guess your day wasn't so bad after all, was it?"

Emily and her partner had chosen a family meal time routine that helped deal with their children's frustrations and social concerns. Additionally, the routine enabled Emily to meet priority demands for family time together and balanced nutrition.

Women tended to emphasize social emotional well-being when they talked about routines. Beth described establishing routines that helped her blend two families:

> Blending a family is one of the hardest things that anybody can do. I took that on, trying to have family nights. We coordinated the visits with the other parents on the same weekends, not just for our sake so that we had a weekend without kids, but so that the kids were all there on the same weekend.

The establishment of routine family nights and weekends required considerable planning and attention, but once established Beth was relieved of the demand and able to attend to other priorities.

Most women expressed satisfaction with their decision style and the resulting routines. Diana, who had dealt with personal and family health crises, said:

> I don't think throughout the years that there's ever been anything that made me do anything differently or made a drastic change, even though I've gone through some difficult times. Maybe it's because I think what I'm doing is right.

Diana described a sense of affirmation in her decision making style based on her ability to deal with crises when they occurred, as well as with everyday health work.

Just as routine decisions could result in health promoting routines that supported individual and family well-being, routine decisions could also result in health damaging routines. Health damaging routines remained beneficial to women in terms of relief from attention to some demands. This benefit, however, was often countered by increased stress and guilt for women who recognized the need to change health damaging routines. Cass commented:

> I am a smoker and I know I have got to quit. And if I want him [partner] to quit, I have got to quit, too. The fear of weight gain after quitting is scary and I think that is why I am just not ready to quit yet.

Cass's smoking was part of her weight control routine that helped her manage chronic musculo-skeletal pain. Cass recognized that smoking was better replaced by routines of

increased low impact activity and carefully controlled diet. These routines, however, required Cass's use of additional family support to accept changes and reduce daily demands on her time and energy. Cass was unable to manage such change, so she accepted the trade-offs in her current routine.

Even as women recognized the need for change in established decision routines, they found this difficult. Routines, both health promoting and health damaging, became comfortable habits that required limited attention to decision making. Over time, however, change in their routine decisions occurred for all women.

Turning Points in Routines

Changes or turning points were stimulated in two general ways: gradual development or focal events. Developmental change primarily occurred as children matured. Focal events were experiences in which either a single crisis or cumulative events revealed the need for change in women's routine decision style. The turning point precipitated a distinct shift in style and routines, that was typically followed by development of routines over time.

Turning points in decision style were distinguished by some women from turning points in life circumstances. For example, Beth considered becoming a lone mother a turning point in her family circumstance as she gained greater self-confidence and control over decision making to foster her children's development. She believed, however, that the expectations and values that guided her decision style had remained consistent:

> I've just always based most of my decision making, probably the strongest base is just caring and love. It [becoming a lone mother] was a turning point in that I became, in a sense, a different person, but underneath still the same person because my morals and my ethics and all that stuff didn't change.

Beth's distinction between her development as a person and the consistency of the values that grounded her decision making style was shared by other women in the study.

All women in the study recognized that their routine decision style changed from "doing for", to "doing with", to "guiding or facilitating" health decision making as children matured from dependent infants to increasingly independent adolescents. These changes parallelled changes in women's approach to family health work and established

health routines.

Typically, women with infant and preschool aged children routinely made decisions for their children's health. Leandra said:

> I do it myself, I take that responsibility on myself to try to get them to have the better nutritious foods. And it's a real struggle that way, just trying to come up with new ideas that might appeal to them. This year, I incorporated that they have to have a glass of orange juice with their breakfast and that's something they are not too crazy about.

Leandra identified herself as routinely making health decisions for her children. She felt responsible for ensuring that they were provided with healthy choices. She also struggled with their lack of cooperation in accepting her choices at times, acknowledging that her ten year old son was beginning to demand participation in such choices. Making the transition from doing for to doing with was difficult for Leandra and other women with early school age children, because change in routine decisions and activities had to be accommodated.

Dol also described the challenge of making a transition, as she shifted from doing with to facilitating in decision making with her early adolescent daughter. Dol recalled her routine approach:

> And so I found when my daughter had headaches I wanted her to take something for it right away to try to alleviate it. Which I wouldn't have done for myself. I just avoided all of that medication because it didn't make me feel any better anyways. And I am finding that she is telling me exactly the same thing and I am trying to talk her into taking it. I think at some point I have to realize that, yes, it is her decision also. She is a child. When it's medication, when she has to have an antibiotic, there is no option.

In this situation, even as Dol focused on persuading her daughter toward one solution, she acknowledged her daughter's input into the decision. Dol tried to include her daughter's views in decision making while retaining a sense of responsibility for the final decision. Dol then recounted a situation that had occurred more recently:

> She [daughter] said, "If I still have my headache in the morning I might consider it." I'll ask her in the morning, "Do you still have your headache?" And she will say, "Yes," and I'll say, "Would you like to take something?" "Well, I am off to school, I really want to be bright and alert, so I don't want to take anything for it." OK, then I have to respect that and I have to agree with that.

In the second situation, Dol asked questions and offered suggestions to help her daughter think through her decision about taking medication. Dol focused on facilitating her daughter's decision making, rather than on the previous routine of providing solutions.

With older adolescent children and partners, women tended to guide or facilitate decision making toward their individual control in making decisions. Dol reflected on her style when dealing with her partner's health concerns:

> With my husband, you can only mention it several times. When I've mentioned it several times too many, I get "the look" and the look says, "Get off the topic."

Dol had learned to recognize when her involvement in his decisions was unwelcome. Strategies to facilitate decision making with adolescent children and partners included exploring the concern through questioning, suggesting alternatives, recommending solutions, and accepting that decisions made might differ from those the woman would make herself.

Women with older adolescent children, such as Olivia, were able to reflect on the gradual development of their routine decisions and activities as their children grew older and more capable of making their own health decisions:

> It's really neat, because there are stages. You could probably graph it with the age of the kids. Some of it doesn't apply to me any more. But I remember doing it and so there are stages in this and, "Hey, look at that! I've already graduated from some of this!"

Olivia recalled simply making all health decisions for her daughters as infants and preschoolers. Olivia's approach had changed to include her daughter's participation when they were school age, and increasingly to facilitate their own decision making as maturing adolescents. As her daughters approached graduation from high school, Olivia felt that she approached graduation from routine decision making and health work responsibility for her children.

In addition to the changes associated with personal and family development, several women in the study attributed changes in their routine decision style to focal life experiences that precipitated change. For a few women, a personal health crisis precipitated the recognition that they needed to change their routine decisions in order to

regain and preserve not only their health, but also their capacity to fulfill family and paid work responsibilities. Scarlett talked about the impact of developing a serious stress-related condition:

> For me there was a huge turning point. Everything in my life changed because of that. The way I viewed myself, the way I viewed my children, the decisions I made for my health, for their health, my mental health, their mental health, everything changed.

Scarlett changed her approach to decision making about personal health problems as well as family problems. She described taking greater control, taking risks in making substantial life changes, and accepting increased support from her social network. She had retained these fundamental changes since that time. Like Scarlett, Ilana described a health crisis that precipitated a turning point for her:

> My turning point came when my back went on me. I was at the point physically and mentally that I could not take no more than I was already handling. After that, I kinda reviewed my practices and my policies in a way. I started doing this pushing the responsibility a bit more onto my husband as well as onto the children. By that time they were a little bit older.

Ilana changed her decision style to secure increased family support in making decisions and managing family health work. Her description indicates a more analytic approach to change than was suggested by many women in this study.

Most women's accounts of personal turning points emphasized raised awareness from questioning their decisions and activities. Lea illustrated this questioning:

> Getting to see who I really was, and that maybe I wasn't this dead loss and I wasn't useless and that there actually was stuff that I could work with if I chose to. And the most empowering thing was realizing that I had a choice today. And I don't think I realized that for a good chunk of my growing up...You know, back then it was a, "What am I doing?" and "Why?" And "What do I need to fix?" And now it's more of a "What's really important here?" If I don't hit anything else, what do I absolutely have to hit? And making sure that those are covered then you can stick in the wanna's and the coulda's and stuff.

Lea identified several turning points in her life, arising from personal or health crises, which she associated with subsequent changes in her acceptance of moderated self-expectations and priority to self-care with family care. She experienced periods of routine style between turning points. She maintained an overall sense of humor and optimism

about her decision making abilities, because of her capacity for change.

The focal event for a few women revolved around family rather than women's personal situations. Olivia described the birth of twins as a turning point in her decision making:

> I think the moment they were born, that became clear that life the way it used to be, it was just going to be filed in history books, just go look at pictures, the way we were! But I didn't even have time to think about it. They were colicky, they were difficult. I didn't have time to worry about what it should have been.

Olivia believed that her decision style had changed dramatically with the birth of twins. Olivia had let go of inflexible self-expectations and had asked for support from her partner and family. She attributed this change to the recognition that her mothering and family work would be framed by the less common experience of caring for two infants simultaneously. As did the other women who cared for children who posed particular challenges to women's decision making, Olivia adapted her style to her changed circumstances. That style then developed as children matured and family circumstances changed.

For some women the turning point resulted from cumulative events. Rose described the effect of cumulative deaths as a series of "wake up calls" that created an awareness of the need to change her decision style:

> I certainly was evolving with thought processes and health issues. But with the sudden, just sit down in the chair and my mother gone, with my husband with his heart attack, with the next door neighbour. And so the realization is there that, "Oh my gosh, some of these people were older and did not take care of themselves health wise." Made me realize that if this was my last day, is this what I would want to be doing?

Rose's description of the effect of the wake-up calls was similar to women's experiences of personal and health crises: Priorities were realigned to include self-care along with family care. Additionally, women let go of inflexible expectations on them and asked for needed support.

A small number of women resisted a recognized need for change in their routine decisions that meant they had to let go of their expectation of independence to ask for support when needed. Geri had experienced crises after which she had considered

changing her decision making style:

> I am still evolving here, this whole process is still evolving. But I don't think there was a turning point where I just said, "Whoa, I can't do that any more!" I did actually say that, but didn't change my behavior.

Geri had retained her routine decision style, attributing the consistency of decision making style to personal expectations and values. Geri's self-expectation for independence strengthened her confidence, but also discouraged her attempts to seek and accept support in decision making. Geri's response was similar to other women in this study who talked about turning points and the need for change, but had not yet made corresponding changes.

All women identified routine decisions and actions that supported personal and family health work, as well as turning points that led to changes in their routines. Changed decision routines reflected their children's maturity and family circumstances and, for some women, their experience with focal life events that resulted in women using different strategies to balance decision making. Typically, women realigned their focus on priorities to include self-care with family care, let go of inflexible expectations, and asked for support to meet their multiple responsibilities. Although many women advocated the use of paid help with house work, none used this strategy themselves. Many, but not all, women indicated that the cost of help was an issue for them. A few women chose to change their paid work situation to increase their access to flexible workplace conditions, although most women accepted their workplace conditions and believed that they had limited options to improve their situations.

Discussion

The experiences of women who participated with me in the current study are consistent with selected findings from previous studies of women's personal and family health decision making and caregiving. Important contrasts with previous findings also have been identified. Understanding of how employed mothers make health decisions for themselves and their families has been extended by the current study. Consistencies, contrasts, and extensions will be presented and potential explanations discussed.

The intensity of family and employment demands, the continual, often

unpredictable nature of caring demands, and the importance of flexibility in personal and social resources were emphasized in the current study. In particular, supportive workplace relationships and policies, as well as family and social networks were central to women's ability to manage demands. These findings were highlighted in previous studies of women's decisions about returning to work after childbirth (Hall, 1987), breast feeding (Morse & Bottorff, 1989) and caring for sick children (Semchuk & Eakin, 1989; Thompson, 1993).

The findings of the current study suggest that in everyday health decision making, women processed the more contextually-focused, relational aspects of decision making concurrently with the more analytically-focused, cognitive or rational aspects. Cited previous studies, however, promoted the impression that women made decisions on a cognitive or rational basis, then considered whether decisions fit within their current context. In contrast to the current study findings, family, workplace and social contexts were presented as external influences on women's decision making processes. Differences between the current study integration of social influences in decision making and previous presentation of influences as external context may relate to the relational perspective I used. From this perspective, all influences must be considered in examining women's decision making process.

My use of a relational perspective supported explication of women's health decision making as a process that integrates multiple individual and social influences. A relational or contextual perspective has been advocated by women's health and critical researchers (Oakley, 1992; Ruzek, et al, 1997; Sandelowski, 1981; Sherwin, 1998; Woods, et al, 1993). This perspective reflects the view that individuals make decisions and take action in their daily lives in the context of personal, interpersonal, family, workplace, and societal expectations and circumstances. Further, accepted dichotomies between women's and men's work, private and public spheres, and individual and collective responsibility are challenged as artificial social constructions that contribute to systematic disadvantage of women in western society (Glenn, 1994). Such dichotomies influence employed mothers' decision making by reinforcing individual responsibility

within gender roles that emphasize health and caregiving as women's private, family work.

This relational perspective contrasts with the dominant cognitive or psychological perspective on decision making as an ultimately individual activity (Janis, 1993). In recent decades, rational choice models of decision making have dominated psychological research literature. These models "assume that decisionmakers deliberately choose their course of action on a rational basis by taking account of the values and the probabilities of the consequences that would follow from selecting each of the available alternatives" (Janis, 1993, p. 56). Within the social sciences, rationality focused theories assumed that all human behavior is goal directed and motivated by calculated self-interest toward maximizing benefits and minimizing costs during social interaction (Waters, 1994). As such, individuals make choices about alternative actions based on a rational analysis of anticipated benefits weighed against costs and barriers. Decision making, therefore, has been depicted as an individual, cognitive process intended to serve the purposes of the individual in social interaction with others. Within the health sciences, health behavior models such as the Health Belief Model developed by Hochbaum (1958) and others (Becker, 1974; Janz & Becker, 1984; Rosentock, 1966) have incorporated assumptions similar to rational choice models (Janis, 1993). Social influences on individual health behavior choices have been acknowledged, but individual capacities have been emphasized over social institutional conditions. This emphasis contrasts with the comparable emphasis on personal and social influences in the current study.

The constantly changing and conflicting nature of caring demands, the dynamic recursive process of decision making to manage demands, and the complex personal and social influences integrated in women's decision making were revealed in the current study. These findings are consistent with Wuest's (1997a, 1997b, 1998, 2000) study of women's decision making about caring work. Wuest reported that women engaged in a process of "precarious ordering" in managing caring demands. Wuest theoretically sampled employed and nonemployed women of diverse social, economic, and cultural backgrounds. Caring work included parenting and elder care in situations of health,

disability, and acute and chronic illness. Wuest's findings are consistent with the current study findings about health decision making for family health work. Wuest did not, however, examine women's decisions about self-care. Self-care as well as family caregiving demands and decisions were a central focus in the current study.

In the current study, women's personal and family decisions were revealed as intricately interconnected through women's role expectations and demands as mothers, partners, employees, caregivers, and volunteers. Therefore, considering either women's personal or family decision making in isolation might not make visible the important, concurrent influences experienced by employed mothers. Unlike the current study, previous studies have not concurrently considered personal and family decision making. Further study is needed to extend understanding of personal and family decision making as a comprehensive process.

The current study reported five phases of finding a balance (keeping track, cueing in, figuring out, balancing solutions, and assessing results) that parallel behaviors described by Demarco and colleagues (2000) in their discussion of stress and coping in family health work. They described family health work as "the process through which families develop or learn problem-solving and growth-seeking skills over time" (p. 315). Active, creative health work was characterized by family use of a problem-solving approach that included behaviors to observe the situation and gather information; analyze the situation; generate alternative strategies to manage the situation; select alternatives by weighing advantages, disadvantages, and fit with the family; and evaluate the actions and modify them as necessary. The phases of finding a balance include the behaviors described in creative health work.

For women in the current study, the dynamic interplay of roles, relationships, and power within the family group related to women's stress and were important influences within the process of finding a balance. These dynamics were not discussed by Demarco and colleagues (2000). The authors, however, acknowledged the influence on family health work of the health of the family group and individual members, the social context of family life, and interaction with health care providers such as nurses who work with

the family. These influences were briefly described, but were not examined interactively within the family health work process. Further, the focus on the family as a unit did not reveal individual member contributions to family health work. Unfortunately, limited understanding was gained of how the various influences were integrated within the process of family health work. This integration was a focus in the current study.

There are essential similarities and important differences between the process of finding a balance in decision making described in the current study and Rettig's (1993) proposed integrative framework for family problem-solving and decision-making. The framework was theoretically, rather than empirically, developed from the perspective of family resource management and an ecological view of family. In the framework, problem-solving focused on the processes of dealing with barriers to goal achievement and was distinguished from decision-making as the process of comparing and selecting alternative solutions. The current study, however, presented these processes as phases within the process of finding a balance, rather than as separate decision making processes.

Women in the current study engaged in the same decision making process when making both personal and family health decisions. This finding supports Rettig's (1993) assumption of an extension from individual to family decision making processes. Rettig also assumed that, like individual decision making, decision making in and by families engaged social, economic, and technical decision processes. Social decision processes focus on problem identification related to values, goals, and role conflicts as well as general living conditions. Family economic processes focus on establishing priority goals for family members and the family group so that resources could be allocated to support priority goal achievement and balance conflicting demands. Family technical processes focus on taking action by organizing and mobilizing resources or implementing decisions. Family decision making also involved evaluation processes that contribute to future decision processes. Consistent with Rettig's framework, the phases of finding a balance included women's activities to identify concerns, establish priorities, consider and select alternative solutions, and assess decision results for potential use in future decision making situations. The current study, however, represented women's views of

decision making for and with their families, rather than decision making by the family group. This latter perspective merits further study in order to extend understanding of individual and family dynamics in family health decision making.

The current study goes beyond Rettig's (1993) description of the overall process of decision making by examining the influence of relational dynamics on decision making. These dynamics included not only interactions within the family, the focus of Rettig's work, but also those in the broader social environment including the workplace and health, education, and social systems. This detailed and comprehensive examination of dynamics that influence decision making is essential to developing in-depth understanding of individual and family health decision making processes.

In the process of finding a balance in decision making, women used multiple strategies to balance solutions. Strategies helped women meet important expectations and demands in family and paid work, use available resources, and work around situational constraints. Meeting expectations and demands involved focusing on family and personal priorities, being fair about time and attention to demands, and letting go of inflexible expectations and demands that were not priorities. Meeting expectations and demands was supported by using available personal, family, workplace, and social resources. Using resources involved using available family network support, asking for help, and sharing decision making within the family. Women used personal resources in recognizing self-rewards, using spiritual support, and using time out to relieve stress. Using workplace and social resources included choosing work with flexibility and valuing available benefits and services in the workplace, health, and social systems. Women also worked around situational constraints to meet expectations and demands, by delaying attention when demands conflicted, by making contingency plans as back-up, by using acceptable alternatives to preferred but unavailable solutions, and by persisting in gaining access to sought after resources.

The strategies used by women in the current study are remarkably similar to many of the strategies identified by Wuest (1995a, 1998, 2000) in her study of women's process of precarious ordering to meet caring demands. Women used strategies to make ground

rules that increased employment flexibility, to juggle time, to relinquish some demands, and to replenish or care for themselves in order to repattern caring demands (Wuest, 1995a). Women also used strategies to set boundaries around caring demands by selectively limiting demands and by accepting the strengths and limitations of their own knowledge, skills, and values (Wuest, 1998). Finally, women negotiated with helping systems available through their social networks and health and social services. The strategy of negotiating involved reframing expectations and responsibility; networking to access information, assistance and support; harnessing available resources, and taking more control to modify inadequate resources to support caring demands (Wuest, 2000). Although Wuest focused on the process of caring rather than decision making, the latter is implicit in the former, potentially explaining the similarities in study findings about women's strategies to meet demands. Unlike the current study, however, Wuest did not focus on women's interaction in the workplace as an important influence on women's health and caregiving work.

Access to workplace flexibility and support, particularly informal support from supervisors and formal support from working conditions and employer-provided benefits and policies, was integral to women's ability to balance solutions in the current study. These findings concur with conclusions from a study (MacDermid & Williams, 1997) of factors contributing to work-family tensions for women support and managerial workers in the banking industry. In large workplaces, like the employer in the current study, women were less likely to report difficulty managing work-family demands when they believed that benefits were available and accessible, that supervision was high quality, and that they had good relationships with co-workers. These findings suggest that access to supportive workplace relationships and benefits is valuable for women in managerial as well as support staff positions.

Women in the current study, however, also found that supervisor nonsupport could block access to formal benefit and policy entitlements, as well as to informal supportive relationships. Supervisor nonsupport was not discussed in the MacDermid and Williams study, reflecting the more common focus in work-family literature on the

presence of support. Further study is needed to provide better understanding of the conditions that promote supervisor support and nonsupport, and strategies to promote the development of supportive workplace environments.

Workplace inflexibility increased the stress of trying to balance solutions for women in the current study. This finding is consistent with many of the stresses identified in studies of women clerical workers in California (Meleis, Norbeck, Laffrey, Solomon & Miller, 1989) and in Brazil (Meleis, Messias & Arruda, 1996). The women in the current study and the California study, however, generally used more proactive strategies to secure workplace flexibility and support in contrast to the reported resigned acceptance of the Brazilian women. The contrast may be explained by differences in social and employment conditions between the Brazilian and the Canadian and American women. I concur with speculation by Meleis and colleagues (1996) that differences may be explained by the Brazilian women's relegation of the paid work role secondary to their family roles and their sense of disempowerment in a stressful workplace environment and an oppressive social structure. Although similar conditions were described by some women in the current and the California studies, comparatively, Brazilian women may experience a greater degree of disempowerment, therefore, greater tendency toward resignation to stressful conditions.

Access to needed support from the family and social network was an essential resource in the current study for women in balancing solutions in health decision making. Women who felt adequately supported had more alternatives available when making decisions, appeared less stressed, and described more of a sense of balance in decision making and in their everyday lives. Despite the need for support, many women described barriers to receiving assistance. These barriers included reluctance to ask for support, concern about reciprocating support, and preference for support from family who share emotional ties and caregiving commitments. These barriers were also identified in an earlier work about women returning to paid work as an employed mother (Harrison, et al., 1995). Additionally, in both studies women preferred support that was offered, available when needed, reliable, and respectful of women's decisions. Support from

individuals such as co-workers and other employed mothers thought to share women's experiences was particularly valued by women.

In the current study, social institutional influences on women's family caregiving affected their comfort in accessing support for caring work. This finding is consistent with Neufeld and Harrison's (2000) examination of social influences, such as ideals about women's work, as barriers to women's access to social support. The authors reported that women's acceptance of social norms that define caregiving work as women's work reinforced their sense of obligation to manage demands on their own. When social network members were absent, lacked resources, or were not considered sufficiently close personally to be acceptable, support was unavailable to women. Women's need to reciprocate support and their concern that they might not be able to do so prevented them from accessing support. Non-support, defined as " unhelpful comments or actions, indifference or conflict with someone who is supportive in other ways" (p. 260), within network relationships limited women's acceptance of support. These barriers have been discussed in the current study as constraints on employed mothers' health decision making for themselves and their families. Constraints limited women's alternatives in balancing solutions, increased women's stress, and reinforced women's attention to family health care, frequently at the expense of self-care.

The influence of stress on decision making was a recurrent theme throughout the current study. All women recognized the influence on their decision making of stress from daily demands and from situations requiring immediate response. The stressfulness of daily demands related more to conflict among concurrent demands and less to multiple daily demands. For example, women found meeting concurrent demands to care for an ill child when they had scheduled workplace meetings or deadlines more stressful than dealing with both demands separately. Women concluded that they compromised their decision making under such stressful circumstances, making decisions considered minimally acceptable to them. They sometimes left children on their own at home while they dealt with paid work, because they had no alternative solution. Women voiced dissatisfaction with such decision making, particularly about family health work.

Women's dissatisfaction with decisions added to their overall stress, reinforcing limited alternatives and a routine of self-care neglect that resulted in women's sense of unbalanced solutions. Unbalance occurred when women faced situations in which they were unable to work around the constraints of time pressures, inflexible expectations, conflicting or competing demands, compromised personal resources, and inadequate access to support from family, workplace, health, and social resources. These constraints are consistent with Wuest's (1997a) description of fraying connections experienced by women trying to meet caring demands. In fraying connections, women faced daily struggles from competing and changing caring demands; inadequate support from social systems; and inadequate support from conflicted relationships. Wuest found that women experienced the stage of fraying connections before they progressed to the stage of setting boundaries, negotiating, and repatterning to manage caring work. This progression is similar to the experiences of the women in the current study who made changes to resolve a pattern of unbalanced solutions. Unlike Wuest's findings, however, most women in the current study experienced unbalanced solutions within specific situations, but did not describe a general pattern of unbalance. Further, many women also described a proactive pattern of balancing solutions in which they used multiple strategies to deal with situations without a sense of threatened unbalance. Differences in findings between the two studies might relate to the broader focus in the current study on everyday decision making compared to Wuest's focus on comparatively intense caring demands.

Women's experiences of stress and unbalanced solutions are consistent with Janis' (1993) examination of individual and group decision making under stress. Janis contended that a moderate amount of stress was necessary to stimulate vigilant decision making, but intense stress contributed to premature closure in deliberation on alternatives and a tendency for rigid thinking or cognitive rigidity. Hypervigilance, "excessive alertness to all signs of potential threat" (Janis, 1993, p. 64), could result from intense stress. Time pressures from emergency situations and constant daily demands were discussed as powerful contributors to intense stress and hypervigilance in decision making. Premature closure and cognitive rigidity resulted in consideration of a narrowed

range of alternatives, overlooking long-term consequences, inefficient searching for relevant information, erroneous assessment of anticipated outcomes, and use of oversimplified decision rules. In the current study, women's descriptions of decision making under intense stress are similar to Janis' description of premature closure and cognitive rigidity. Women tended to explore few alternatives, to consider immediate more than long term consequences, and to be ruled by their priority to family caregiving.

The importance of understanding conditions that support the development of health promoting rather than health damaging routines in everyday decisions and activities has been emphasized in the current study. Findings support a critique by Graham (1984) of dominant psychological orientations to health decision making. Health decisions were discussed as health compromises in her study of women and family health in Britain. Graham critiqued the literature emphasis on individual psychological orientations to health decision making, while acknowledging the contribution of personal attitudes, perceptions, and skills to health decision making. She concluded that in circumstances where resources such as time and energy are limited,

> health choices are more accurately seen as health compromises, which, repeated day after day, become the routines which keep the family going....Understanding routines, and the constraints which bear upon them, thus appears to be essential to a broader understanding of choice and change in everyday life (p. 187).

Study findings support the continuing relevance to women and families of recognizing health decision making as a complex, dynamic, and contextually-grounded process.

In the current study, women's descriptions of decision making about family health work suggest a routine style that was used consistently and developed with experience. These findings are consistent with Demarco and colleagues' (2000) examination of family decision making styles and stress and family health work. The authors concluded that families and individuals within families establish a decision making style that developed through experience in decision making situations as families evaluated their decisions. The authors suggested that families tend to use a routine style, progressively expanding their repertoire of experience, as long as the style contributes to management

of family health work that the family considers workable or successful. The current study findings lend support to the conclusion that routine decision styles are developed within families and that decision routines support family health work.

Women's descriptions of how they made health decisions suggests their use of routine styles similar to those discussed by Rettig (1993). Most women in the current study described an analytic style of decision making as they talked about asking questions, seeking information, and considering alternative solutions. The descriptions by Ilana and Lea of self-questioning to identify issues, information, and possible alternatives illustrate women's analytic style. However, women also described an intuitive style, emphasizing their values in making decisions. Faith's reliance on intuitively knowing her child and Scarlett's trust in her instincts illustrate women's intuitive style. Dol's description of knowing her daughter's voice and questioning her concerns, illustrated how many women described using both analytic and intuitive styles to make health decisions. A pragmatic style was reflected by women like Haley, who described dealing with her daughter's behavior problems at school as a situation that required immediate response without time for full decision consideration. Women focused on accepting that they would do their best to find a solution that was workable within the constraints of time and access to resources. These findings are consistent with Rettig's (1993) discussion of previous literature about individual decision making styles. She concluded that styles reflect a range of patterns of processing information, including intuitive or values-focused, analytic or information-focused, and pragmatic or solution-focused styles. Individuals use all styles, but may develop dominant styles that they apply generally or situation-specifically. Descriptions by women in the current study support women's use of multiple styles. Most women used a more analytic than intuitive style to identify concerns and alternative solutions, mixed with a pragmatic style to develop balanced solutions.

The current study findings also emphasize the contribution of value priorities of the family, their priority to individual independence or family group interdependence, as an important influence on decision style in families. Women's descriptions of family

decision making suggest that women engaged in either collaborative or accommodative, but not individualist, styles of family decision making as described by Rettig (1993). An individualist style gave priority to member independence and individual goals. A collaborative style was characterized as a balance between individual and group goals, valuing children's democratic involvement in decision making. An accommodative style emphasized member interdependence, placing priority on group over individual goals and parent control in the process of making decisions for their children. In the current study, women with older children considered able to participate in decision making described a more collaborative style. This style also was described by women with consistent, shared participation from their partner in family health work. A more accommodative style was described by women who made decisions for younger children. Additionally, this style was described by women with limited partner support or women who held themselves up to the social expectations of "the good mother". These women consistently gave priority to family needs and goals over their own. A combination of personal expectations and family dynamics, including children's development and partner participation in family health work, contributed to women's adoption of an accommodative style in which they felt responsible for family health decisions.

All women in the study experienced change in their decision making style over time in response to developmental change in their family or focal events that raised women's awareness of potential inadequacies in their established decision routines. Family, particularly child, development contributed to gradual shifts in women's style from doing for, to doing with, to facilitating in family health decision making. Additionally, several women experienced either critical incidents or cumulative events that raised women's awareness of a need to change their style in order to regain or preserve personal health, as well as important family and paid work roles. Women's changes in decision style reflected shifts in their priorities, typically to realign personal priorities with, rather than behind, family priorities. The women who talked about, but had not carried through changes in their decision style appeared not to have made this realignment. Realigning priorities that involved personal and family interests was

undertaken when women recognized substantial personal threats and received family support to change. Even with such support, women did not make these changes easily. In contrast, women more readily made developmental changes that were associated with personal and family growth.

Women's recognition that their decision style changed as their children developed in knowledge, skills, and maturity is consistent with Liprie's (1993) study of parent and adolescent perceptions of their participation in family decision making. An anticipated increase in decision making participation and influence by adolescents was reported. Just as women in the current study did, parents in Liprie's study encouraged adolescent participation in decision making by including them in discussions and seeking their opinions about alternative solutions. The influence of family member development on family style also was apparent in Rettig's (1993) theoretical discussion, although family decision making styles were not presented from a developmental perspective. Member contribution to family decision making might change as members increase their knowledge, skills, and interest in participating indecision making. As children grow in relative independence, their participation in decision making would reasonably be expected to increase. Such developmental influences were evident in the current study. As such, child development is one influence on the family decision making style.

Many women in the current study also identified both critical incidents and cumulative events that precipitated subsequent changes in their routine decision style. Critical incidents included role transitions such as mothering twins or becoming a lone parent. Most often, however, women described critical incidents related to personal health that represented a threat to continued fulfilment of important life roles, particularly to family roles. A few women also described cumulative events that raised their awareness of the need for change, having a more gradual in impact on women's lives. These findings are consistent with findings from an empirical study of turning points in adult lives (Clausen, 1995). The influences of gender and social context on experience were studied from an ecological perspective. As defined in the study, turning points marked a directional change from a previous course. Clausen found that the majority of turning

points described by study participants were role transitions related to family and paid work. Clausen related study findings to Strauss' (1959) earlier description of a typology of turning points. In the typology, turning points occurred through transforming incidents that represented a discontinuity in identity, or through an accentuated continuity that resulted in a gradual shift to a new identity. Admittedly, cited literature focused on turning points in the life course, rather than the more specific focus in the current study on decision making style. Yet, similarities are evident related to stimuli to and the consequences of turning points in everyday life between the study findings and this literature, supporting continuity between life experience and decision making.

For most of the women in the current study, focal turning points led to changes in their priorities to make room for themselves as well as their families in their routine decision style. Typically, women made this change only after they, often with support from their families, acknowledged the need to care for themselves. Women changed their decisions about managing personal and family health demands when they recognized that they needed to accept personal limits and support from others. The changes women made as a result of focal turning points are similar to changes reported in two recent studies. Harrison and colleagues (1995) studied women's use of social support during normative life transitions. Changes were reported in women's use of social support, implicitly suggesting that their decision making about the acceptability of using support also changed. As in the current study, stimuli to change "included illness and personal recognition that the informant could not continue to cope in her usual pattern" (p. 862). Similarly, Robinson's (1998) study of women's management of family health including the care of a chronically ill family member found that women needed to change their orientation to personal and family priorities in order to shift from a sense of burden to balance. These women, like women in the current study, needed to "take charge" of their lives in order to find a "life-enhancing balance between self and all other family members" (p. 285). For women in the current study, balanced solutions incorporated women's focus on self-care as a priority along with their focus on family caregiving responsibilities.

Conclusion

In conclusion, the work of balancing health with family and paid work is continuous for employed mothers. Health decision making is framed within everyday experiences as women, mothers, partners, paid workers, caregivers, and volunteers.

The portrayal of employed mothers' health decision making as an individual cognitive process that takes place in an admittedly complex social context would be inconsistent with women's experiences in this study of health decision making in everyday life. Personal, family, workplace, and social contexts influenced the process of finding a balance for women in health decision making. These influences were internal to the decision making process. The sub-process of balancing solutions reflected the complex considerations integrated within the overall process of finding a balance in decision making.

Women's social circumstances including family dynamics, employment conditions, and socioeconomic status clearly influenced women's decision making about health and caring demands. The importance of flexibility, responsiveness, and availability of supports and resources to women has been underscored. Based on the findings of this study and relevant published research, I conclude that important common themes in decision making to manage health and caring work exist across diverse social circumstances. The social context of women's everyday experiences continues to reinforce women's responsibility for health and caring work, in addition to their responsibilities for paid work. Workplace, health, and social systems are inconsistently responsive to women's multiple responsibilities. Promoting shared responsibility for health work among women, families, and society is important to supporting the achievement of balance in health decision making, therefore in everyday life, for women and their families.

CHAPTER 7

A REVIEW OF MAJOR FINDINGS AND DISCUSSION OF IMPLICATIONS

The women in this study evidenced remarkable resilience and resourcefulness, particularly in making decisions and caring for their family's health while managing their multiple responsibilities in family and paid work. Women's social circumstances including family dynamics, employment conditions, and socio-economic status integrally influenced women's decision making about health and caring demands. The social institutions of motherhood; the family; the health, education, and social systems; and the workplace were pervasive influences on women's decision making and health experiences. Social institutional influences shaped the expectations, demands, resources, and constraints women accounted for in finding a balance.

Finding a balance emerged as the core process of health decision making for the employed mothers in this study. Finding a balance was an active and recursive process that was influenced by continuous changes in personal, family, workplace, and social demands. Women found it easier to achieve a balance if they had flexible self-expectations and were comfortable with their personal resources and priorities. Balance was also easier to achieve for women who had flexible demands from their family, the workplace, and their children's school. Support from women's family, the workplace, and the health, education, and social systems was valuable to achieving balance. Time pressures imposed by managing multiple, sometimes competing demands were a major constraint on women. Other constraints included inflexibility in women's self-expectations or in the expectations and demands from women's family, their workplace, and the education system. Difficulty accessing workplace, health, and social system resources also constrained women's ability to achieve balance.

Strategies to balance solutions helped women meet important expectations and demands in family and paid work, use available resources, and work around situational constraints. Women met expectations and demands by focusing on family and personal priorities, being fair in attending to demands, and letting go of inflexible expectations and lower priority demands. Women's use of resources involved using available family

network support, asking for help, and sharing decision making within the family. Using personal resources included recognizing self-rewards, using spiritual support, and using time out to relieve stress. Women used workplace and social resources in choosing work with flexibility and valuing available benefits and services in the workplace, health, and social systems. Women worked around situational constraints to meet expectations and demands, by delaying attention when demands conflicted, by making contingency plans, by using acceptable alternatives to preferred but unavailable solutions, and by persisting in gaining access to sought after resources. Women however, often managed multiple demands at the expense of attention to their own health, as women gave priority to family over self-care.

The focus on family over self-care combined with constraints that women could not work around resulted, at times, in unbalanced solutions for women. Under time constraints, women made compromised decisions that were unacceptable or unsustainable beyond the immediate situation. Constrained by inflexible expectations, women tried to manage demands by themselves. Women who dealt with chronic illness faced conflicting demands between self-care and family care, were concerned that they neglected family responsibilities, and felt guilty. Inadequate family and social support reinforced women's efforts to manage demands by themselves. Inadequate workplace support increased women's sense of job vulnerability, decreased flexibility, and limited access to entitled policy provisions. Inadequate access to health and social system services reduced women's alternatives and intensified their efforts to manage without needed support. Women's dissatisfaction with unbalanced solutions added to their overall stress and sense of guilt, reinforcing limited alternatives and a routine of self-neglect.

Women's descriptions of decision making about family health work suggest a routine decision style which was used consistently, developed with experience, and supported health routines that relieved women from otherwise continuous demands. Women's routine style typically combined analytic, intuitive, and pragmatic strategies to identify concerns and alternative solutions and to develop balanced solutions. All women experienced change in their decision style in response to developmental change in their

family or focal events that raised women's awareness of potential inadequacies in their established decision routines.

The process of finding a balance was framed within women's views of personal and family health as the capacity for everyday living. Women considered physical, spiritual, and social emotional aspects of health. Women described health by the presence or absence of attributes, as well as by actions. This inclusive view of health was reflected in the everyday health work women engaged for themselves and their families.

The reported findings represent the perspectives of the women who participated in this study and reflect issues important to them in their everyday health, family, and paid work. As such, this study contributes to understandings of women's experiences and to knowledge relevant to theory and practice in women's and family health. Directions for future research based on the strengths and limitations of this study are suggested. Additionally, the critical feminist grounded theory method developed in this study contributes to the theoretical knowledge base about critically-oriented research methodologies useful in nursing research. These contributions will be discussed in the following sections of this chapter.

Contribution to Theory in Nursing and Health Promotion

The intersections between the findings of the current study and relevant current theory in nursing and health promotion have been discussed in each of the three previous chapters. These chapters dealt with women's meanings of health for themselves and their family and their personal and family health work, the social institutional influences on women's health work and decision making, and the process of health decision making. Conclusions from these discussions will be highlighted.

The findings of the current study support theoretical conceptualizations of individual and family health as personally meaningful, complex, dynamic, active, and part of everyday living (e.g. Backett, 1992; Labonte, 1993; Woods, et al., 1988). Further, support is provided for a conceptualization of family health that considers both individual member and group aspects of family experience (e.g. Danielson, et al., 1993; Denham, 1999d). The meanings of "healthy person" and "healthy family" are equated with living

fully in daily life. In contrast, illness is considered an individual experience that occurs in a family context. Given this inclusive view of individual and family health, everyday health decision making is equivalent to everyday life decision making.

Attention is directed to ecological or socio-environmental conceptualizations of health that include individual, family, and social aspects of health experience (e.g. DeMarco, et al., 2000; Denham, 1995, 1999d; Labonte, 1993). Conceptualizations of health that reflect the breadth, depth, and diversity of health meanings without assumptions that each individual holds all aspects equally valuable or personally meaningful (e.g. Nettleton, 1995) are supported.

Women's health work, the actions directed at caring for personal and family health, supports current health behavior theory that proposes complex relationships between individual, family, and social influences on action. Theory that focuses on individual health behavior is relevant, but only addresses part of women's experience. Ecological or socio-environmental theories of health behavior (e.g. Blaxter, 1990; Denham, 1999a, 1999b, 1999c; Woods, et al., 1993) are consistent with the descriptions of women's health work in this study. Such theory integrates social as well as individual and family influences on health behavior. Importantly, such theory challenges the utility of current societal emphasis on individual responsibility for health and health work.

The substantive theory of finding a balance explicates and integrates social as well as personal contexts within the process of decision making, supporting and extending critically-oriented and ecologically-based decision making theory (e.g. DeMarco, et al., 2000; Graham, 1984; Rettig, 1993). The strategies women used and the conditions that supported or constrained women's capacity to achieve balance extend previous understanding of how women make decisions about both personal and family health care.

The study resulted in a substantive theory of employed mothers' health decision making that merits continued development toward potential integration with formal decision making theory. The women who volunteered to participate in the study had a vested interest in talking about their experiences and learning from other women's experiences. Therefore, the sample in this study cannot be considered "representative" of

employed mothers generally, or even within the region. However, the intent in qualitative research is to develop intensive or in-depth understanding of experience. Such understanding is gained through participants who have the necessary experience and are able to give voice to their experience. This intent was met in the study.

This study focused on mothers employed in support positions and adds to previous research that has mainly sampled women in professional positions. This study, however, was limited by the self-selection of participants, exclusion of non-English speaking women, and recruitment from a single employer. Potential cultural, socio-economic, and social diversity that would extend understanding about women's experiences under these diverse conditions may not be represented.

The demonstrated influences on women's experiences and decisions need to be examined under conditions of greater social diversity in order to extend understanding that contributes to comparatively generalizable theory.[7] The women who participated in this study were part of the dominant Euro-Canadian culture. Although three women were immigrants from Europe, they had established lives here, were comfortable in Canadian culture, and were fluent in the English language. Most women's socio-economic status was considered middle class based on their education and family income. Additionally, most women were in legally married, heterosexual relationships. The research focus in this study needs to be extended to include the experiences of women from other cultures including First Nations; non-English speaking immigrant women; women from lower as well as upper socio-economic status; and women in alternative family forms including lone parent, common-law, lesbian, and multi-generation families. Additional conditions of social and cultural diversity that merit further study include the experiences of women

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Comparative generalization is an explanatory strategy, advocated by Morrow (1994), in which patterns "found in the cognitive, cultural, or structural constitution" (p. 212) of individuals, social interactions, and social systems are explicated and compared. Patterns are generated through research using a strategy of intensive explication. The strategy is grounded in hermeneutic assumptions and is intended to empirically examine underlying social-structural relations among individuals within the social world. The strategy of comparative generalization makes possible limited generalizations in theory construction.

in different geographic regions that potentially reflect differences in dominant views about family responsibility, the context of women's paid and unpaid work, or access to health and social resources. This recommendation is consistent with feminist and critical scholars (e.g. Collins, 1994; Eyer, 1996; Smith, 1993) who critique the tendency in research literature to ignore diversity in representing the dominant culture. Such representation limits understanding and further marginalizes non-dominant groups in society, who often face greater barriers to health promotion.

Further study is needed to provide better understanding of the conditions that promote or constrain the development of supportive workplace environments including supervisor support. Inclusion of the perspectives of managers or supervisors as well as employees in diverse workplace environments such as those in small and large, private and public, and male and female dominated workplaces. Additionally, women in support staff as well as professional positions need to be included in order to examine the influence of women's position in the workplace on access to workplace support. Greater understanding of workplace dynamics that contribute to supportive workplace environments could guide the development of intervention studies to test strategies for promoting such environments.

The focus on women's perspectives needs to be extended to include family perspectives directly in future research about health decision making in families, to avoid an implicit assumption that the mother speaks for the family. Denham (1999a) found that women's reports about family health and activities were consistent with family reports. She concluded that mothers "are generally reliable reporters of family health activities" (p. 144). Nonetheless, women's perspectives on family health, health work, and health decision making are only one among many perspectives when the family is the unit of study.

Future research that focuses on the family in social context as the unit of study can contribute additional knowledge about the influences of family and social dynamics on decision making and action to guide health promotion practice. The use of a critical feminist perspective for research would direct attention to broader social, economic,

cultural, and political contexts, as well as gender influences on experience. This broader focus remains consistent with a feminist concern for woman-centered inquiry that contributes to change, while also supporting a critical concern for social change compatible with family-centered inquiry. Family-centered critical feminist inquiry provides a means to engage the family in reflection and action that can contribute to shared family responsibility and improved family health, promoting greater gender equity within families. Focusing on the family as the unit of study also provides a means to support consistency between research and practice that recognizes the importance of family-centered understandings. Ultimately, I concur with Killien's (1999) conclusion that future research needs to contribute to the development and implementation of strategies, programs, and policies that effectively promote change to address identified issues for employed mothers and their families.

Implications for Health, Social, and Workplace Policy

Women who participated in this study hoped that the profile of employed mothers' issues and concerns in the workplace as well as in the health and social systems would be raised, and could influence program and policy decisions. Women hoped that their issues and concerns would be seriously considered in future policy discussions, thereby influencing health, social, and workplace policy decisions that would support meeting the multiple responsibilities of paid and family work.

Health program and service providers can incorporate ecological or socio-environmental conceptualizations of health and health promotion, consistent with the meanings held by women in this study, in the development of programs and services that are responsive to the everyday realities of employed mothers. Working from these health conceptualizations, program and service provider attention is directed to identifying and addressing social conditions as well as individual behaviors that contribute to health. Further, the dominant focus on lifestyle risk reduction and individualist responsibility for health is questioned. This focus has been critiqued for the assumption that behavior is primarily controlled by individual motivation, disregarding broader social conditions that shape behavior (Labonte, 1993). This assumption contributes to a narrow health system

emphasis on individual-level change, and subsequently to increased individual stress, guilt, and "victim blaming" if change does not occur. Questions need to be raised about the utility of campaigns and facilities that advocate women's physical fitness, smoking cessation, or stress reduction without addressing the family and social conditions that contribute to and prevent change in health damaging behaviors. These conditions might include lack of childcare, inadequate social support, and inflexible hours in the workplace. Programs and services could address these conditions by offering childcare, support groups, evening or weekend hours, and partnerships with employers to promote needed flexibility.

Without concurrent challenge to the dominant individual responsibility view of personal and family health, program and service development may continue to emphasize individual risk reduction over collective action to promote social change. In Canada, the determinants of health (e.g. socio-economic status, social support, education, employment, social and physical environments, personal health practices and coping, biology, gender, culture, health services) have been increasingly emphasized within health promotion and population health literature (e.g. Canadian Public Health Association, 1996; Health Canada, 1998, 2000). This emphasis holds promise for the development of programs and services that address the practicalities of women's everyday health experiences.

Health program and service providers, as well as health and social policy makers, need to recognize the potential health risks associated with dominant reliance on an individual responsibility model of service. Women in the current study were held responsible for family health work and embodied social expectations of the good mother who cares for her family. When constrained by time pressures from conflicting demands and inadequate access to health services, including limited hours of service, inconvenient locations, and difficulty obtaining information about alternatives, women routinely neglected self-care in favor of attention to family care. This study reveals some of the health risks associated with routine decision making that subverts women's self-care to the priority of family care. Women's health suffered secondary to stress and self-neglect.

Family health also suffered when women's capacity to provide care was compromised by their own health problems. The individual responsibility view dominant in the Canadian health system combined with the more recent shift toward community-based care implicitly reinforces potentially oppressive reliance on women's unpaid caring work as an extension of the formal system (Wuest, 1993). I concur with Wuest's (1998) conclusions that women's caring work is an important resource for the health care system and that women must be able to provide care without promoting their own subordination.

Program and service providers need to establish and ensure access for women, and families, to services that appropriately support family caregiving. Decisions need to address issues such as those identified in this study, including the convenience of service in terms of hours and location and the availability of useful information about services and family-based care recommendations. For example, evening and weekend hours of service, mobile service provided by home visit programs, and multiple strategies for information dissemination including internet, print, and personal contact are all means of increasing access to available services. The recently initiated Capital Health Link that provides 24 hour, 7 day a week telephone health advice and information is one example of a service designed to increase accessibility. Women and their families also need access to affordable services that provide in-home or community-based support for the care of ill children or aging extended family members. Services might include short-notice temporary in-home care and respite care to deal with unexpected demands when other alternatives are unavailable.

To address the childcare concerns identified by women in this study, health and social system providers need to work with employers to develop creative solutions. Access to high quality, affordable, and convenient childcare was a concern for women in the current study. Childcare policy in Canada needs to address current system inadequacies to ensure the availability of a variety of affordable, quality childcare alternatives to meet the diverse needs of employed parents. The current Canadian policy approach to childcare has been structured from within the dominant individualist view that holds families primarily responsible for childcare (Baker, 1995; Eichler, 1997).

Although regulations exist for formal childcare services, the current childcare system has been criticized as inadequate to meet the demands of families in Canada (Baker, 1997). Solutions to identified concerns could include extended daycare operating hours for parents who do not work the regular office day, services for ill children who cannot attend regular childcare or school, and workplace provision of on-site daytime and out of school childcare. Additionally, greater flexibility in workplace conditions could support mothers and fathers to meet childcare demands. Parents might choose, like a few mothers in this study, to work shifted hours to accommodate children's school schedules, or to work at home when needed. These solutions are consistent with Baker's contention that, in addition to changes in social and health policy, changes need to be made in the workplace to remove the assumption that paid work is separable from personal life. Just as personal, family, and social contexts are integrated in women's health decision making and health work, so too must these contexts be integrated in health, social, and workplace programs, services, and policies.

Employers need to address the identified vulnerability of employed mothers, especially those in support positions, to workplace pressure to minimize their use of available health and family policy provisions. Women valued the progressive, family friendly benefits and policies provided by their employer. In addition to formal support from personal and family leave policies, health benefits, on-site health facilities, and assistance programs, many women received informal support from supervisors and co-workers for flexible time to meet family demands that encroached on the paid work day. Many women, however, also found that their access to benefits, policies, and flexibility was constrained by workplace pressures, particularly from supervisors, to meet expectations as good workers who kept their family life out of the workplace. In the workplace, employers need to develop and support the implementation of family friendly policies including provisions for flexible working conditions, personal and family leave, and health benefits within their organizations. I agree with Lowe's (2000) advocacy of flexible provisions for work-sharing, "cafeteria-style" benefit options, and funded educational and sabbatical leaves. Importantly, employers need to ensure the availability

of such workplace policy provisions to support staff as well as management positions.

Women's experiences in this study reveal that policy development without attention to policy implementation is insufficient. Employers need to ensure that employees are fully supported to access available policy provisions intended to promote work-family balance among all employees. Supervisor orientation and in-service could address the importance of employee access to available workplace benefits and policies, as well as strategies to promote flexibility and respectful relationships among supervisors and co-workers. Additionally, in-services could sensitize supervisors and employees to the links between stress, absenteeism, and productivity and the value of creating supportive workplace environments. The establishment and support of union-management or employee-employer committees could promote better communication about women's, and all employee's, concerns and a forum for collaborative resolution of issues. Similarly, workplace wellness initiatives could be supported to broaden their focus to include workplace conditions that promote support and flexibility, in addition to the more common focus on lifestyle risk reduction and occupational health and safety. Wellness initiatives could also establish creative means, such as web-based discussion groups, to promote support and information sharing among employed mothers and other employees with caregiving responsibilities about strategies to achieve balance.

Employers need to recognize and be responsive to the continuing personal, family, and social pressures on women to fulfill primary caregiving responsibilities. Study findings revealed how employed mothers regularly confront the discontinuity between social expectations of the good mother and the good worker that reflect traditional, gendered female and male social roles. These roles are further reflected in the workplace where clerical and service support positions are mainly held by women. Gender dynamics frequently have been minimized or ignored in workplace initiatives intended to promote a transition to more progressive, gender desegregated, and humane workplaces (Henry & Franzway, 1993). For example, the focus group report that formed the basis for the workplace wellness initiative discussed in the current study, acknowledged the importance of including a demographically diverse sample of employees, but did not

consider gender-based analysis of findings and recommendations. Gender dynamics need to be acknowledged by employers and employee representatives alike, so that gender-based issues can be identified and addressed. The recent shift to gender-neutral language in policy and public discussions has masked, but not changed the pressures on employed mothers (Baker, 1997).

Employer support for the use of family friendly policies by men as well as women could promote a shift, advocated by women in this study, from current social pressures based on traditional gender roles toward social as well as workplace gender-equity. Employed fathers can be supported to use available policies to share family responsibilities, even as employed mothers need to be supported. I agree with scholars concerned that failure to support the use by men as well as women of family policies may inadvertently reinforce existing disadvantage for women in the workplace (e.g. Bergman, 1997; Eichler, 1997). Women have been the primary users of family policy and alternative work schedules such as part time hours. As long as women more often than men accommodate paid work to family work, family work will remain associated with women's work (Bergman, 1997). Without movement toward gender-equity, current tensions generated between the social ideals of the good mother and the good worker likely will continue to create substantial stress for employed mothers. Such stress is a concern for women's health directly, as well as indirectly when women place priority on family caregiving and neglect self-care.

Employers, program and service providers, and policy makers in all sectors, not just health and social sectors, need to establish formal procedures to incorporate gender and diversity based analysis as part of policy, program, and legislation development. Such analysis focuses on an assessment of the differential impact of policies, programs, and legislation on men and women (gender based), as well as on people in diverse circumstances (diversity based) that include cultural, ethnic, economic, and personal differences from the dominant view (Status of Women Canada, 1998). Guidelines for gender based analysis can be adapted to reflect consideration of diversity more generally. Two examples of gender based guidelines already in use in Canada are available from

Status of Women Canada (1998) and from the British Columbia Ministry of Women's Equality (1997). Analytic guidelines are intended to promote awareness and resolution of potential inequities that result from differences among people affected by existing and proposed policies, programs, or legislation. The women in the current study regularly faced situations, such as supervisor nonsupport for use of family leave or school demands for in-class volunteers, in which conflict between their multiple family and paid work responsibilities might have been reduced or avoided if existing policies and programs had been more responsive to gender based differences.

Many of the recommendations for policy development and implementation in this study are consistent with those advocated by health and social science scholars (e.g. Baker, 1997; Daly, 1996; Lowe, 2000; Messias, et al., 1997; Neal, et al., 1993; Ruzek, 1997; Wuest, 1993, 1998). Although the recommendations based on the current study may not be unique, their importance to the employed mothers in this study supports the need to continue advocating for change.

Implications for Practice in Nursing and Health Promotion

When asked what they would say to other women with family responsibilities who were considering also taking on paid work responsibilities, women made suggestions that corresponded with the multiple strategies identified from their descriptions of balancing solutions. I asked for their suggestions to other women as a closing question in the follow up interview and the focus group. A summary of their suggestions is provided in Appendix I as a possible informational handout to women, whether they are preparing for or already dealing with the multiple responsibilities of paid and family work.

Women's suggestions and the corresponding strategies used by women to balance decision making form the basis for my practice recommendations to nursing and health promotion practitioners who work with employed women and their families. Women focused primarily on what individual women might do to prepare and sustain themselves. Women also focused on what they might do to secure adequate support from their families, social network, workplace, and social system. The women in this study recognized that family, workplace, and social conditions could be changed to promote the

achievement of balance in health decision making and health work, but expected that such change would be slow and long-term. Therefore, they made suggestions more likely to be within the individual and immediate control of women in their everyday lives.

Asking women and their families what being healthy means to them is a simple assessment strategy that could be used by nurses and health promoters. Women's meanings of being healthy and having a healthy family comprise one aspect of the social context of their health actions and health decision making. Understanding women's meanings is essential to understanding their daily experiences of health and health work for themselves and their families.

Exploring family health activities and routines with a woman and her family is a means of promoting their reflection on the interplay between meaning and action in everyday life. Such reflection encourages greater awareness of health promoting and potentially damaging actions that are part of family routines. This awareness can form the basis from which a woman and her family can examine current health actions and routines, both as individuals and as a family group, and consider areas for development or possible change. This recommendation is consistent with Denham's (1999a) contention that family health routines provide a means of connecting with health promotion strategies for change. Recognized family health routines provide a basis for developing acceptable and workable modifications to individual and family behavior that serve to strengthen health promoting family health routines.

Like the women in this study, other women, their families, and health practitioners need to recognize the constant demand for health decision making and that decision making changes over time and by situation. Women's everyday circumstances were characterized by continuous demands, constant change, and the challenge of multiple concurrent responsibilities in family and paid work. Women advocated accepting that they would do their best to balance decisions under the circumstances they faced. Women focused on making decisions that were reasonable, acceptable, and practical at the time. Practitioners can provide opportunities for women and their families to identify family and social circumstances that support and constrain their health decisions.

The importance to women of being able to let go of inflexible expectations and demands underscores the need for practitioners to work with women to reflect on what they expect of themselves in their various areas of responsibility in family and paid work. Additionally, women can be encouraged to reflect on their priorities, whether these include self-care, and how they might let go of selected demands to support focusing on priorities. From this reflection, women can be supported to examine strategies to maintain or increase their flexibility and their comfort in how they manage everyday health work.

Strategies for sharing decision making with their partners, asking for help, and using available family support can be encouraged by practitioners, recognizing the importance of these strategies for women in the current study. Women can be encouraged to reflect on how family responsibilities are assigned within the family and how they might strategically increase and maintain support and shared responsibility. I concur with Denham's (1999a) caution to practitioners to recognize the potential consequences of implicitly pressuring women as mothers to fulfill a primary role as family health caregivers. I support Denham's suggestion that practitioners address with women ways to frame shared responsibility within families. Shared responsibility can reframe health caregiving as family work. Such reframing relieves women of assumptions that health caregiving is their primary responsibility and that their need for support implies personal inadequacy in fulfilling this responsibility.

Practitioners can help employed mothers identify strategies to use resources and work around constraints to achieve balance in decision making. Practitioners can help women reflect on and sustain their own resources by using time out, recognizing self rewards, and using spiritual support in ways that are comfortable for them. Women and their families need to consider how their family, workplace, and social circumstances influence their health decision making and health work. Such consideration needs to include reflection on individual and family strategies that might help them recognize and respond to personal and social context influences on health decisions and actions in daily life. For example, women in this study chose paid work with flexibility, including flexible and part time hours and informal supervisor support to meet family demands. Women

also accessed available benefits provided by their employer and health and social system services. To work around situational constraints, women delayed demands, planned contingencies, used acceptable alternatives to preferred choices, and persisted in accessing chosen alternatives. Practitioners can explore women's use of these strategies to stimulate consideration of strategies responsive to women's family and social context.

Implicit in my discussion of implications for nursing and health promotion practice, is my position that practice needs to be framed within conceptualizations of health, family, work, and life context consistent with the inclusive meanings represented in this study. This position suggests the need for review of nursing and health promotion education curricula, course content, and practical experience. Critical challenges of dominant views about work, family, and responsibility; recognition of the multiple dimensions of women's work; and examination of existing policies, programs, and practices that disadvantage women need to be integrated in education programs. I support the contention by Messias and colleagues (1997) that such integration is a component of expanding the visibility of women's work, in all its forms, and of incorporating this expansion in everyday practice with women and their families.

Along with the women in this study, I hope that their experiences can provide guidance to nursing and health promotion practitioners about ways they can work with employed mothers and their families to promote health. Women in this study willingly shared their experiences as employed mothers trying to balance health decisions in their everyday lives. Women who shared their experiences hoped to learn from other employed mothers about better ways to balance their decisions and lives. They said they did learn from each other when they reflected on interview summaries and participated in subsequent interviews. Women also hoped to help other employed mothers find ways to achieve balance more easily. The preceding recommendations are part of my commitment to helping women realize this hope.

Contribution to Critical Feminist and Nursing Research Design

The design of this study was based on my contention that symbolic interactionist theory, feminist theory, and critical theory could be methodologically integrated as a

critical feminist grounded theory method of research. My stated intent in using this integrated method was to support a research focus on individual meaning and action concurrently with a focus on the social institutional influences that shape this meaning and action. In keeping with critical and feminist theory, the research was intended to contribute to emancipatory transformation for women. I believe that this study represents substantial progress toward achieving my intent. I engaged a critical feminist perspective in the development of the substantive grounded theory of finding a balance that integrates the personal, family, and social contexts of employed mothers' everyday experiences of health decision making.

I agree with Wuest (1995) that the use of a critically-interested grounded theory method requires continuous reflexivity in the research process. This reflexivity has contributed to the development of my own ideas about the method and suggestions for consideration by other researchers engaged with similar methods. My suggestions focus on issues related to the potential for harmful effects on participants, the influences on theory development, the expectations for participant involvement in the research process, and the emancipatory intent of critical feminist research.

Potential for Harmful Effects on Participants

Guided by Wuest's (1995) reflection on the potential for harmful effects on participants of the research interview, I was consciously sensitive to women's reactions during interviews. I intentionally used language to facilitate comfort and mutual understanding. I used my experience as a community health nurse to prepare myself to deal with potentially sensitive topics and the resulting emotions. Several women chose to talk about sensitive issues and some women became emotionally upset during interviews. However, women chose to continue interviews and indicated they appreciated the opportunity to reflect on these issues with someone considered by them to be neutral and a safe distance from their daily lives. My greatest challenge was dealing with the woman who agreed to a follow up interview, then cancelled and subsequently withdrew from the study. I was concerned that she felt guilty about withdrawing, given her apologetic wording and upset tone of voice when leaving a voice message for me. I chose to respond

directly to her by following up with a written message reassuring her that I understood and supported her decision. In turn, she thanked me for the reassurance. On reflection about this exchange, I recognized that efforts to establish rapport with study participants could inadvertently pressure them to participate beyond their comfort. The need for researcher sensitivity to this pressure has been reinforced.

Influences on Theory Development

The chosen research method, critical feminist grounded theory, raised issues for theory development during the research process. I found that my presentation of study findings was influenced by my commitment to discuss interpretations with the women who participated in the study. I also shared the caution of other critical scholars (DeMarco, Campbell & Wuest, 1995) about presenting findings with consideration for how the theory might be interpreted by other women and how the theory might be used against women. Additionally, my interest in developing a theory that could be influential in program and policy development directed my focus on women's workplace and social context. This focus supported my examination of social institutional influences on women's experience. This examination raised questions about the similarities and distinctions between the critical feminist grounded theory method used in this study and Smith's (1987) institutional ethnography. Each of these issues will be discussed.

The commitment to discuss data interpretations with women usefully served to "keep me grounded" in the data as it reinforced the value of reflecting participant voices in the developing codes, categories, and theoretical presentation. However, at times I struggled with how to present my interpretations and developing theoretical links. I tried to balance the need to present ideas clearly without theoretical jargon with the need to avoid over-simplifying the ideas. I introduced selected concepts in discussions with women during follow up interviews in order to explore their sense of fit with these concepts. The strategy worked well, providing direct response from women that was incorporated in the continuing theory development. For example, I asked women about social pressures on them associated with the ideal of the good mother, as well as about the concepts of balancing and juggling.

My concerns about clarity and accuracy in presenting the study findings extended to a concern about how the developing theory would be understood by other women and how it might be used by scholars as well as program and policy developers. For example, in presenting women's experiences of conflicting demands between family and paid work, I avoided implying that these are inherently opposing demands. Certainly, the women in this study did not view the demands in this way, even as they recognized the potential for conflict. Rather, women looked for workable strategies that supported combining family and paid work. I have tried to present the theory of finding a balance consistent with women's views.

My intention to develop a grounded theory potentially useful in program and policy development guided my focus on the workplace, health, education, and social system contexts of women's experiences. I situated my examination of women's personal and family circumstances in the broader social context, reflecting how women tended to begin with their individual viewpoint then consider social influences on their experience.

The in-depth examination of social institutional influences on women's health decision making illustrates the similarities in data analysis between a critical feminist grounded theory as developed in this study and Smith's (1987) institutional ethnography. My analysis for this section of the study was guided by Smith's work. In both critical feminist grounded theory and institutional ethnography, the point of departure for study is women's everyday experience. The intent in both is to explicate how this experience is socially organized. I contend, however, that critical feminist grounded theory is distinguished from institutional ethnography by the emphasis in grounded theory on examining social process. As such, my examination of social institutional influences on women's decision making had to be integrated with my examination of women's meanings and actions in the process of decision making.

Expectations for Participant Involvement

A repeat interview study design was chosen deliberately to promote rapport and comfort for the women with the issues discussed and with me as a researcher. Repeat interviews also provided several opportunities for women to respond to my

interpretations to confirm, clarify, or modify the developing concepts and proposed theoretical linkages. I was aware that these opportunities could become oppressive to women if the researcher dictates the type and intensity of participant involvement (Wuest, 1995). I discussed with the women various opportunities for their involvement, sought their agreement before pursuing each of these opportunities, and structured interviews to facilitate their control over the intensity and time commitment of their involvement. Additionally, I offered women alternatives for responding to my interpretations, including by telephone, in-person, or electronic mail. All of these alternatives were used during the study.

Emancipatory Intent

A central tenet of critical feminist design is that the research contribute to emancipatory transformation toward improving the social conditions of women's everyday experience. I believe the current study realized this potential for the women participants. Women thanked me for the opportunity to examine issues important to them in their daily lives. Women said that this examination helped them to reflect on their experiences, including expectations and meanings, and to consider potential changes they could make to improve their everyday lives. The two interview summaries provided women an opportunity to learn about other women's experiences. Many women commented that they gained a clearer sense of shared experience, reducing their feeling that they were abnormal or somehow inadequate when they faced difficulties dealing with their multiple responsibilities for paid and family work. Women also supported my intention to make public the study findings and recommendations.

My commitment to make findings public includes a commitment to provide a written summary of the knowledge generated from the study to the local union representing most women who participated. The union staff supported the research proposal and have expressed interest in reviewing study findings for potential contribution to joint union-management discussions about workplace conditions. Additionally, I have committed to providing a written summary to the coordinator of the employer-sponsored workplace wellness committee that was created while the study was

in progress. The coordinator indicated interest in study findings that could support the development of initiatives to address identified workplace issues. Finally, I have committed to publish the study findings so that they are accessible to women, as well as to researchers and practitioners interested in health promotion with employed mothers and their families. The influence of these methods of publicizing study findings on program and policy development, and subsequently on women's everyday lives will need to be reviewed in the future.

The critical feminist grounded theory method engaged in this study extends the repertoire of critically-oriented research methods suitable for nursing research. The method reflects an interdisciplinary approach to knowledge generation. In this study, interdisciplinarity was achieved by my theoretical integration of the health and social science knowledge bases within which the theory has been situated, as well as by the interdisciplinary membership of my doctoral committee.

Conclusion

Findings of this study and relevant published research suggest that across diverse social circumstances, there exist important common themes in women's decision making to manage health and caring work. Women's everyday experiences of health decision making continue to be framed by social expectations that reinforce women's primary responsibility for health and caring work, in addition to their responsibilities for paid work. Yet, workplace and social institutional conditions are inconsistently responsive to women's multiple responsibilities. Documenting women's issues is necessary in order to create the potential for change that will confront social, workplace, and family responsibilities, as well as women's responsibilities for health. Finding a balance in health decision making, therefore in everyday living, is important to the well-being of women and their families; it is as important to workplaces, communities, and society.

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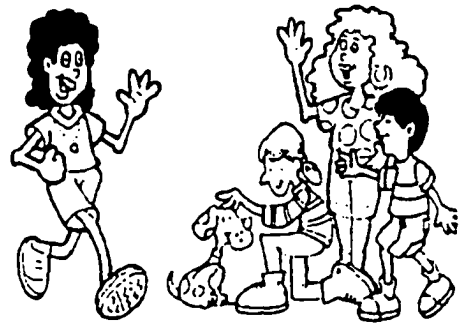
Appendix A
Recruitment Notice for Participants

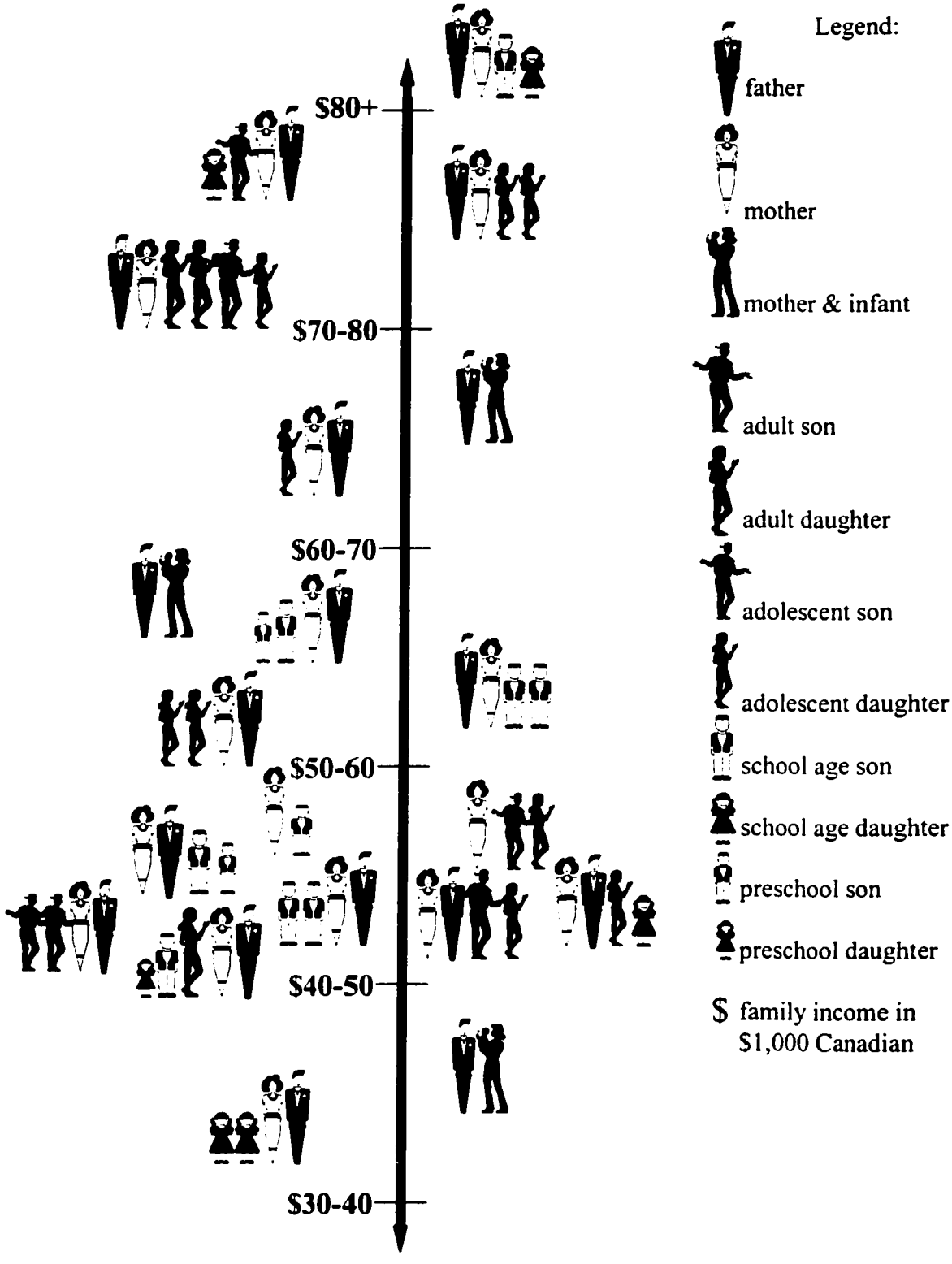
EMPLOYED MOMS

Do you work outside the home at least 20 hours per week?
Do you have a child under 18 years old living at home?

Moms look after the health of their family everyday. I would like to talk with you about how you do this.



Appendix B
Family Configuration by Family Income for Study Participants



Appendix C
Background Information Form

Participant Information **Research Code:** _____

Age (in years): _____

Years of **education** completed:

<Grade 9 ____ Grade 9-13 ____ Trade or technical certificate/diploma ____

University undergraduate degree ____ University graduate degree ____

Employment Status:

Full-time _____ Regular Part-time _____ Irregular or Casual Part-time _____

Hours worked per week: _____

Occupation: _____

Family membership (Total number in household, gender, age, and relationship)

_____

_____

_____

_____

If applicable, Partner's information:

Age (in years): _____

Years of **education** completed:

<Grade 9 ____ Grade 9-13 ____ Trade or technical certificate/diploma ____

University undergraduate degree ____ University graduate degree ____

Employment Status:

Full-time _____ Regular Part-time _____ Irregular or Casual Part-time _____

Hours worked per week: _____

Occupation: _____

Annual Family Income (in $1,000's):

<10 ____ 10-<20 ____ 20-<30 ____ 30-<40 ____ 40-<50 ____

50-<60 ____ 60-<70 ____ 70-<80 ____ 80> ____

Appendix D
Initial Individual Interview Guide

I am talking to women who work in their homes caring for their families and who also work at a paid job. I am interested in learning how women make decisions about their own health care and practices. I am also interested in knowing how health decisions are made for other family members.

1. Please tell me about a "typical" workday, both at home with your family and at your job.
   (a) What are your day-to-day responsibilities at your job? With your family? In your home? In your community?
   (b) What do these responsibilities mean to you in your daily life? What does being an employee, a mother, +/- a wife/partner, a family member, a community member mean to you?
2. (a) Please tell me about some of the recent health decisions you have made for yourself.
   (b) Also, please tell me about some of the recent health decisions you have made for someone else in your care.
(May need to prompt with typical examples such as: How do you decide when and how to take personal time? How do you decide what you eat? Or what to feed your family? How do you decide when a child is ill enough to need to go to a doctor or to be kept home from usual activities?)
3. (a) What do you do to take care of your health? How do you decide what to do for yourself?
   (b) What do you do to take care of the health of others in your care? (Probe: Whose health do you take care of - children, partner, extended family?) How do you decide?
4. (a) What helps you take care of your health and the health of others in your care? How?
   (b) What does not help? How?
(To examine influence of social context, prompt re: workplace, social support, health and community services, personal expectations, family relations and expectations, availability of information.)
5. (a) What does being healthy mean to you? How would you describe your health generally?
   (b) What does having a healthy family mean to you? How would you describe your family's health generally?
6. Is there anything else you want to add now?

Thank you for talking with me. Now that this interview is done, I want to confirm that you are willing to let me include this interview in the study. Are you still willing to let me include the interview?

Appendix E
Follow-up Individual Interview Guide

To begin, please fill me in on any important changes in your personal, family, or workplace situation since our last interview. If these changes have made a difference in how you take care of health for yourself and your family, please describe the differences.

I am interested in your thoughts about the summary that I sent you. I wrote about my impressions from the initial interview with you and the other women. I'd like to work through the sections of the summary and hear your thoughts about how each fits for you and what corrections or additions you'd make.

Overall demands, supports, barriers

Views of personal and family health

Process of "Finding a balance"

Does image of balance fit for you? Some women talk about "juggling" rather than balance - how does the image of juggling compare to what you said about balance?

Do you agree with the characteristics of balance, reasonability, practicality?

List of demands - which are most important for you?

Process of decision making - are the phases accurate? What would you change?

Types of responsibility in decision making - do these fit? Where are you?

Some women talked about an experience or event (eg. personal illness, birth of twins) that seemed to be a "turning point" in their approach to their responsibilities and decision making.

For women who talked about this - (Briefly describe the event and changes.) Have I understood the event and resulting changes?

For women who did not talk about this - Is this part of your experience? What changes resulted?

What advice would you give to another mother who is preparing to return to employment?

Do you have anything else you'd like to add?

Again, I want to make sure that you are willing to continue to participate in this research. Now that you know what we've talked about, are you willing to have me use this interview?

When I have reviewed all follow-up interviews, I will again write a brief summary. I will send this summary to you for your comments. As I expect this to be short, I plan to talk with you by telephone at that time.

Please let me know if your contact information changes. I would also like to get your home mailing address so that I can send a summary of the research to you when that is ready.

Appendix F
Focus Group Interview Guide

I have been talking to women who work in their homes caring for their families and who also work at a paid job. I am interested in learning how women make decisions about their own health care and practices. I am also interested in knowing how health decisions are made for other family members. I want to talk with you in this group about the ways your experiences are common to you as a group of employed mothers. I also want to talk about the ways your experiences may differ between you as individuals. In particular, I want to talk with you about how workplace policies and working conditions affect employed mothers' experiences and the health decisions they make.

1. I want to begin our talk by asking you each to tell us a little about yourself, your family, and your job. Please tell us your first name, who is in your family, where you work, and one interesting thing about your family or your job.
2. If you were talking to a woman about to re-enter the workforce as an employed mother, what suggestions would you give her about identifying a "health promoting workplace"? Think about a workplace that would support employed mothers in dealing with health responsibilities. What are the important features that she should look for?
    a. First, I want to talk about what she should look for to help her with her own care and health practices.
    b. Now, I want to talk about what she should look for to help her to care for the health of her family members.
3. What are the most important features of the workplace to support employed mothers? Specifically ask about policies for paid and unpaid leave, benefits (medical, EFAPs), on-site programs such as fitness facilities, childcare, lifestyle practices (e.g. smoking cessation).
4. (If time permits) What other changes in the family, in the community, in the health and social system, or in society would support employed mothers?

Again, I want to make sure that you each are willing to continue to participate in this research. Now that you know what we've talked about, are you each willing to have me use what you said in this interview?

Thank you for talking with me today. I know that your time and energy are precious and I very much appreciate you sharing it with us in this group.

Appendix G
Informed Consent Form for Individual Interviews
Information Sheet

Study Title: How Mothers Make Health Decisions as They Work in the Family and in Paid Employment

Investigator: Kaysi Kushner, RN, PhD Candidate, phone: 492-5667, Fax: 492-2551, e-mail: kkushner@gpu.srv.ualberta.ca

Sponsor: Faculty of Nursing, University of Alberta

Study Purpose: The purpose of this research is to learn how employed mothers make health decisions as they deal with family and paid work responsibilities. I want to learn how you think about your health and what you do to take care of your health. I want to know how you decide what to do for your health and how your family and job affect your decisions. I also want to learn about the decisions you make to take care of your family's health.

Study Background: I am a community health nurse working on a PhD degree in nursing. I am interested in women's and family health promotion. I know that employed mothers deal everyday with their many responsibilities at home and at work. I want to learn how employment as support staff affects mothers' health decisions for themselves and their families. Results from this study may help nurses work with community agencies and employers to provide policies, programs and services that will be helpful to employed mothers caring for themselves and their families. Results also may help employed mothers think about ways to deal with the many health decisions they make.

Study Procedures: I want to talk with you two times. The interviews will take place either in your home or in another place we agree on. I expect that the first interview will last about one hour. The second interview likely will be shorter. Also, I want to talk with you once by telephone after all interviews are done. You will be sent a summary of what was learned from the interviews. I will then telephone you to ask about your response to the summary.

I will tape record all interviews. What you say on tape will be typed out. Only I, the investigator, my supervisor and committee members, and a typist will listen to the tapes. Only code numbers will be used to identify tapes and transcripts. Tapes, transcripts, and notes will be kept in a locked file cabinet. They will be kept for seven years after the research is completed. Consent forms will be kept in a locked file separate from the tapes, transcripts, and notes. Consent forms will be kept for at least five years. Data may be used for another study in the future. The investigator must receive approval from the appropriate ethics review committee.

The information and findings of this study may be published or presented at conferences.

Your name or any information that may identify you will not be used. If you have questions or concerns about this study at any time, you can call the investigator at the number above.

Study Participation: You do not have to be in this study if you do not wish to be. If you decide to be in the study, you may drop out at any time by telling the investigator. You do not have to answer any questions or talk about anything in the interview if you do not want to. Being in this study or dropping out will not affect your care in a hospital or in the community.

I do not expect that you will be harmed by being in the study. Nor do I expect that you will benefit directly from this study. Sometimes talking about your experiences can be uncomfortable or can make you think about concerns you have not dealt with. I will talk with you about this if it happens and assist you with finding the help you need.

If you tell me any information about abuse of someone under 18 years of age, I will discuss this with you. I will need to report this information to Family and Social Services. I will also contact the community health nurse and ask her to visit you. This information cannot be kept confidential.

Additional Contacts: If you have any concerns about any aspect of this study, you may contact Dr. Janice Landers, Associate Dean Research, Faculty of Nursing, University of Alberta at 492-6832. Dr. Lander is not part of this study.

Informed Consent

Part 1 (to be completed by the Principal Investigator):

Title of Project: How Mothers Make Health Decisions as They Work in the Family and in Paid Employment

Principal Investigator(s): Kaysi Kushner, RN, PhD Candidate, phone: 492-5667, Fax: 492-2551,
e-mail: kkushner@gpu.srv.ualberta.ca

Part 2 (to be completed by the research participant):

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care in a hospital or in the community.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records?	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____
Signature of Research Participant Date

_____
Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Investigator or Designee Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Reading Level:

Information Sheet	**Grade 7.49**
Consent	**Grade 5.77**
Combined	**Grade 6.88**

Appendix H
Informed Consent Form for Focus Group Interviews
Information Sheet

Study Title: How Mothers Make Health Decisions as They Work in the Family and in Paid Employment

Investigator: Kaysi Kushner, RN, PhD Candidate, phone: 492-5667, Fax: 492-2551, e-mail: kkushner@gpu.srv.ualberta.ca

Sponsor: Faculty of Nursing, University of Alberta

Study Purpose: The purpose of this research is to learn how employed mothers make health decisions as they deal with family and paid work responsibilities. I want to learn how you think about your health and what you do to take care of your health. I want to know how you decide what to do for your health and how your family and job affect your decisions. I also want to learn about the decisions you make to take care of your family's health.

Study Background: I am a community health nurse working on a PhD degree in nursing. I am interested in women's and family health promotion. I know that employed mothers deal everyday with their many responsibilities at home and at work. I want to learn how employment as support staff affects mothers' health decisions for themselves and their families. After talking with employed mothers individually, I want to talk with them as a group. In the group, I want to focus on how workplace policies and working conditions affect employed mothers' health decisions.

Results from this study may help nurses work with community agencies and employers to provide policies, programs and services that will be helpful to employed mothers caring for themselves and their families. Results also may help employed mothers think about ways to deal with the many health decisions they make.

Study Procedures: In a focus group, I will talk with you about your experiences. It is expected that the focus group interview will last about one hour.

I will tape record all interviews. What you say on tape will be typed out. Only I, the investigator, my supervisor and committee members, and a typist will listen to the tapes. Only code numbers will be used to identify tapes and transcripts. Tapes, transcripts, and notes will be kept in a locked file cabinet. They will be kept for seven years after the research is completed. Consent forms will be kept in a locked file separate from the tapes, transcripts, and notes. Consent forms will be kept for at least five years. Data may be used for another study in the future. The investigator must receive approval from the appropriate ethics review committee.

The information and findings of this study may be published or presented at conferences.

Your name or any information that may identify you will not be used. If you have questions or concerns about this study at any time, you can call the investigator at the number above.

Study Participation: You do not have to be in this study if you do not wish to be. If you decide to be in the study, you may drop out at any time by telling the investigator. You do not have to answer any questions or talk about anything in the interview if you do not want to. Being in this study or dropping out will not affect your care in a hospital or in the community.

I do not expect that you will be harmed by being in the study. Nor do I expect that you will benefit directly from this study. Sometimes talking about your experiences can be uncomfortable or can make you think about concerns you have not dealt with. I will talk with you about this if it happens and assist you with finding the help you need.

If you tell me any information about abuse of someone under 18 years of age, I will discuss this with you. I will need to report this information to Family and Social Services. I will also contact the community health nurse and ask her to visit you. This information cannot be kept confidential.

Additional Contacts: If you have any concerns about any aspect of this study, you may contact Dr. Janice Landers, Associate Dean Research, Faculty of Nursing, University of Alberta at 492-6832. Dr. Lander is not part of this study.

Informed Consent

Part 1 (to be completed by the Principal Investigator):

Title of Project: How Mothers Make Health Decisions as They Work in the Family and in Paid Employment

Principal Investigator(s): Kaysi Kushner, RN, PhD Candidate, phone: 492-5667, Fax: 492-2551, e-mail: kkushner@gpu.srv.ualberta.ca

Part 2 (to be completed by the research participant):

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care in a hospital or in the community.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records?	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____

Signature of Research Participant Date

_____

Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____

Signature of Investigator or Designee Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Reading Level:

Information Sheet	**Grade 7.62**
Consent	**Grade 5.77**
Combined	**Grade 6.95**

Appendix I
From Women to Women: Strategies for Promoting Balance

From the women in this study to other women facing multiple responsibilities in family and paid work, the following is a list of suggested strategies for promoting balanced decision making:

1. Identify and keep your priorities and multiple demands in perspective.

2. Be aware of and accept your own expectations, abilities, and limits so that you can be comfortable with your choices without guilt or unnecessary stress.

3. Look after and rejuvenate yourself by making time for yourself, having fun, connecting with friends.

4. Develop your own sense of balance in your life by deciding if and how much paid work is good for you, by separating your expectations from those imposed by others, and by maintaining a sense of yourself as a woman.

5. Accept the need to deal with conflicting demands, plan for flexibility, and recognize the influence of family and social circumstances on your decisions and actions.

6. Secure partner and family support and participation in shared family responsibilities.

7. Secure social network support to help meet demands, talk about concerns, and look after yourself.

8. Secure good, reliable childcare.

9. Use available supports such as time saving appliances, house cleaning help, and adjusting expectations to reduce house work demands.

10. Know about and secure support for the use of workplace policies that enable dealing with conflicting demands from family and paid work.