

## Volume 6 Issue 3 - October 2012

### CONTENTS

|                             |   |
|-----------------------------|---|
| <b>EDITORIAL</b>            | Welcome to the latest Issue of MSo..... 1<br><i>Jacqueline Watts</i>  |
| <b>CONFERENCE PAPERS</b>    | <b>Plenary Papers presented at the<br/>MedSoc Conference, September 2012</b>  |
|                             | The Power and Potential of Grounded<br>Theory ..... 2<br><i>Kathy Charmaz</i>   |
|                             | Durkheim's Body ..... 16<br><i>David Armstrong</i>  |
| <b>CONFERENCE REPORT</b>    | Early Career Researchers' Event..... 21<br><i>Catriona Rooke et al.</i>   |
| <b>PEER REVIEWED PAPERS</b> | Family Unit in the Context of Diabetes<br>Management Among The Igala, North-<br>Central, Nigeria ..... 24<br><i>Samuel Ojima Adejoh</i>       |
|                             | Doctors at Risk of Job Burnout, Diminishing<br>Performance and Smoking Habits..... 36<br><i>Abida Abi Ellahi &amp; Rabia Mushtaq</i>          |
| <b>COMMENTARY</b>           | Familiarity Bonds: A Neglected Mechanism For<br>Middle-Range Theories Of Health & Longevity .. 48<br><i>Graham Scambler &amp; Aksel Tjora</i> |
| <b>RECENT PhD ABSTRACTS</b> | Young Adults' Discursive Constructions<br>of Chronic Illness Experience..... 52<br><i>Benjamin Saunders, Cardiff University</i>               |
|                             | Prison mental health: Context is crucial ..... 54<br><i>Melanie Jordan, University of Nottingham</i>  |

|   |    |
|---|----|
| Caring and working .....  | 56 |
| <i>Linda Birt, University of East Anglia</i>  |    |
| Neurofibromatosis Type 1 (NF1) .....  | 58 |
| <i>Daniele Carrieri, University of Exeter</i>   |    |
| Who joins a UK right to die society and why? ....   | 59 |
| <i>Marion Judd, Queen Mary University of London</i>   |    |
| Care closer to home .....   | 60 |
| <i>Charlotte Overgaard, Aalborg University/King's College</i>                                   |    |
| Involvement in practice.....  | 62 |
| <i>Sarah Robens, Peninsula College of Medicine &amp; Dentistry</i>                              |    |
| Chronic illness and self-management in primary<br>care .....                                    | 63 |
| <i>Lucy Moore, Peninsula School of Medicine and Dentistry</i>                                   |    |
| An Ethnography of Changes In The Giving<br>Relationship.....                                    | 65 |
| <i>Patricia Mahon-Daly, Bucks New University</i>  |    |
| Heart Transplantation: Its Risks, the Expectations,<br>and Cultural Negotiations in Japan ..... | 66 |
| <i>Ikuko Tomomatsu, Queen Mary, University of London</i>  |    |
| Towards the Camisation of Health .....  | 67 |
| <i>Joana Almeida, Royal Holloway, University of London</i>                                      |    |
| Empowerment and HIV Prevention among<br>Women in Nigeria.....                                   | 68 |
| <i>Oluwatosin Alo, University of Warwick</i>  |    |
| Schneiderman & Jecker: Wrong Medicine:<br>Doctors, Patients and Futile Treatment.....           | 69 |
| <i>Reviewer: Jacqueline Watts</i>   |    |

## BOOK REVIEW

## Editorial

**Jacqueline Watts**  
**Editor-in-Chief**

This latest issue of Medical Sociology online follows on from the highly successful BSA Medical Sociology 2012 conference held last month at the University of Leicester. The conference programme included papers covering a wide range of policy, theoretical and methodological issues of interest to medical sociologists.

This issue of Medical Sociology online opens with the conference plenary papers from Kathy Charmaz from Sonoma State University, USA and David Armstrong from Kings College, London. Charmaz offers some reflections on the power and potential of the grounded theory approach to qualitative inquiry and points out similarities and differences between major proponents of this methodology. Armstrong's paper compares Darwin's construction of the biological body, with that of Durkheim's body. While Darwin's body has underpinned Western medicine, Armstrong shows how the body as constructed by Durkheim, helps us to understand how the body's identity has changed over time. His critique highlights the tension between Darwin's and Durkheim's bodies and the on-going debate between biology and sociology.

This year, for the first time at the Medical Sociology conference, the main event was preceded by an afternoon workshop for early career researchers. Catriona Rooke and colleagues report on this workshop, which is expected to become a regular feature at the annual Medical Sociology conference.

Other content in this issue includes two peer-reviewed articles discussing very different topics. Adejoh's article considers the influence of the family in diabetes management among the Igala in north-central Nigeria, whilst Ellahi and Mushtaq explore the issues of job burnout, work performance and smoking habits among doctors in Pakistan. The commentary from Scambler and Tjora takes the form of a conceptual note that introduces the idea of 'familiarity bonds' that the authors suggest are likely to be protective of health.

A new section in this issue is that of abstracts from recently awarded PhDs. We hope that this will become a regular feature in forthcoming issues of Medical Sociology online but that is dependent upon submissions. So if you are a PhD supervisor, please encourage your students to submit their abstract. Alternatively, if you have recently completed a PhD, we would welcome hearing from you.

The issue concludes with a single review of a recently published book that seeks to restore a vision of medicine's proper ends and reform medical practice so that it is accountable to society. We would like to encourage readers to contribute reviews so if you have read a recently published book, or indeed an interesting article, that is relevant to our field, please consider submitting a short review for Medical Sociology online.

Finally, we welcome your comments and suggestions about ways in which we can continue to develop Medical Sociology online.

## The Power and Potential of Grounded Theory

**Kathy Charmaz**

Sonoma State University, USA

charmaz@sonoma.edu

This conference is the second time I have given an address at the University of Leicester. When I arrived the first time, I trudged up the street from the train station pulling a suitcase behind me. A misstep on the uneven pavement caused a fall that smashed my glasses into my eyebrow. Such wounds often bleed profusely but may not be serious. Despite my protests, two young women called an ambulance, which arrived forthwith. The two emergency technicians examined, cleaned, and bandaged the cut with strips. They said that they thought it would heal without stitches but would be glad to take me to the hospital, should I wish to go. I agreed that a hospital visit was not necessary and promised to follow their advice to apply ice packs to the wound. At this point, the technicians looked at each other, nodded, and without saying a word between them, took their seats and drove me to my hotel. They left me at the hotel door with a swollen, red eye but feeling very well cared for. I began my opening address the next morning by telling the audience that I was giving whole new meaning to arriving in the UK with the Red Eye.

In the town where I live in the US, an emergency ambulance call enlisting the care of two emergency medical technicians followed by non-emergency transportation of less than a mile would be approximately \$1300 US. The costs would rise if the treatment involved any of the following: more serious procedures such as defibrillation, paramedics, who are more skilled, further distance and emergency transport after initial treatment. Would your insurance pay for this medical misadventure? Maybe. It depends on definitions of 'emergency,' as well as diagnoses and deductibles and whose definition prevails. Claims that do not fit the standard parameters of an insurance policy may be routinely denied. The moral of this story? *Preserve your national health service.*

Now I turn from medical misadventures to grounded theory adventures. Why use grounded theory? In which ways does this method have power and potential? To enable us to consider these questions, we need to start with a definition of grounded theory. What is it? Grounded theory is a systematic method of analysing and collecting data to develop middle-range theories. This method begins but does not end with inductive inquiry. It is a comparative, iterative, and *interactive* method. The emphasis in grounded theory is on analysis of data; however, early data analysis informs data collection. Most grounded theorists follow an iterative approach, many make comparisons, few construct theory. But the potential is there.

I aim to offer a short introduction to grounded theory to clarify questions about the method that you may have. Much more detailed presentation of flexible grounded theory strategies can be found in my 2006 book, *Constructing Grounded Theory*, its forthcoming revision, and Juliet Corbin's 2008 revision of *Basics of Qualitative Research*. Rather than only talking about the power and potential of grounded theory, I also want to show you a bit of grounded theory guidelines and suggest where they can lead you. Along the way, I will point out similarities and differences between major proponents of grounded theory.

Grounded theory is a method for studying processes; it is also a method in process (Charmaz, 2009). This method can be adopted by researchers who hold different theoretical

perspectives, focus on various levels of analysis, pursue varied objectives, and address diverse areas - including social justice research, policy analyses, organisational studies, societal issues - and social psychology. Critics of the method sometimes conflate how leading proponents have used the method with the method itself. Major grounded theory strategies that I will discuss here include coding, memo-writing, and theoretical sampling, the most misunderstood strategy. Theoretical sampling means sampling for development of a theoretical category, not sampling for population representation.

In my view, scrutiny of grounded theory and qualitative inquiry reveals reciprocal influences over the past 45 years. Grounded theory has had profound influence on the development of qualitative methods. Qualitative researchers who subscribe to other forms of analysis often use coding and memo-writing strategies. Qualitative inquiry has had profound influence on several contemporary renderings of grounded theory (see for example, Birks and Mills, 2010; Bryant & Charmaz 2007; Charmaz, 2000, 2006, 2011; Corbin and Strauss, 2008; Clarke 2005; 2007; 2012). Reflexivity and representation of research participants, for example, have influenced most second generation grounded theorists. Barney Glaser (1998, 2005, 2009), in contrast, differentiates his version of grounded theory from qualitative inquiry and rejects common practices within it, such as beginning research with a literature review, making accuracy a central concern, transcribing interviews, and sample size. Glaser and his followers do not explicitly attend to epistemological questions about data collection and quality, research relationships, and researchers' roles and standpoints, as Corbin and Strauss (2008) and my constructivist version do.

How has grounded theory influenced qualitative inquiry? It served to legitimise inductive qualitative inquiry at a time that it was losing ground in the United States. Quantitative researchers saw qualitative research as idiosyncratic, impressionistic, unsystematic, biased, and impossible to replicate. Over the decades, some cynics claimed conducting grounded theory to legitimate their studies while many researchers believed that they used grounded theory but did not. Rosaline Barbour (2003), Antony Bryant (2003), Ian Dey (1998), Derek Layder (1998) and numerous others, including myself, have taken issue with Glaser's (1978, 1998, 2001; Glaser and Strauss, 1967) insistence on delaying the literature review to avoid preconceiving data analysis.

Many, if not most, qualitative researchers have adopted some grounded theory strategies. These qualitative researchers engage in simultaneous data collection and analysis, coding, and memo-writing but use the strategies in a more general way than grounded theorists do. As a result, their work does not realise the power of grounded theory. Must a researcher use all the strategies of grounded theory? Jane Hood (2007) contends that researchers must engage in theoretical sampling to claim using grounded theory. Do most researchers engage in theoretical sampling? No. Grounded theorists' claims to constructing theory might be a little over-stated. Nonetheless, using grounded theory strategies fosters giving your work an *analytic edge*. What constitutes theory has neither been agreed upon nor codified. I say use the strategies that work for you and your study but be aware of what you do and what you claim.

I view grounded theory as a general method but one that has been generalised - and diluted (Charmaz 2009). Many qualitative researchers have adopted coding and memo-writing strategies as an integral part of analysing their data but how they code data and write memos differs from grounded theorists.

Grounded theory has certain distinctive features that distinguish it from other forms of qualitative analysis (see Wertz et al. 2011). What are the distinctive features of grounded theory? This method:

- Provides explicit tools for studying processes
- Promotes an openness to all possible theoretical understandings
- Fosters developing tentative interpretations about the data through coding and categorising
- Builds systematic checks and refinements of the researcher's major theoretical categories.

Grounded theory is primarily a method of analysis. Grounded theory guidelines call for using each phase of inquiry to raise the analytic level of the work. Developing theoretical categories is a central part of the analytic process. We grounded theorists fill out, check, and presumably saturate the properties (i.e. characteristics) of our theoretical categories with data. In addition, we look for variation in these categories and relationships between them.

Most qualitative studies address “what” and “how” questions. Researchers identify their topic or theme and then show how participants view, act, and feel about it. Jaber Gubrium and James Holstein (1997, 2002) describe how we address what and how questions. They, like Jack Katz (2002) and Snow, Morrill, and Anderson (2002) express concern about the descriptive nature of much qualitative research. Gubrium and Holstein (1997) propose that naturalistic qualitative researchers could address “why” questions “by considering the contingent relations between the *whats and hows* of social life” (p. 200). I propose that grounded theory gives you tools to answer “why” questions from an interpretive stance. By interrogating our data - and emerging ideas - with analytic questions throughout the research, we can raise the level of conceptualisation of these data and increase the theoretical reach of our analyses.

### **Getting to Why Questions with Grounded Theory**

What are the main analytic strategies of grounded theory? These consist of coding data from the start of data collection, using comparative methods, writing memos, and conducting theoretical sampling to fill out your emergent theoretical categories and make them robust. Grounded theory involves using comparative methods at all levels of analysis. Thus, grounded theorists compare data with data, data with codes, codes with codes, codes with categories, and their finished analyses with relevant theoretical and research literatures. The last form of comparison has been scant among grounded theorists, as Rosaline Barbour (2003) has noted.

By analysing both your data and your emerging ideas about them throughout inquiry, you integrate and streamline data collection and analysis. Through studying your emerging analysis, you focus data collection on analytic questions. Gathering focused data helps you to test and sharpen your ideas. *Grounded theory strategies enable researchers to control and to expedite the research process.*

So how do grounded theory strategies work in practice? As I answer this question, I aim to show not only how you can control and expedite your research but moreover, the power and potential of the method.

### **Starting with Coding**

Like the overall method, grounded theory coding is inductive, comparative, interactive, and iterative - and later - deductive. Do we begin coding as a *tabula rasa*, encased in theoretical innocence and substantive ignorance? Not a chance. Karen Henwood and Nick Pidgeon's

(2003) stance of theoretical agnosticism makes more sense. They argue that grounded theorists should subject prior theories to rigorous critical analysis rather than ignoring or denying them. I have long advocated acknowledging and grappling with our starting points and standpoints and the shifting positions we make and take as our studies proceed (see, for example, Charmaz 2000, 2006, 2009). I also advocate beginning coding with general sensitising concepts (Blumer 1969; van den Hoonaard 1997). As a social psychologist, I think about self, identity, and interaction. As a methodologist who takes grounded theory into social justice research (Charmaz, 2005, 2011), I am attuned to concepts such as power, privilege, equity, and oppression. In any case, if the sensitising concepts don't fit, don't use them.

Two aspects of grounded theory coding distinguish it from other forms of qualitative research: First, grounded theory coding involves a close coding of statements, actions, events, and documents. This coding does more than sift, sort, and summarise data. It breaks the data up into their components or properties and defines the actions that shape or support these data. We code for processes, actions, and meanings. Most qualitative researchers, and some grounded theorists, code for topics and themes. Coding for actions and processes helps researchers to define connections between data

Second, grounded theory coding invokes analytic questions from the start. These questions include:

- "What is this data a study of?" (Glaser, 1978, p. 57; Glaser and Strauss, 1967)
- What do the data suggest? Pronounce? *Assume*? (Charmaz, 2006, p. 47)
- From whose point of view? (Charmaz, 2006, p. 47)
- What theoretical category does this datum indicate? (Glaser, 1978)
- "When, how, and with what consequences" are participants acting? (Corbin & Strauss, 2008)

Such questions foster analysing the data rather than describing them. I advocate looking for research participants (and our own) tacit assumptions and explicating their implicit actions and meanings. This type of coding can help us crystallise significant points early in the research.

The unit of coding needs to fit the purpose of the study. Grounded theorists may code line-by-line, paragraph-by-paragraph, incident-by-incident, or story-by story. I advocate line-by-line coding in the early stages of research as a *heuristic device*, particularly for interview data. Line-by-line coding means labelling each line of data. This type of coding helps us to see our data anew. Line-by-line coding means that researchers actively engage with data and begin to conceptualise them.

Codes rely on *interaction* between researchers and their data. Codes are not something to be discovered on your way to theory construction. Neither are they prescriptive formulae to be applied to your data as Corbin and Strauss (1990, 1998) imply and have spawned much criticism and debate (Atkinson, Coffey and Delamont, 2003; Glaser, 1992, Kelle, 2005; Melia 1996). Rather, codes consist of short labels that we construct as we interact with the data. Something kinesthetic occurs when we are coding; we are mentally and physically active in the process. I also advise researchers to code in gerunds, the noun forms of verbs, to the extent possible. Gerunds build action right into the codes. Hence, coding in gerunds allows us to see processes that otherwise might remain invisible.

Most qualitative researchers code for topics and themes. Grounded theorists code for actions and meanings and do so in gerunds, as much as possible. Of course you may have different

actors portrayed in your codes even if you use interview data. Line by line coding probably works best with interview and narrative data. Using gerunds is difficult at first but you rapidly gain speed and confidence. And the process sparks your ideas. When you grapple with line by line coding, you may be amazed at how much more you see in your data than when you code for topics and themes. Observe the differences between coding the same data for topics and themes and coding with gerunds.

| <b>Example - Coding for Topics and Themes</b>  |   |
|--|---|
| <b>Examples of Codes</b>   | <b>Narrative Data to be Coded</b>   |
| <p>Friends' support</p> <p>Hospitalisation</p> <p>Conflict with doctor</p>           | <p>P: They called the clinic to see if they could see me, if they would re-evaluate some of my meds and stuff, and they said, "Oh yeah." When I got there they decided that they were going to put me in, put me away or whatever. And I ended up with a really bad doctor. Really bad. I even brought charges against him, but I lost.</p> <p>I: What did he do?</p>   |
| <p>Hospital transfer</p> <p>Loss of choice of doctor</p> <p>Conflict with doctor</p> | <p>P: They put me in this one place, then the next day they sent me over to West Valley [hospital 60 miles away], and they didn't have any female doctors there, they only had male, so you didn't have a choice, and you get one and that's who you get the whole time you're there. For some reason he just took a disliking, I guess, and I tried to tell him about some of the problems I had with my Lupus and stuff, and angered him. [He had ordered her to take off her dark glasses.] And I wore [dark] glasses all the time and I tried to tell him, you know, that if he would turn off the fluorescent lights, I would take off the glasses. And he felt I was just being stubborn. I gave him the name and number of my doctor that makes the glasses and he just ripped it up in front of me and threw it away.</p> |
| <p>Physician control</p>   | <p>From Kathy Charmaz, 2011, <i>Grounded Theory Methods in Social Justice Research</i>, in N.K. Denzin &amp; Y. Lincoln (Eds.), <i>Sage Handbook of Qualitative Research</i>, Thousand Oaks, CA: Sage Publications, p. 369. Reprinted by permission of Sage Publications. Please contact the publisher for any further usage.</p>   |



| <b>Example: Initial Grounded Theory Coding</b>   |   |
|--|---|
| <b>Examples of Codes</b>   | <b>Initial Narrative Data to be Coded</b>   |
| <p>Receiving friends' help in seeking care<br/>                     Requesting regimen re-evaluation<br/>                     Gaining medical access<br/>                     Being admitted to hospital<br/>                     Getting a "bad" doctor<br/>                     Taking action against MD</p> <p>Being sent away</p> <p>Preferring a female MD<br/>                     Losing choice; dwindling control<br/>                     Getting stuck with MD<br/>                     Accounting for MD's behaviour<br/>                     Trying to gain a voice - explaining symptoms<br/>                     Remaining unheard</p> <p>Asserting self<br/>                     Attempting to bargain<br/>                     Being misjudged<br/>                     Countering the judgment<br/>                     Offering evidence, being discounted</p> | <p>P: They [her friends] called the clinic to see if they could see me, if they would reevaluate some of my meds and stuff, and they said, "Oh yeah." When I got there they decided that they were going to put me in, put me away or whatever. And I ended up with a really bad doctor. Really bad. I even brought charges against him, but I lost.</p> <p>I: What did he do?</p> <p>P: They put me in this one place, then the next day they sent me over to West Valley [hospital 60 miles away], and they didn't have any female doctors there, they only had male, so you didn't have a choice, and you get one and that's who you get the whole time you're there. For some reason he just took a disliking, I guess, and I tried to tell him about some of the problems I had with my Lupus and stuff, and angered him. [He had ordered her to take off her dark glasses.] And I wore [dark] glasses all the time [because of her photosensitivity] and I tried to tell him, you know, that if he would turn off the fluorescent lights, I would take off the glasses. And he felt I was just being stubborn. I gave him the name and number of my doctor that makes the glasses and he just ripped it up in front of me and threw it away.</p> <p>From Kathy Charmaz, 2011, Grounded Theory Methods in Social Justice Research, in N.K. Denzin &amp; Y. Lincoln (Eds.), Sage Handbook of Qualitative Research, Thousand Oaks, CA: Sage Publications, pp. 369-370. Reprinted by permission of Sage Publications.</p> |

Ethnographic observations may be more amenable to coding larger units such as descriptions of incidents and routine actions. The close coding that grounded theorists conduct keep them interacting with their data. These interactions become comparative because you compare data with data, data with codes, and then later, data and codes with your tentative categories.

The next coding example illustrates how the narrator quotes the other person, her surgeon, and recalls her experience of their interaction. I took both into account. To make multiple voices more visible and separate for analytic purposes, it might help to use separate colored fonts or colored highlighting to distinguish these codes and, perhaps also, each individual's respective statements.

**Example of Initial Grounded Theory Coding**

| Examples of Codes   | Excerpt from Initial Narrative Data from a Personal Account   |
|---|---|
| Imparting bad news<br>Being forewarned<br>Receiving the worst news;<br>Receiving warning<br><br>Being paralyzed, caught by unimaginable loss<br>Feeling wounded<br>Reeling in shock and sorrow<br>Responding to shock<br>Offering reassurance<br>Establishing <i>the</i> priority<br>Giving and receiving promises<br>Attempting to add reassurance | <p>Teresa quoting her surgeon: “Because of where this thing is and what we’re going to have to do, there’s a chance you won’t be able to even speak the same way again. You may not be singing anymore after this.”</p> <p>Teresa: I froze. I couldn’t breathe, couldn’t move, couldn’t even blink. I felt like I had just been shot. My gut had locked up like I’d been punched in it. My mouth went dry and my fingers, which had been fumbling with a pen, were suddenly cold and numb. Apparently picking up on my shock, the surgeon smiled a little. “We’re going to save your life, though. That’s what counts. And you know what? The other surgeon working with me is a voice guy. We’re going to do everything we can not to be too intrusive.”</p> <p>From Frederick J. Wertz, Kathy Charmaz, Linda M. McMullen, Ruthellen Josselson, Rosemarie Anderson, and Emalinda McSpadden. 2011. <i>Five Ways of Doing Qualitative Analysis: Phenomenological Psychology, Grounded Theory, Discourse Analysis, Narrative Research, and Intuitive Inquiry</i>. New York: Guilford, pp. 105-106. Reprinted with permission of The Guilford Press.</p> |

Data for these codes comes from an autobiographical account by a young voice student, “Teresa”, who retells learning that she might lose her voice during throat surgery for life-threatening cancer. Note that the codes stick pretty closely to the data although I move between Teresa and her recounting of what the surgeon said. The actions I recorded as codes reflect my interpretations. Ultimately, what you code reflects your interpretation and derives from the interaction that you have with the data. The codes result from what strikes you as happening in the data. In this case, I looked at what had happened from the research participant’s perspective. I could have given more emphasis to her embodied response. Does this make my coding wrong? No, coding is partial and you can always go back and re-code the same material. Similarly, grounded theory guidelines lead you to check to see if your codes hold up empirically. A code that you treat as a tentative category must account for other data as well. You test the robustness of this category with other data. Such checks are an integral part of grounded theory, logic and practice. Barney Glaser advises whenever you have an idea to write it down. I advise the same logic with coding because you may tap something fundamental, but implicit.

How long do you conduct line-by-line coding? The short answer is that you only conduct line by line coding until you have codes that you want to explore. Then you take these codes and see how they account for further data. You also shape the questions you ask in interviews, of documents, or through observations to focus on learning more about these codes. In this way, grounded theory, expedites your work. Rubin and Rubin (2011) give researchers poor advice when they claim that grounded theory is too much work. Rather, doing the close work early makes further research move quickly.

The power of grounded theory begins with coding. The combination of asking analytic questions, coding in gerunds to the extent that you can, and comparing data and codes lifts the analytic level of your emerging interpretations of the data. What do you do if your codes

are mundane? Study the codes and ask: What analytic story do these codes tell? To which theoretical issues and debates do these codes speak? Some grounded theorists categorise their initial codes into a theme at this point; others categorise their initial codes as a larger process. I recommend first seeing where your initial codes take you because they may spark new ideas and you may make connections that had been implicit or invisible.

*In short, grounded theory strategies foster analytic momentum.*

### **Moving to memo-writing**

Memo-writing is the intermediate step between coding and writing the first draft of your manuscript. When using grounded theory, we begin memo writing from the very start of our research. Memo-writing speeds analytic momentum. It gives you a handle on your material and a place to consider, question, and clarify what you see as happening in your data. Memo-writing is a form of interacting with your data and nascent analysis.

Memo-writing prompts you to study your data and codes in new ways. The code itself gives you a specific title for the memo. Grounded theorists define a code according to its empirical properties. Hence, you not only move into analysis but also may be taking the first step toward an original contribution. Your specification of properties may challenge taken for granted ideas in your field. Checking these properties through further data collection strengthens your emerging analysis.

Action codes provide the grist to write memos in which you identify and analyse processes. Then comparing data with codes and codes with codes in your memos you begin to specify the conditions under which the process arises, persists, or changes. All kinds of questions can occur to you while memo-writing. Who's involved? How? When? What do they do? What are consequences of their actions?

Asking analytic questions in memos enables us to move swiftly from description to conceptualising data. Memos also expedite your work because you can sort them into sections of articles and chapters. By bringing data into your narrative from the start, you provide ready evidence without having to search for it. Memos are places to evaluate which codes to raise to raise to tentative categories. I often raise initial codes to categories although occasionally I need to do a more intensive comparative analysis to arrive at a telling code.

### Example of an Excerpt from an Early Memo: Loss of Voice as Defining Loss of Self

...Loss of voice spreads throughout Teresa's life. She knows that she lost connections, her calling, her trump card and ticket to a future. Teresa's tale of wrenching loss suggests the suffering that she experienced.

The prospect of possible loss of function may result in loss of self. For Teresa, loss of self began with the threat of losing her voice. Her suffering was immediate. Teresa understood how fragile her voice and existence had become when the surgeon said, "You may not be singing anymore after this." She was overtaken by shock and anguish. Teresa recalled this defining moment,

I froze. I couldn't breathe, couldn't move, couldn't even blink. I felt like I had just been shot. My gut had locked up like I'd been punched in it. My gut had locked up like I'd been punched in it. My mouth went dry and my fingers, which had been fumbling with a pen, were suddenly cold and numb. Apparently picking up on my shock, the surgeon smiled a little. "We're going to save your life, though....The other surgeon working with me is a voice guy. We're going to do everything we can not to be too intrusive.

The immediacy, force, and severity of impairment intensify loss of self, if people recognize what is happening to them. Sudden thudding awareness of immediate, extensive, and life-threatening loss is overwhelming. Teresa's tumor appeared suddenly. Not only had she been without warning, but also her two early diagnoses of a goiter made her diagnosis of cancer all the more shocking.

I was sure this was no big deal. After all, this was just a thyroidectomy, and only affecting one lobe... people have their thyroids taken out all the time. I was actually just taken up in the whole strangeness of suddenly being on the verge of surgery. "Wow," I thought. "My first surgery... weird."

In this memo, I examined the effects of Teresa's loss of voice and begin to tie it to suffering and loss of self. I note her shock and sorrow and view the moment as defining. The analysis of time lurks in the background. I catch the immediacy of receiving unexpected bad news and the intensity of the moment. Her instantaneous awareness of the surgeon's ominous pronouncement struck me. I compared Teresa's immediate awareness of potential loss with other people who had had actual loss but learned long afterwards of its life-threatening nature. For example, one middle-aged woman was the youngest patient in her cardiac rehabilitation programme. She described herself as "bopping along" in the programme without taking either exercise or other programme goals seriously. She saw everyone else as old and sick and therefore different from herself. The other patients had had one or more heart attacks but she only had angina. This woman's view that her condition was minor lasted until a nurse told her that staff counted angina as a heart attack. Here the moment of realisation of the gravity of one's diagnosis comes after receiving it. Such comparisons elicited some intriguing ideas about time and agency. How does being unaware of the meaning of a diagnosis affect what people do and when they do it? What actions do they take and do not take? How does the amount and quality of experienced time affect choices, shape relationships, and influence possibilities, including prognoses? In the case of this woman, her medical practitioners viewed her as resisting medical guidelines. The comparisons we make and the questions we ask of them take us from how and what questions to why questions.

### Using Theoretical Sampling to Ask and Answer Why Questions

Theoretical sampling is one of the most advantageous and least used grounded theory strategies. When you conduct theoretical sampling, you gather data to develop and refine your tentative theoretical categories. That means you need to have at least one category. Part of the confusion about theoretical sampling concerns the term, "sampling". Many researchers view this term from the perspective of traditional research design of identifying

populations to sample. In contrast, theoretical sampling is predicated on your fresh analytic categories and thus occurs later. Identifying initial research participants, documents, or field sites to study is not theoretical sampling. Gathering data to fill out the properties of a tentative category is theoretical sampling. You keep gathering data until no new properties of your categories emerge (Thornberg & Charmaz, 2011). This strategy means that you saturate the *properties* of your *category*, not the data. Qualitative researchers often report that they stop data collection when the stories in the data became repetitive. If they were not working on developing categories as they proceeded with data collection, it's likely that they ask the same kinds of data collection questions. Subsequently, the data does indeed become repetitive.

Theoretical sampling encourages you to ask increasingly focused questions and seek answers as you progress through inquiry. It builds systematic checks into your analysis. You put your ideas to empirical test. In grounded theory, saturation means theoretical saturation, despite suspect claims to achieving saturation. No new properties of your theoretical categories have emerged. You have gathered compelling and robust data to support your theoretical categories. Therefore, your work gains substance and moves beyond interesting conjectures.

These dimensions of theoretical sampling distinguish grounded theory from other types of qualitative inquiry. Theoretical sampling involves both inductive and deductive reasoning, and some grounded theorists develop specific hypotheses to test. In a word, theoretical sampling is abductive. C. S. Peirce's (1935-1958) original conception of abductive inference rested on considering all plausible theoretical explanations for a scientist's surprising finding while conducting inductive research (see also, Rosenthal, 1994; Strübing, 2007). Hence researchers form hypotheses for each possible explanation, and test these hypotheses empirically by examining data to arrive at the most plausible explanation. The abductive logic of theoretical sampling not only strengthens your categories but affords them more theoretical reach.

*Grounded theorists' categories and concepts can travel.* I developed a category, "Situating the self in time" in my earlier study of chronic illness (Charmaz, 1991). It rested on the notion of people seeing themselves in different time frames of the past, present, and future. Jennifer Lois (2010) was puzzled by the degree of time sacrifice that some home schooling mothers made for their children. Why did these mothers give all of their time to their children? She decided to pursue their time sacrifice. But how could she account for it? Lois considered various explanations and then turned to Michael Flaherty's (2000) work on the subjective experience of time and my work on time frames and self. She went back to the data with new, focused questions that explored her code, "time sacrifice". Subsequently, she created new codes and continued to interview. Next she developed and checked new categories. Lois's efforts resulted in an innovative theoretical analysis and an award-winning article. She argues that home schooling mothers engage in temporal emotion-work based on savouring the present, and sequencing their lives. Yet she takes the theoretical significance of her analysis further. Lois proposes:

*That there may be a subclass of emotions, which I call temporal emotions that can only be felt by crossing timeframes... Nostalgia, regret, disillusionment, ambition, hope, optimism, and dread...cannot be felt without bridging the present to either the past or the future... As such, it is possible that the ways we use temporal emotions have a particularly important effect on constructing a continuous self over time. (2010, p. 441)*

Lois's argument meets Rosaline Barbour's (2008) criticism that grounded theorists often fail to show the larger import of their work. Nonetheless, Barbour might see Lois's analysis as containing the echoes of disciplinary concepts.

One grounded theory study demonstrates precisely the kind of theoretical reach and challenges to current theoretical ideas that Barbour advocates. Susan Leigh Star (1989) book, *Regions of the Mind: Brain Research and the Quest for Scientific Certainty*, depicts how late nineteenth and early twentieth century neurologists called localisationists institutionalised their contested theory that brain functions depended on specific regions of the brain. She writes, "when I was feeling overwhelmed with the complexity and interdependence of all the issues, Strauss asked me: what would it have taken to overthrow the theory?" (p. 196).

By addressing what and how questions Star subsequently could move to why questions. She delineated what overtaking the localisationist's theory would have demanded and discovered why it did not occur. Her categories depicted localisationists' actions. Their actions included: borrowing evidence from other fields, evaluating operational procedures rather than actual technical failures, substituting ideal clinical pictures for anomalous findings, generalising from case results, and reducing epistemological questions to debates about technique (Star, pp. 87-93). In short, localisationists swayed interpretation of data, ignored anomalies, controlled the debate, invoked deceptive organisational tactics, and manipulated what stood as credibility (pp. 134-152). Star's analysis brought her to forming a new explanation for change and stability in scientific theorising. In this sense, Star's analysis presages Gubrium and Holstein (1997)'s advice to look for the contingent relationships between the what's and how's of social life.

Star does not end with her telling analysis of the take-over by localisation theory. Instead she invoked the particular case of localisation theory to account for why scientific theories do or do not change. She opposes Thomas S. Kuhn's (1970) explanation of scientific theoretical revolutions. He argues that at certain critical points, scientists have amassed numerous anomalous findings that they cannot ignore and their current theory cannot explain. Thus, these anomalous findings force a paradigm change that overthrows the reigning scientific theory. In contrast, Star shows that routine actions in the everyday work of scientists lead to which theories gain currency. She writes: "practical negotiations with and about anomalous events are constitutive of science at every level of organisation" (p. 64). For Star, the complex multiple dimensions of doing scientific work are "interactive and developmental" (p. 196) and thus result in the construction of scientific theorising.

## CONCLUSION

Before ending, I want to mention three directions grounded theory is taking. First, grounded theory is becoming much more international and multi-disciplinary in all of its variants. Second, the grounded theory turn toward social justice research brings the method into social policy areas. Third, mixed methods researchers often look to grounded theory as a useful qualitative method for their studies. In the past, social justice research in the US largely relied on quantitative research. Now, more studies in both critical and conventional inquiry use combinations of qualitative and quantitative approaches. But in any case mixed methods studies are fraught with knotty problems (Barbour, 1998). Thomas Christ (2009) points out that transformative research to reduce oppression does not readily fit traditional quantitative research designs. Jennie Popay et al. (2003) observe that mixed methods can generate different and conflicting data. And I have argued that "Mixed methods may divide, collide, or cohere" (Charmaz, 2012, p. 127).

Last, the benefits grounded theory offers qualitative researchers in medical sociology derive from its strategies. Grounded theory offers explicit analytic guidelines, ways of seeing data, control over the research process, and the promise of completed projects. This method can help you develop your power and potential as medical sociologists. And finally, my answer to why use grounded theory? It's exciting!

## ACKNOWLEDGMENTS

I thank Catherine Will and the organising committee for the invitation to speak at the 2012 Medical Sociology Conference, Elaine Forester and the Events Team at the British Sociological Association for planning my trip, and all the conference participants for the congenial and inspiring meetings.

## REFERENCES

- Atkinson, P., Coffey, A., & Delamont, S. (2003) *Key Themes in Qualitative Research: Continuities and Changes*, New York: Rowan and Littlefield.
- Barbour, R. S. (1998) Mixing Qualitative Methods: Quality Assurance or Qualitative Quagmire? in *Qualitative Health Research* 8(3): 352-361.
- Barbour, R. S. (2003) The Newfound Credibility of Qualitative Research? Tales of Technical Essentialism and Co-Option in *Qualitative Health Research*, 13(7), 1019-1027.
- Barbour, R. S. (2008) *Introducing Qualitative Research: A Student Guide to the Craft of Doing Qualitative Research*, London: Sage.
- Birks, M. & Mills, J. (2011) *Grounded Theory: A Practical Guide*. London: Sage.
- Blumer, H. (1969) *Symbolic Interactionism*, Englewood Cliffs, NJ: Prentice-Hall.
- Bryant, A. (2003) Doing Grounded Theory Constructively: A Reply To Barney Glaser, in *Forum Qualitative Sozialforschung: Qualitative Social Research*. <http://www.qualitative-research.net/fqs/fqs-eng.htm> (accessed March 2004).
- Bryant, A. & Charmaz K. (2007) Grounded Theory in Historical Perspective: An Epistemological Account, in A. Bryant & K. Charmaz (eds.), *Handbook of Grounded Theory*, London: Sage.
- Charmaz, K. (2000) Constructivist and Objectivist Grounded Theory, in N. K. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed.), Thousand Oaks, CA: Sage.
- Charmaz, K. (2005) Grounded theory in the 21st Century: A Qualitative Method for Advancing Social Justice Research, in N. Denzin & Y. Lincoln (Eds.), *Handbook Of Qualitative Research* (3<sup>rd</sup> ed.), Thousand Oaks, CA: Sage.
- Charmaz, K. (2006) *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage.
- Charmaz, K. (2008) The Legacy of Anselm Strauss for Constructivist Grounded Theory, in N. K. Denzin (ed.), *Studies in Symbolic Interaction* 32, Bingley, UK: Emerald Publishing Group, Ltd.
- Charmaz, K. (2009) Shifting the Grounds: Constructivist Grounded Theory Methods for the Twenty-first Century, in J. Morse, P. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. Clarke, *Developing Grounded Theory: The Second Generation*, Walnut Creek, CA: Left Coast Press.

- Charmaz, K. (2011a) A Constructivist Grounded Theory Analysis of Losing and Regaining a Valued Self, in Wertz, F. J., Charmaz, K., McMullen, L. J., Josselson, R., Anderson, R., and McSpadden, E., *Five Ways of Doing Qualitative Analysis: Phenomenological Psychology, Grounded Theory, Discourse Analysis, Narrative Research, and Intuitive Inquiry*, New York: Guilford.
- Charmaz, K. (2011b) Grounded Theory Methods in Social Justice Research, in N. K. Denzin and Y. E. Lincoln (eds.), *Handbook of Qualitative Research* (4<sup>th</sup> ed.), Thousand Oaks, CA: Sage.
- Charmaz, K. (2012) Mixing or Adding Methods?: An Exploration and Critique, in N. K. Denzin and M. Giardina (eds.), *Qualitative Inquiry and the Politics of Advocacy*, Walnut Creek, CA: Left Coast Press.
- Christ, T. W. (2009) Designing, Teaching, and Evaluating Two Complementary Mixed Methods Research Courses, *Journal of Mixed Methods Research* 3(4): 292-325.
- Clarke, A. E. (2005) *Situational Analysis: Grounded Theory after the Postmodern Turn*, Thousand Oaks, CA: Sage.
- Clarke, A. E. (2006) Feminism, Grounded Theory, and Situational Analysis, in S. Hess-Biber and D. Leckenby (eds.), *Handbook of Feminist Research Methods*, Thousand Oaks, CA: Sage.
- Clarke, A. E. (2012) Feminism, Grounded Theory, and Situational Analysis Revisited", in S. N. Hesse-Biber, *The Handbook of Feminist Research* (2<sup>nd</sup> ed.), Los Angeles: Sage.
- Dey, I. (1999) *Grounding Grounded Theory*, San Diego: Academic Press.
- Flaherty, M. J. (2000) *A Watched Pot: The Subjective Experience of Time*. Philadelphia: Temple University Press.
- Glaser, B. G. (1978). *Theoretical Sensitivity*, Mill Valley, CA: The Sociology Press.
- Glaser, B. G. (1992). *Basics of Grounded Theory Analysis*, Mill Valley, CA: The Sociology Press.
- Glaser, B. G. (1998). *Doing Grounded Theory: Issues and Discussions*, Mill Valley, CA: The Sociology Press.
- Glaser, B. G. (2001) *The Grounded Theory Perspective: Conceptualization Contrasted with Description*, Mill Valley, CA: The Sociology Press.
- Glaser, B. G. (2005) *The Grounded Theory Perspective III: Theoretical Coding*, Mill Valley, CA: The Sociology Press.
- Glaser, B. G. (2009) *Jargonizing: The Use of Grounded Theory Vocabulary*. Mill Valley, CA: The Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967) *The Discovery of Grounded Theory*. Chicago: Aldine.
- Gubrium, J. F., & Holstein, J. A. (1997) *The New Language of Qualitative Research*, New York: Oxford University Press.
- Henwood, K., & Pidgeon, N. (2003). Grounded Theory in Psychological Research, in P. M. Camic, J. E. Rhodes, & L. Yardley (eds.), *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*, Washington, DC: American Psychological Association.
- Hood, J. (2007) Orthodoxy Versus Power: The Defining Traits of Grounded Theory, in A. Bryant & K. Charmaz (eds.), *Handbook of Grounded Theory*, London, UK: Sage.
- Katz, J. (2002) From How to Why: On Luminous Description and Causal Inference in Ethnography (Part 2), in *Ethnography*, 3(1): 63–90.



- Kelle, U. (2005, May) Emergence vs. Forcing of Empirical data? A Crucial Problem of 'Grounded Theory' Reconsidered, in *Forum Qualitative Sozialforschung: Qualitative Social Research* 6(2), Art. 27. <http://www.qualitative-research.net/fqs-texte/2-05/05-2-27-e.htm> (accessed 30 May 2005).
- Kuhn, Thomas S. (1970) *The Structure of Scientific Revolutions*, Chicago: University of Chicago Press.
- Layder, D. (1998) *Sociological Practice: Linking Theory and Social Research*, London: Sage.
- Lois, J. (2010) The Temporal Emotion Work of Motherhood, in *Gender & Society*, 24(4), 421-446.
- Melia, K. M. (1996) Rediscovering Glaser, in *Qualitative Health Research*, 6, 368–378.
- Peirce, C. S. (1935-1958) *Collected Papers*, Cambridge, MA: Harvard University Press.
- Popay, J., Bennett, S., Thomas, C., Williams, G., Gatrell, A., & Bostock, L. (2003) Beyond Beer, Fags, Egg and Chips? Exploring Lay Understandings of Social Inequalities in Health, in *Sociology of Health & Illness*, 25 (1): 1-23.
- Rosenthal, G. (2004) Biographical Research, in C. Seale, G. Gobo, J. F. Gubrium, & D. Silverman (eds.), *Qualitative Research Practice*, London: Sage.
- Rubin, H. J., & Rubin, I. S. (2011) *Qualitative Interviewing: The Art of Hearing Data (2<sup>nd</sup> ed.)*, Thousand Oaks, CA: Sage.
- Snow, D. A., Morill, C. & Anderson, L. (2003) Elaborating Analytic Ethnography: Linking Fieldwork and Theory, in *Ethnography*, 4(2): 181–200.
- Star, S. L. (1989) *Regions of the Mind: Brain Research and the Quest for Scientific Certainty*, Palo Alto, CA: Stanford University Press.
- Strauss, A., & Corbin, J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*, Newbury Park, CA: Sage.
- Strauss, A., & Corbin, J. (1998) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques (2nd ed.)*, Thousand Oaks, CA: Sage.
- Strübing, J. (2007) Research as Pragmatic Problem-solving: The Pragmatist Roots of Empirically Grounded Theorizing, in A. Bryant & K. Charmaz (eds.), *Handbook of Grounded Theory*, London: Sage.
- Thornberg, R. & Charmaz, K. (2011) Grounded Theory, in S. Lapan, M. Quartaroli, F. Riemer (eds.), *Qualitative Research: An Introduction to Methods and Designs*, San Francisco: Jossey-Bass.
- van den Hoonaard, W. C. (1997) *Working with Sensitizing Concepts: Analytical Field Research*, Thousand Oaks, CA: Sage.
- Wertz, F. J., Charmaz, K., McMullen, L. J., Josselson, R., Anderson, R., and McSpadden, E. (2011) *Five Ways of Doing Qualitative Analysis: Phenomenological Psychology, Grounded Theory, Discourse Analysis, Narrative Research, and Intuitive Inquiry*, New York: Guilford.

## Durkheim's Body

David Armstrong

Department of Primary Care and Public Health Sciences  
King's College London, UK

david.armstrong@kcl.ac.uk

Three years ago the 150th anniversary of the publication of Darwin's *The Origin of Species* was marked by celebrations around the world. Darwin's seminal text had revealed how the complex world of biology had emerged, in particular how the human body was itself embedded in that biological explanatory framework. The idea that the human body was a biological construct though had first emerged earlier in the 19th century when biology had replaced natural history. The latter was concerned with the study of 'natural' objects – animals, plants and rocks – but Man was not included in that natural world. In contrast, biology placed Man centre-stage and Darwin's account of origins (particularly in his later *Descent of Man*), served to consolidate this biological view of human identity. It is this body, anatomical, physiological, genetic and molecular, which forms the familiar basis of our existence today. This biological body has also underpinned Western medicine as new discoveries are announced almost daily; it is therefore difficult to construe the body as anything other than biological. Yet there are alternatives.

This year marks another publication anniversary which has received considerably less attention than the hoopla surrounding *Origin of Species*. In 1912 Emile Durkheim published his *Elementary Forms of Religious Life* (in French, but translated into English in 1915) and this remarkable book can be used as a basis for identifying and developing a different reading of the human body. One of its core themes, which has underpinned the sociology of religion and the sociology of knowledge, is the claim that 'the ideas of time, space, class, cause (and) personality are constructed out of social elements'. This insight at once provides another language and conceptual framework with which to examine the human body. Not only would this body reflect social elements – and enable the body to be read as an encoding of social elements – but it directs attention to changes over time, unlike the biological constancy that underpins Darwin's body.

Durkheim's idea that space, and classification, are social constructs derives from the collective experience of the social group. For Durkheim the fundamental spatial division is a binary one, between the social group and not the social group, which, as it applied to religion, differentiated the sacred from the profane. This fundamental binary classification then comes to underpin subsequent ways of seeing the world: just as the basic categories of human thought were either sacred or profane, so one geographic or classificatory space could be labelled as 'A' and another as 'not A'.

The social anthropologist, Mary Douglas, took this Durkheimian insight into the origin of classification and pointed out that far from a chasm separating the sacred and profane, as Durkheim had argued, there was a potential space which existed outside the classification system: this 'unclassified' space polluted the purity of classification and was therefore seen as potentially dangerous. Many of the examples in her classic text *Purity and Danger* were drawn from Leviticus in the Bible. For example, she pointed out that animals were classified as either walking on land with legs or swimming in the sea with scales. So a crab which lived in the sea yet walked on legs did not fit the existing classification. This anomaly, which

represented impurity, was viewed as dangerous and eating shellfish was therefore proscribed.

Douglas's analysis of purity and danger can equally be applied to the rules underpinning public health which are concerned with maintaining hygiene. The basic rule of hygiene is that some things are clean and others are dirty and therefore dangerous. Danger arises primarily from objects existing outside the classification system and therefore by determining what is dangerous and where it comes from it is possible to reconstruct the contemporary classification system. In the mid 19th century, for example, public health, which had largely relied on quarantine as its method of intervention, began to identify new sources of danger in objects and processes such as faeces, urine, contaminated food, smelly air, masturbation, dental sepsis, etc. The key to understanding how these different dangers fitted together can be found in the contemporary public health strategy of Sanitary Science which tried to prevent dirt from crossing body boundaries. In other words, all of these dangers represent ways in which objects enter into the body (air, food, water) or leave it (faeces, urine, etc). Sanitary Science therefore monitored objects entering the body in case they should be contaminated by dirt and tried to decontaminate those objects leaving the body as they were of ambiguous status (were they part of the body or not?). In effect, this contemporary emphasis on dirt crossing body boundaries can be seen as marking out a new object in the mid 19th century classification system: that object was the anatomical body which was separated from the world of nature by a permeable body boundary.

Earlier in the 19th century the ideas of the biological body also appeared in a new form of clinical practice (nowadays often called biomedicine) which introduced three new transformative practices into medicine. The biological body could be examined to identify the internal pathological lesion which was causing illness, it could be dissected after death to confirm the lesion which brought about death, and it could be placed in a hospital bed where it could be observed. This biomedical gaze to the interior of the body together with Sanitary Science's focus on body boundaries meant that in mid century the two key elements of the anatomical body were stabilised: an internal structure dominated by cells, tissues and organs and external boundaries which differentiated that interior from nature.

This anatomical body is so familiar today that it is difficult to imagine a time when social perception could not see it. Yet in the 18th century and earlier the illnesses that invaded the body were often perceived as being made up of imbalances in the four humours which moved in and out of the body. The humours, which had been so visible, have now of course disappeared as a body which was once so legible using one language has been replaced by another. Our bodies, the anatomical biological bodies we see and experience today, were in fact forged in those central decades of the 19th century rather than in an African rift valley millions of years ago.

In the early 20th century new sources of danger emerged within public health. These included school infections, venereal disease, tuberculosis and the neuroses (anxiety and depression). These different sources of danger were addressed by the new public health regime of Interpersonal Hygiene. Interpersonal Hygiene identified the new dangers not as emerging from nature and threatening body boundaries but as arising from other human bodies. Tuberculosis, which had been a disease of insanitary conditions in the 19th century, became a disease of human contact, of coughing and sneezing. Venereal disease and contagion in schools also forced into stark relief the connections between bodies which had to be monitored, traced, etc. And contemporary ideas on the neuroses, especially from the Freudian school, emphasised the importance of early social relationships for later mental health. Just as Sanitary Science of the 19th century outlined an anatomical body, so the new

sources of danger underpinning Interpersonal Hygiene established an interpersonal psychosocial space between bodies. Once this new space began to crystallise it was possible for new academic disciplines, particularly psychology and sociology, to emerge to study it and further its existence.

In the mid 20th century yet a new sources of danger emerged for public health. Pollution, global warming, food additives, BSE, radiation from ozone holes, pesticide residues, stress, etc, marked out new dangers for the New Public Health. The framework that held all these new dangers together was the idea that it was not other bodies that directly threatened the self but the products of social activity creating indirect dangers. It was bodies interacting together (such as in industrial production) that created dangers of pollution which threatened the individual. The response was to address ecological concerns and promote green solutions. But because the risks were everywhere, inside and outside the body, it was difficult to police a boundary as had been possible under Sanitary Science. Instead the population and the individual had to maintain constant vigilance against seen and unseen threats; this reflexive activity therefore implied yet a new identity to be superimposed on the now well established anatomical body. In short, Durkheim's view of space and classification as social constructions allows us to see a changing body over the last 200 years reflecting a changing identity: anatomical through psychosocial and subjective to reflexive.

Time, as well as space, for Durkheim was socially constructed. Our sense of time, he claimed, derived from the rhythm of the collectivity. So again we can examine the temporal envelope in which we construe the human body, particularly its beginning and its end. When does the body begin? Darwin famously provided us with a point of origin for Man (once he could see a biological body which needed an origin). But it is ironic that a couple of years before Darwin the British Registrar-General, who was trying to establish the annual number of live births so he could use it as a denominator for an infant mortality rate, decided that the beginning of life was a single gasp for air after birth which distinguished a live from a stillbirth. So in the middle of the 19th century the body had two points of origin, an historical past and a biographical moment.

Accounting for the end of the body was more complex. In the 18th century death was a natural event, a call from nature from outside of the body and of life. We still have the image of the skeleton or black-cloaked figure scythe in hand arriving to announce that life is ending. But for the new clinical medicine of the 19th century the cause of death was not a natural event but a pathological lesion located inside the body. In other words, the new biological body was characterised by a struggle between the physiological life forces and the pathological death forces which would ultimately end in the triumph of the latter.

One of the problems of constructing a biological body as separate from nature, with a beginning and with an end, was the difficulty of transferring this 'object' back to nature. As with any object made sacred, it is a difficult task to make it once again profane. Sanitary science therefore developed a range of strategies for transferring the body back to nature such as the large number of Burial Acts to guard against incipient dangers arising from the corpse. These dangers were also captured in fictional concerns with premature burial and the undead as described in contemporary Gothic novels.

While a pathological death caused by a lesion inside the anatomical body mapped on well to the construct of a biological body it was less suited to a psychosocial/reflexive body or identity: how could death be reconstructed for this new identity? In the early 1960s a new idea of anticipatory grief emerged which suggested that it was not death but dying which medicine had to address. In a great reversal, instead of a death being mourned by friends and relatives, it had to be the patient themselves who went through the grieving process

about their own death. This process would be aided by the attentive healthcare professional who could elicit the confessions of the dying as they proceeded through the various psychological stages of grief. In effect, while pathological death from inside the body had replaced natural death from outside the body, the new construction of death over the last half-century might be labelled 'normal death' which is above all a psychological process.

As well as the temporal ordering of the beginning and end of the body we can also see over the last century or so increasing segmentation of the time in-between. We are now familiar with 'stages of development' whether of infants of children or adults,. We also have increasing numbers of temporally specified diseases such as chronic illness and techniques, such as pre-symptomatic screening and risk factor profiling to address the increasingly temporal space of illness.

For Durkheim the notion of causality reproduced the relationship between the individual and the social group. When group attachment was strong the world was construed as fatalistic; when group attachment was weak the world came more contingent. This pattern can be seen in the history of medicine over the last two centuries when asking 'what causes disease?'. In the 19th century the answer was mainly in terms of unique causal explanations, in the early 20th century 'seed and soil' explanations appeared and in the late 20th century causation is increasingly dominated by 'multi-factorial aetiology' and risk factors. In that sense, recent more complex causal models reflect the growth of individualisation and conversely the development of individuality reproduces the expansion of multi-factorial explanations of why diseases arise.

Another shift in ideas about causation that has occurred over the last few decades is the increasing emphasis on 'reasons'. Causes are preceding factors that in some way predict and can be measured using quantitative positivist methods. Reasons on the other hand require qualitative, interpretive approaches to identify the explanation of the person themselves in terms of justifications for their actions. For example, studies within medical sociology of why patients go to the doctor in the 1960s attempted to identify the causal factors that drove patients to take symptoms to health care but a couple of decades later the emphasis moved more to patients' own explanations and reasons, a movement of which was reflected in changes in primary care illness classification which emphasised the reasons for attendance rather than the underlying pathology.

The changing place of personality can also be tracked alongside changes in society. Identity might be inferred from what is construed as the underlying driver leading to behaviour. In the 19th century behaviour was only used with reference to the movement of inert objects. In the early 20th century it was applied to humans, largely as a reaction to events (such as response to a stimulus). But in the second half of the 20th century behaviour was construed as more problematic as scientists such as Kinsey and Lorenz moved from non-human domains into explaining behaviour. The problem of patient behaviour then began to appear in public health programmemes and a new role for medicine emerged, that of changing patients' behaviour by addressing their attitudes, intentions, self-efficacy, etc, that were seen to underpin choices and actions. In other words, over the last few decades the way explanatory framework in which behaviour is embedded has changed and now increasingly has produced a sense of self or agency.

The contrast between what might be termed Darwin's body and Durkheim's body cannot be greater. Darwin's body, embedded in a biological view of the world, is a constant body little changed over the last several hundred thousand years, fixed by its very nature. This has meant constant work for Darwinism as it has had to keep developing new sub-disciplines, such as socio-biology and behavioural genetics, through which it tries to capture changing

identity and subsume it within its immutable framework. On the other hand Durkheim's body implies a changing object and changing identity which reflects contemporary society, surely a more suitable object for sociological investigation? Indeed, the explanatory framework underpinned by Darwin's body is based on an unchanging identity which prioritises the author/actor as the independent variable. It is the author who writes, the actor who acts. Yet while Durkheim's body also allows this perspective, it also opens up the opportunity for examining explanation in the other direction. How did the text construct the author? And how did the deed constitute the actor? These important questions which have largely been submerged by Darwin's body can be brought above the threshold of description by Durkheim's body.

In recent years many sociologists have identified what is here called the tension between Darwin's and Durkheim's bodies and they have promoted a debate, a rapprochement even, between biology and sociology. Yet we should recognise the dangers in such engagement. Given its powerful contemporary position it is more than likely that biology would be the dominant partner; the current encroachment of neuroscience into psychology should serve as a warning of how one explanatory framework can become subservient to another. In the latter case it is as if instead of being content to study a television programme we have been persuaded that we can have a better understanding of what's on by taking the back off the set and closely studying the patterning of pixels.

So how should we respond to the tension between Durkheim's and Darwin's bodies? In a world dominated by the latter it is probably wise to be cautious. Perhaps the best strategy is to follow Graham Greene's advice: "be disloyal ... if you have to learn a living, and the price they make you pay is loyalty, be a double agent".

#### **BIBLIOGRAPHY:**

- Armstrong, D. *Political Anatomy of the Body: medical knowledge in Britain in the twentieth century*. Cambridge University Press, 1983. [available for download from <http://kcl.academia.edu/DavidArmstrong>]
- Armstrong, D. Public health spaces and the fabrication of identity. *Sociology* 1993;27: 393-410.
- Armstrong, D. *A new history of identity: a sociology of medical knowledge*. Palgrave, Basingstoke, 2002.
- Armstrong, D. Embodiment and ethics: constructing medicine's two bodies. *Sociology of Health and Illness* 2006;28:866-881.
- Armstrong, D. Origins of the problem of health-related behaviours: a genealogical study. *Social Studies of Science*. 2009; 39: 909–926.
- Armstrong, D. Diagnosis and nosology in primary care. *Social Science and Medicine*, 2011, 73: 801-807.
- Armstrong, D. Screening: mapping medicine's temporal spaces. *Sociology of Health & Illness* 2012; 34: 177–193.
- Douglas, M. *Purity and danger*. London: Routledge Kegan Paul, 1966.
- Durkheim, E. *Elementary forms of the religious life*. Oxford University Press, 2001.

## BSA Medical Sociology Study Group Early Career Researchers' Event, 4 September, 2012

### Careers in Medical Sociology

**Catriona Rooke, Donna Bramwell, Greg Hollin, Louise Lavery & Jessica Wright**

The first BSA MedSoc Study Group event organised for, and by, early career researchers was held the day before the 44<sup>th</sup> MedSoc Annual Conference in Leicester. Forty five delegates including PhD students, postdoctoral researchers and research fellows gathered to gain insights into, and share their experiences of, establishing a career in medical sociology.

Delegates were lucky to hear personal reflections from two distinguished sociologists on their careers: **Kathy Charmaz** – Professor of Sociology at Sonoma State University and a plenary speaker at the annual conference – gave an opening plenary that looked back over her career, whilst **Elizabeth Murphy** – Professor of Sociology, Pro-Vice Chancellor and Head of the College of Social Science at the University of Leicester – closed the event with some personal reflections on 'making one's way' in medical sociology. Both talks revealed the role of pragmatism, opportunity and serendipity in the unfolding of career paths and foregrounded the intertwining of the personal and the professional. Delegates were also provided with valuable guidance in moving forward with their careers.

Professor Charmaz's reflections provided a fascinating glimpse of starting out in American Sociology in the 1960s, and the role of class, race, disability and especially gender at that time. She talked about how her personal experiences of illness and her training in occupational therapy led to her interest in medical sociology. Turning to general advice on career progression, Professor Charmaz discussed the importance of finding a suitable mentor. Related to this was the value of obtaining, and taking on board, advice – from both peers and supervisors. She highlighted the importance of finding networks that are the right fit for you, and suggested carefully choosing societies to be involved with in order to create an intellectual home. Finally, she emphasised the value of putting oneself forward in the academic community and taking on professional roles such as reviewing for journals.

Professor Murphy's presentation underlined the importance of making the most of wherever you find yourself no matter the constraints. She suggested that two key endeavours as your career progresses are figuring out the best balance for yourself between doing sociology *of* medicine and sociology *for* medicine, and learning to articulate what your sociological focus is. Echoing Professor Charmaz, she highlighted identifying and making contact with key people in your field and making oneself useful in the academic community. Developing mutually respectful relationships with healthcare professional collaborators is also crucial for medical sociologists, and Professor Murphy had found that explaining what is interesting to you about your topic was helpful. Getting your publication strategy right is, of course, crucial. Finally she emphasised the need to keep in touch with what gets you excited intellectually.

**Michael Traynor**, Trevor Clay Professor of Nursing Policy at Middlesex University and editor of *Health: an Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, gave a workshop on the **process of publishing**. He started by emphasising the importance of getting to know the journals you want to publish in. His advice when preparing a manuscript included:

- Make sure to underline explicitly the contribution you are making early on in your paper
- A good title and abstract – that fit the paper you have written – are crucial.
- ‘Be standard’ – if you produce a ‘perfect example’ of the type of paper the journal publishes it is hard to reject.
- Engaging with popular topics or theoretical debates in your chosen journal demonstrates that your paper is part of a discourse.

Whilst some things to avoid were:

- Submitting a paper that has obviously been rejected from another journal and repurposed.
- A piece that is so specialised the editor will wonder who the audience is.

Professor Traynor noted that the most likely response you will get is to revise and resubmit your paper. He reminded delegates that this is something to be pleased about! When dealing with critical reviews, he highlighted taking the time to engage with and respond graciously to the reviewers' comments, explaining clearly the rationale for your changes in the response. Finally, and refreshingly, he reminded delegates to enjoy the creative process of writing.

**Jacqueline Watts**, Senior Lecturer in the Faculty of Health and Social Care at the Open University and new editor-in-chief of *Medical Sociology online*, outlined the publishing opportunities provided by *MSo*. She particularly encouraged early career academics to consider submitting their work to *MSo*.

**Jude Robinson**, Reader in the Anthropology of Health and Illness at the University of Liverpool, gave a parallel workshop in which she drew on her extensive experience in securing grants to give advice on **applying for funding**. Dr Robinson started by emphasising that one should be pro-active in seeking out funding rather than waiting for it to come to you. She suggested that researchers have a number of options open to them, all of which give benefits. One possibility is working as a researcher alongside teams of senior academics who have extensive experience of bid-writing, securing funding and delivering research, to gain experience of different areas and research methods and how inter- and multi-disciplinary teams work. Researchers may also want to consider applying for small amounts of money in order to build a track record in applying for – and being successful at – getting funding as Principle Investigators and budget holders. Another tip was to request feedback from the bid process if unsuccessful. Dr Robinson also covered what makes a good application, this included: having a great idea and being able to demonstrate its relevance to your field and (in health research) a benefit to a particular population; a clearly written and clearly readable application, with the use of bullet points and clear mapping; and a clear plan for delivery, sensible time frame and demonstrating value for money.



The organisers would like to thank the speakers for making the time to share their experience and knowledge, along with Elaine Forrester at the BSA and Catherine Will, Graham Martin and the rest of the MedSoc committee for their assistance in the organisation of the event. Two postgraduate student representatives – John Gardner and Laura Knight – were added to the MedSoc Group committee at this year's AGM to represent the interests of postgraduate students and to take forward this successful event.

## Family unit in the context of diabetes management among the Igala, North-Central, Nigeria

Samuel Ojima Adejoh

Department of Sociology  
University of Lagos, Nigeria

sadejoh@unilag.ng

### ABSTRACT

**Objective:** This study investigated the influence of the family unit factors in diabetes management among the Igala, in North-Central Nigeria.

**Methods:** The quantitative and qualitative methods of data collection were used. The respondents were purposively selected through clinics and snowballing. A total of 152 respondents living with diabetes participated in the study. The quantitative data were analysed using SPSS, while the qualitative data were analysed using manual content analysis.

**Results:** The findings show that living arrangement, family support and different food consumptions all had significant relationship with diabetes management at  $P < .05$ . Family support had negative influence on diabetes management ( $\beta = -1.791$ ,  $P < .001$ ). The qualitative data show mixed findings of positive and negative influences of the family on diabetes management.

**Conclusion:** Close family members of those living with diabetes should be incorporated into the diabetes management team of the individual with diabetes.

**Keywords:** Diabetes management, Igala, family support, influence and family members

### INTRODUCTION

It is argued that diabetes must be understood not only by the individual who has developed it, but also by his/her family members and other significant people in his/her lives. Supports from loved ones and others regarding diabetes management programme are vital throughout the life of people with diabetes (Paul, 2004). A relatively consistent finding is that adolescents from more supportive and cohesive families have better metabolic control and adherence (Burroughs, Harris, Pontius, & Santingo, 1997). Many studies have demonstrated that only individual factors contribute to diabetes management among children and adolescents (Soveren et al. 2007; McGredy & Laffel 2009) but that family variables also contribute to diabetes management (Miller & Drotar, 2003; Berg et al., 2008). However, not much is known about the impact of family unit on adults with type 2 diabetes among the Igala, in North-central Nigeria. What are the influences of family unit factors on adults' diabetes management status?

Prevalence and incidence of diabetes vary across culture and ethnic groups in Nigeria. Data on specific cultures or groups are lacking or limited. Where available, the limitations of such studies or data may cast doubt upon the reliability of such data. In the last four decades, there is evidence of steady increase in diabetes prevalence in Nigeria (Owoage et al. 1997; Nyenwe et al., 2003; Nwafor & Owhoji, 2004). The International Diabetes Federation (2009) puts the national prevalence of diabetes in Nigeria at 3.9 %, while World Health Organisation

(WHO) estimated the prevalence to be 3.4 %. However, in 2004, the Nigeria Diabetes Association estimated that 10 million Nigerians were living with diabetes (Ogbera et al. 2005). There is no data available on the number of people with diabetes among the Igala. It is the national prevalence rate for the whole country that is relied on.

The household is an important locus of social roles and social relations; individuals encounter this enrolment on a daily basis. Understanding the importance of familial context of control in type 2 diabetes is now being recognised (Barth, 2000; Fisher, Walker, Bostrom, Fischhoff, Haire-Joshu & Bennett, 2002).

Family social supports in managing diabetes treatment regimen are important (Wen, Shepard & Parchman, 2004; Karlsen, Idose, Hanestad, Murberg & Bru, 2004). There is lack of research regarding what family members know and feel about type 2 diabetes (Fisher, Chelsea, Bartz, Gilliss, Staff & Sabigal, 1998; Gonder, Cox & Ritterband, 2002) and the potential influence of family member on individuals with type 2 diabetes has not been explored (Trief, Grant, Eibert & Weistock, 1998).

Studies have demonstrated that strong family and social support appear to have a positive impact on Glycemic control and or self- management behaviour (Boehm, Schlenk, Funnel, Powers & Ronis, 1997; Fisher, Chesla & Staff, 2000). However, some studies have recognised that no relationship exists between family support and self-management behaviour (Trief, Grant, Elbert & Weinstock, 1998). Hunt, Pugh & Valuezuela (1998) found that, among the Mexican Americans the traditional social role may influence adherence to self- care recommendation. For example, women may take on the role of caregivers to the family and may find it hard to exercise since they must be at home taking care of younger children or taking care of ill relatives. However, all these studies were not conducted in an African setting. The available literature shows that, to date, no study has examined the relationship between family unit and diabetes management among the Igala. More importantly, attentions have predominantly been focused on communicable disease, such as malaria, HIV/AIDS and tuberculosis, while people with diabetes are left to fend for themselves. Since there is no cure for diabetes for now, it is expedient to examine the institution (family) where most of the decisions on where, when and from whom to seek remedy for ill-health conditions are taken. Hence, this study focuses on factors within the family unit that act as either facilitators or barriers to following biomedical recommendations. This will assist health-care practitioners working in the field of diabetes in securing compliance from patients as well as family members involved in diabetes management.

## THE STUDY DESIGN

The study was cross sectional in design. The research focused on adults living with type 2 diabetes that are using orthodox means of managing the condition. The data for this article were gathered from three sets of respondents, including those with diabetes. The respondents were conveniently sampled since there was no central registry detailing individuals' illnesses in the communities. A total of 152 respondents consented and participated in the study. A combination of quantitative and qualitative methods was used. These include survey methods, using questionnaire and in-depth interview (IDI).

The study purposively selected four local government areas that have government general hospitals, faith-based hospitals, and private hospitals so as to have easy access to the respondents. These local government areas were Idah, Ofu, Dekina and Ankpa. In each local government, the selected hospitals formed the sampling frame for those living with diabetes. Contacts with the respondents were made as they came to the hospital for regular

check-ups. The respondents were selected on the criteria that they had been diagnosed as being diabetes, mental soundness in order to consent to participation, willingness to participate, and having visited the clinic three times within one year before the commencement of the study. This was to ensure that those that participated were using biomedical pathway of managing the condition and had adjusted to living with the condition. Participants were also recruited through snowballing but they were those making use of orthodox clinics for managing the condition.

### **Methods of data analysis**

The data were analysed based on the method of data collection used. The quantitative data were analysed using SPSS version 15.0. Bivariate analyses were conducted to describe the socio-demographic characteristics of the sample and to examine relationships among the variables. Associations among categorical variables were tested for statistical significance, using chi-square, while complex relationships among the dependent and independent variables were investigated using regression techniques. The qualitative data were analysed using manual content analysis.

### **Measurement of diabetes management**

This comprised diabetes management activities of dietary management, medication taking, glucose testing, weight management, clinic visit, eye and foot examinations and regular exercise. Questions were asked on all the mentioned activities, and participants' responses were scored and ranked and classified as either good or poor.

### **Ethical considerations**

The study was reviewed and approved by the Ethical Review Committee of Kogi State Ministry of Health. Participants gave verbal informed consent before the administration of questionnaire and conduct of in-depth interviews.

## **RESULTS**

The summary of socio-demographic characteristics of the respondents with diabetes shows that 53.9% of the respondents were women, while 46.1% were men. Respondents' mean age was 56.20. The mean age supports Akinkugbe's (1997) claims that diabetes increases 3 to 4 folds after age 44 and the view of Nyenwe et al. (2003), that diabetes is more frequently found in people aged 50 years and above in Nigeria. A total of 28.9 % of the respondents had no formal education; 32.1 % had primary education, 18.4% had secondary education; and 26.3% had post-secondary education. A total of 75.0 % of the respondents were married, 11.8 % were never married, while 10.5 % and 2.6 % were widowed and divorced, respectively. 34.2% of them were civil servants; 14.5 % were both retired and unemployed; while 18.4 % were self-employed. Others were housewives and private employees.

### **Family unit and diabetes management status**

Table 1 shows that 49.3% of those who were married and living together had good management status, while 77.8% of those who were single had good management status. The good management status among those who were single may be as a result of less responsibility, which enabled them to have enough financial resources to carry out health-seeking behaviour. A total of 50.7% of those who were married had poor management status, while 22.2% of those who were single and were living without their partners had poor management status. The high number of respondents who were living with their partners but with poor management status could be as a result of family demands and responsibilities. The Pearson Chi-square shows association between management status and living

arrangement at  $P < 0.05$ . This finding is related to the findings by Connell, Davis, Gallant & Sharpe (1994); Garay-Sevilla et al. (1995), and Burke, Gianguilio, Gillam, Beilin, & Houghton (2003); that social relationships and, particularly marriage, negatively mediate diabetes-related lifestyle behaviours, glycemic control, and other health outcomes.

**Table 1: Relationship between Family Unit Factors and Management Status**

| Independent Variables                                  | Diabetes Management status |          |            | Df | $X^2$  | P.Value |
|--|----------------------------|----------|------------|----|--------|---------|
|  | Poor                       | Good     | Total      |    |        |         |
| <b>Decision making</b>                                 |                            |          |            |    |        |         |
| Self   | 46(51.1)                   | 44(48.9) | 90(100.0)  | 1  | 1.240  | .260    |
| Others   | 26(41.9)                   | 36(58.1) | 62(100.0)  |    |        |         |
| Total  | 72(47.4)                   | 80(52.6) | 152(100.0) |    |        |         |
| <b>Household size</b>                                  |                            |          |            |    |        |         |
| >5   | 18(52.9)                   | 16(47.1) | 34(100.0)  | 3  | 4.838  | .184    |
| 6-10   | 36(46.2)                   | 42(53.8) | 78(100.0)  |    |        |         |
| 11-15  | 14(58.3)                   | 10(41.7) | 24(100.0)  |    |        |         |
| 15+  | 4(25.0)                    | 12(75.0) | 16(100.0)  |    |        |         |
| Total  | 72(47.4)                   | 80(52.6) | 152(100.0) |    |        |         |
| <b>Living arrangement</b>                              |                            |          |            |    |        |         |
| Married  | 68(50.7)                   | 66(49.3) | 134(100.0) | 1  | 5.179  | .023    |
| Single   | 4(22.2)                    | 14(77.8) | 18(100.0)  |    |        |         |
| Total  | 72(47.4)                   | 80(52.6) | 152(100.0) |    |        |         |
| <b>Family responsibility</b>                           |                            |          |            |    |        |         |
| yes  | 8(36.4)                    | 14(63.6) | 22(100.0)  | 1  | 1.250  | .264    |
| No   | 64(49.2)                   | 66(50.8) | 130(100.0) |    |        |         |
| Total  | 72(47.4)                   | 80(52.6) | 152(100.0) |    |        |         |
| <b>Family support</b>                                  |                            |          |            |    |        |         |
| Yes  | 72(54.5)                   | 60(45.5) | 132(100.0) | 1  | 20.727 | .000    |
| No   | -                          | 20(100)  | 20(100.0)  |    |        |         |
| Total  | 72(47.4)                   | 80(52.6) | 152(100.0) |    |        |         |
| <b>Family perception</b>                               |                            |          |            |    |        |         |
| Yes  | 6(37.5)                    | 10(62.5) | 16(100.0)  | 1  | .699   | .403    |
| No   | 66(48.5)                   | 70(51.5) | 136(100.0) |    |        |         |
| Total  | 72(47.4)                   | 80(52.6) | 152(100.0) |    |        |         |
| <b>Freely discuss diabetes with family members</b>     |                            |          |            |    |        |         |
| Yes  | 68(49.3)                   | 70(50.7) | 138(100.0) | 1  | 2.185  | .139    |
| No   | 4(28.6)                    | 10(71.4) | 14(100.0)  |    |        |         |
| Total  | 72(47.4)                   | 80(52.6) | 152(100.0) |    |        |         |
| <b>Different food preparation</b>                      |                            |          |            |    |        |         |
| Yes  | 70(50.0)                   | 70(50.0) | 140(100.0) | 1  | 4.926  | .026    |
| No   | 2(16.7)                    | 10(83.3) | 12(100.0)  |    |        |         |
| Total  | 72(47.4)                   | 80(52.6) | 152(100.0) |    |        |         |
| <b>Experience conflict because of food preparation</b> |                            |          |            |    |        |         |
| Yes  | 10(38.5)                   | 16(61.5) | 26(100.0)  | 1  | .998   | .318    |
| No   | 62(49.2)                   | 64(50.8) | 126(100.0) |    |        |         |
| Total  | 72(47.4)                   | 80(52.6) | 152(100.0) |    |        |         |

Table 1 shows that those who received family supports (45.5%) had good management status compared with those with family support who had poor management status (54.5%). All the respondents without family support had good management status. This result lends credence to the argument that diabetes management is an individual responsibility. This is in line with other studies that posit that most individuals attempt to prevent, contain, or manage

illnesses on their own (Stoller, 1993). The test of association shows that there is significant association between family support and diabetes management status at 0.05 level.

### Regression Analysis

Table 2 shows the influence of the independent variables – conflict on food preparation, family responsibility, free discussion with family members about diabetes, different food preparation, making self-decision or taking decision alone, family members perception of diabetes, family support, and having a person who reminds you on what to do concerning your diabetes on diabetes management behaviour.

**Table 2: The Joint Influence of Family Context on Diabetes Management Behaviour**

|  |            |                       |           |                    |          |             |
|--|------------|-----------------------|-----------|--------------------|----------|-------------|
| R = .390<br>R. Square = .152<br>Adjusted R. square = .104<br>Std. Error of the Estimate = 1.90 |            |                       |           |                    |          |             |
|  |            | <b>Sum of squares</b> | <b>df</b> | <b>Mean square</b> | <b>F</b> | <b>Sig.</b> |
| Model 1  | Regression | 92.020                | 8         | 11.502             | 3.200    | .002        |
|  | Residual   | 513.980               | 143       | 3.594              |          |             |
|  | Total      | 606.000               | 151       |                    |          |             |

Table 2 reveals a significant joint effect of family unit context factors of self-decision making, family reminder, family responsibility, family support, family perception, freely discuss with family members, different food preparation, and conflict on food preparation to the prediction of diabetes management behaviour ( $R = .390$ ,  $P < .05$ ); the multiple regression coefficient  $R$ .Square = .152, and Adjusted  $R$ .Square .104. The analysis of variance reveals significant effect of the independent variable on diabetes management behaviour ( $F = (8,515) = 3.200$ ,  $P < 0.05$ ).

As shown in this table, the Adjusted  $R^2$  value of 0.104 implies that the above mentioned independent variables of family unit will explain about 10.4% of management behaviour of the study participants. In other words, 10.4% of the variance in diabetes management behaviour ( $R = .396$ ,  $R^2 = .104$ ) was accounted for by the independent variables.

Table 2 shows that family context factors put together are significant in explaining management behaviour ( $P < .002$ ). Thus, composite influence of family factors did not occur by chance, as the  $F$ -ratio value of 3.200 shows the strength of the eight independent variables as predictors of diabetes management behaviour of the study participants. The table also reveals the joint contribution of the independent (family unit) variables to the prediction of diabetes management behaviour. This influence is not a result of chance.

The multiple regression analysis shown in Table 3 reveals that family support had negative impact on diabetes management status of the respondents ( $\beta = -.303$ ,  $t = -3.478$ ,  $P < 0.001$ ). Other factors that were statistically insignificant were self-decision ( $P = .384$ ), family reminder ( $P = .262$ ), family responsibility ( $P = .466$ ), family member's perception ( $P = .229$ ), conflict on food preparation ( $P = .195$ ), free discussion of diabetes with family members ( $P = .057$ ), and different food preparation ( $P = .053$ ).

**Table 3: Relative Influence of Family Unit Factors on Diabetes Management Behaviour**

|                       | Unstandardised coefficients |            | Standardised coefficients |        | Sig    |
|-----------------------|-----------------------------|------------|---------------------------|--------|--------|
|                       | B                           | Std. Error | Beta                      | T      |        |
| Constant              | 8.350                       | .789       | -                         | 10.589 | .000*  |
| Self-decision         | -.295                       | .338       | -.073                     | -.874  | .384   |
| Family reminder       | -.487                       | .433       | -.099                     | -1.125 | .262   |
| Family responsibility | .357                        | .489       | .063                      | .730   | .466   |
| Family support        | -1.791                      | .515       | -.303                     | -3.478 | .001*  |
| Family perception     | .667                        | .552       | .102                      | 1.208  | .229   |
| Free talk to family   | 1.215                       | .632       | .176                      | 1.922  | .057** |
| Different food prep.  | -1.144                      | .587       | -.155                     | -1.948 | .053** |
| Conflict on food      | .547                        | .420       | .103                      | 1.301  | 1.95   |

\*, \*\* and \*\*\*: represent significance at 1%, 5% and 10% respectively

Variables under family context (except self -decision), are *Yes-dummies*, Consequently they all have "No" as their respective reference categories

*Dependent variable: Diabetes management behaviour*

The findings from the quantitative data are supported by the qualitative data. The semi-structured questions and in-depth interviews (IDIs) show that respondents identified such supports within the family to include assistance in the provision of money and food items, cooking and household chores, moral support, including prayers and encouragement, accompanying them to clinics, providing them with information and advice got outside the home environment, and buying of drugs.

Some respondents said they were able to cope financially, as they were being assisted by brothers, sisters and close relatives so they could easily afford drugs and the recommended food items. However for some of them, the illness had created conflict between them and their daughters-in-law. This is illustrated in the excerpt below:

*You see, I am old, all my children have grown up, and my husband is no more. Some of my grandchildren are with me but they are just little kids and can do very little for me. When it started I thought it was fever but was told at the hospital that it was diabetes. I have never heard of the condition in my life. My children were supportive together with their wives. At a point, my eldest son came to carry me to go and live with him and was there for over a year. The wife and children were at first very supportive but later the whole thing changed. Then came a time, whenever I joined them to watch TV, they would all leave the place for me. At first I did not know but later discovered that they were all running away from me because they felt I had stayed enough and should return home. It became so bad that I had to leave but did not tell my son because I feared the fight that would follow.*

*(IDI female)*

Table 3 also shows that there is an association between respondents whose food preparation is different from the rest of the household and diabetes management status, at <0.05 significant level. Although there is an association, the data show that an equal number of those whose food preparation was different from that of the household had both good and

poor management status; while 83.3% of those whose food preparation was the same with the rest of the household had good management status. These were likely to be households that could afford balanced diet at most times for the household and, hence, there may not be any need to cook different types of meals. This finding is further supported with data from IDIs, as captured below:

*I do not experience any conflict nor fight from my wife as a result of food preparation. Before the illness, she understood and knew that there was no such thing as preparing different food for me. Now I am old and sick and why would she not cook food for me, especially now that the doctor has asked me not to eat much of certain foods? She cooks for me and it is helping me a lot.*

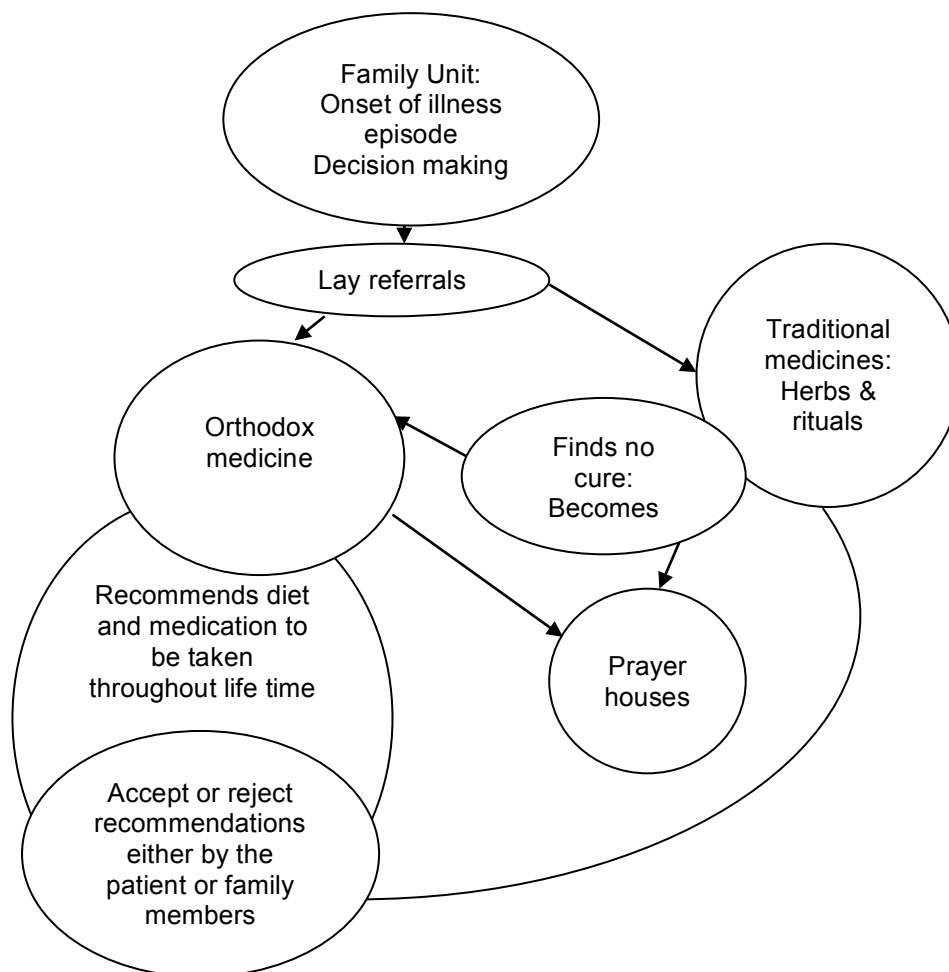
(IDI Male)

*My children assist me in preparation of my food and they have come to understand what I eat and the quantity of what I eat. They are trying their best for me. We have different pots but, at times, we eat the same food but not the same quantity.*

(IDI Female)

The above analysis implies that the influence of the family unit cannot be ignored. Living arrangement, family support and different food preparation, at different levels, significantly relate to diabetes management.

**Fig. 1: Hypothesised relationship between the family as a unit, diabetes treatment and management among the Igala.**





## DISCUSSION AND CONCLUSION

This study is an investigation of factors within the family unit/context that influence diabetes management behaviour. Results from the chi-square analysis provide evidence that living arrangement, family support and different food preparation are all statistically significant at  $P < .05$  level.

The finding of negative influence of family support on management status partly supports similar studies where negative support behaviour was predictor of not taking medication as recommended by a physician (Tang, Brown, Funnell, & Anderson, 2008). Chlebowy & Garvin (2006) did not find social support to be related to dietary adherence and physical activity in a sample of 27 African American adults. This is because an individual is likely to be aware of the implication of not doing the right thing and so will likely want to give it all it takes to remain normal. This finding is also partly in line with social support theory, which claims that social interaction may have unintentional negative influences on self-management behaviour (Wortman & Conway 1985, Kranse, 1990). However, Kaplan (1990) avers that, because of misconceptions or lack of understanding, friends and family members may behave in unsupportive or inappropriate ways, offer well-intentioned advice that conflicts with self-management recommendations, or directly or indirectly promote unhealthy behaviours (such as, preparing high-fat foods).

Some studies assert that family and peer support were important influences on overall diabetes self-care (Maillet, Eramo, & Spollett, 1996) and on diabetes dietary adherence (Maclean, 1991). Studies in other illnesses did not find social support as significant in self-management of asthma, chronic kidney disease (Boyer et al. 1990, Bosley et al. 1995) and epilepsy (Dilorio et al. 1994). Also, some studies have shown that strong family and social support appear to have a positive impact on glycemic control and/ or self-management behaviours (Boehm, 1997; Fisher, 2000; Albright, 2001), while in some studies no relationship was found (Trief, 1998, Gleeson-Kreig, 2002). The findings of some studies suggest that perceived family support specific to diet and exercise are associated with levels of diet and exercise (Wen, Shepherd, & Parchman, 2004).

The mixed findings of family support among the Igala could be attributed to the illness beliefs among the people. Not all the supports given and received will have positive influence on diabetes management. Some supports in form of lay referral could be with good intention but with unintended consequences or influences, as illustrated in this statement: 'I was told by my relative that there is a medication from herbalist that can cure my illness'. Also not all supports given are directly related to the performance of diabetes management tasks or activities. The participants attributed negative influence of family members on diabetes management status to inadequate knowledge of diabetes to render relevant health assistance in manners that will be beneficial. In this case, the role of the family and its specific medical orientations, values and opinions tend to direct the individual with diabetes into taking or not taking particular courses of action concerning his or her diabetes. In some cases, some people suggest food that should be eaten outside the recommended food, while others engage in providing traditional medicine from herbalists and, in most cases, move from one herbalist to another in search of cure. This could be attributed to the belief among the Igala that there is no illness without a cure and it is left for the sick person and members of his/her family to ask and find out where a particular herbalist that can cure such illness will be found. When attempts at using herbalists to cure the illness fail, they move to prayer houses. Where this fails, they return to the clinic, critically ill, as illustrated in Figure 1.

The family tries to help find solutions to the cure of diabetes, which is part of the primary responsibility of the family but, in the process, orthodox recommendations for diabetes

management are neglected. This has negative and unintended consequences on the individual living with the condition and the family in general. In other words, the family in the process of performing its manifest functions inadvertently performs the latent function, which is always in the negative. This finding on negative family support is in line with Mckinlay's (1973) suggestion that persons with close-knit and interlocking social networks tend to display greater conformity with the reference groups than those with loose-knit, differentiated social networks. These networks, according to Suchman (1965), can either direct sick persons initially towards a lay referral system or toward professional health-care delivery systems, as found by Geertseen, Melville, Klauber, Robert, & Rober (1975). In the case of the Igala people, because of the common belief that there is no disease without cure, as documented by Boston (1969), the tendency is for the family members to rally round to find a cure from the right herbalist for such disease.

The negative influence of the family is also manifested through the activities of wealthy members of the family, who live in cities, where health facilities are relatively better than those in the semi-urban and cities. The mechanism is such that these members of the family would move their sick ones for treatment in cities. When they had received treatment and recovered from the initial shock and complications, they would return them home. In most cases, the patients suffer relapse because the kind of care they received in the city may not be readily available in the town or rural areas where such individuals live.

Wallander and Varni (1989) observe that high support from only family or friends is not associated with better adjustment. However, the qualitative data reveal that most of the participants were not happy with the fact that their foods had, in most times, been prepared differently. This could lead to stigmatisation and depression that could act as a barrier to diabetes management. The implications of this are that the role of communal eating in strengthening the bound within the family may be broken and also poses some financial burden on the family. This is clearly easier in some families than others because of their level of education or income.

The dysfunctional role of the family noted in this study suggests the need for further studies on the roles of family members of those with diabetes. This study has demonstrated the role of family support in diabetes management and how the beliefs among the Igala – that there is “no disease without cure” - operates through the family unit to impact negatively on the individual with diabetes. The families of those with diabetes most often determine whether the individual should continue with the orthodox recommendations of what to eat, when to visit the clinic, to take medications, frequency of glucose tests and whether to exercise, which, in most cases, is to take a long walk around the neighbourhood.

The belief among the Igala that there is no “no disease without cure” is heightened and reinforced by the financial implications of developing diabetes. That is, the individual would be on pill or insulin for the rest of his or her life, in addition to frequent clinic visits and tests to be carried out. This is a very difficult position for most of them to accept, hence they find a way of “escaping this trap” by the diagnosis by the orthodox medicine. This belief is also reinforced by the fact that no family would like to be given the label of “sick family” because of the frequency of clinic visits demanded by diabetes management. This also has implications for young men and women of marriageable age in such families. This is because, part of the marriage tradition among the Igala is for the family that wants to marry from another family to do a background investigation of the family, not just to confirm the character and integrity of such a family but also to know if there is any “disease” that runs in such family, which may lead to discontinuation of such union. In a bid to overcome a situation like this, the family tries to find a cure from traditional medicine. In essence the hereditary

characteristic of diabetes and the incurability of the disease for now reinforce the belief among the Igala that there is “no disease without cure”. This belief impacts negatively on diabetes management through some of the supports rendered by family members of those with diabetes among the Igala.

## REFERENCES

Adejoh, S.O. 2011. Sociological investigation of diabetes management among the Igala in Kogi State Nigeria. Unpublished thesis submitted to the Department of Sociology, University of Ibadan.

Akinkugbe, O.O. 1997. (Ed). Non-communicable disease in Nigeria. Final report of national survey, Federal Ministry of Health and Social Services, Lagos, pp 64-90.

Albright, T.L., Parchman, M. and Burge, S.K. 2001. Predictors of self-care behaviour in adults with type 2 diabetes: An RRNeST Study. *Family Medicine* 33: 354- 360.

Barth, J.C. 2000. Families with chronic physical illness. In Nichols, W.C., Pace-Nichols, M.A., Becvar, D.S., Napier, A.Y., Eds. *Handbook of family development and intervention*, 1st Ed. New York.

Boehm, S., Schlenk, E.A., Funnell, M.M., Powers, H. and Ronis, D.L. 1997. Predictors of adherence to nutrition recommendations in people with non-insulin dependent diabetes mellitus. *Diabetes Educator* 23: 157-165.

Boehm, S., Schlenk, E.A., Funnell, M.M., Powers, H. and Ronis, D.L. 1997. Predictors of adherence to nutrition recommendations in people with non-insulin dependent diabetes mellitus. *Diabetes Educator* 23: 157-165.

Bosley, C.M., Fosbury, J.A. and Cochrane, G.M. 1995. The psychological factors associated with poor compliance with treatment in asthma. *European Respiratory Journal* 8: 899-904.

Boston, J.S. 1969. *The Igala kingdom*. Ibadan University Press.

Boyer, C.B., Friend, R., Chlouverakis, G. and Kaloyanides, G. 1990. Social support and demographic factors influencing compliance of hemodialysis patients. *Journal of Applied Social Psychology* 20: 1902-1918.

Burke, V., Gianguilio, N., Gillam, H.F., Beilin, L.J., and Houghton, S. 2003. Physical activity and nutrition programmes for couples: A randomized controlled trial. *Journal of Clinical Epidemiology* 56: 421-432.

Burroughs, T.E., Harris, M.A., Pontious, S.I. and Santiago, J.U. 1997. Research on social support in adolescents with IDDM: a critical review, *Diabetes Educator* 23: 438- 448.

Byng-Hall, F.F.W. 1918. Note on the Okpoto and Igala Tribes. *Journal of the African Society*, Vol. Vii, No. xxvi, p. 166.

Chen-Yen, W. and Fenske, M.M. 1996. Self-care of adult with non-insulin dependent diabetes mellitus: influence of family and friends. *Diabetes Educator* 22(5):465-469.

Chlebowy, D.O and Gravin, B.J. 2006. Social support, self-efficacy, and outcome expectations: impact on self-care behaviours and glycemic control in Caucasian and African American adults with type 2 diabetes. *Diabetes Educator* 32(5): 777-86.

Cleaver, G. and Pallourios, H. 1994. Diabetes mellitus: experiencing a chronic illness. *South Africa Journal of Psychology* 24(4):175-183.

Connell, C.M., Davis, W.K., Gallant, M.P., and Sharpe, P.A. 1994. Impact of social support, social cognitive variables, and perceived threat on depression among adults with diabetes. *Health Psychology* 13: 263-273.

- Dilorio, C., Faherly, B. and Manteuffel, B. 1994. Epilepsy self-management: Partial replication and extension. *Research in Nursing Health* 17: 167-174.
- Fisher, E.B., Walker, E.A., Bostrom, A., Fischhoff, B., Haire-Joshu, D. and Bennett J. S. 2002. Behavioural science research in the prevention of diabetes. Status and Opportunities. *Diabetes Care* 25: 599-606.
- Fisher, E.B., Walker, E.A., Bostrom, A., Fischhoff, B., Haire-Joshu, D. and Bennett J. S. 2002. Behavioural science research in the prevention of diabetes. Status and Opportunities. *Diabetes Care* 25: 599-606.
- Fisher, L., Chelsa, C., Bartz, R.J., Gilliss, C., Skaff, M.A. and Sabigal, F. 1998. The family and type 2 diabetes: A framework for intervention. *Diabetes Educator* 24: 599-607.
- Fisher, L., Chesla, C. and Staff, M.M. 2000. The family and disease management in Hispanic and European – American patients with type 2 diabetes. *Diabetes Care* 23: 267-272.
- Garay-Sevilla, M.E., Nava, L.E., Malacara, J.M., Huerta, R., Diaz de Leon, J. and Mena, A. 1995. Adherence to treatment and social support in patients with non-insulin dependent diabetes mellitus. *Journal of Diabetes Complications* 9: 81-86.
- Geertseen, R., Melville, R., Klauber, M.R., Robert, L.K. and Rober, G. 1975. A re-examination of Suchman's views on social factors in health care utilization. *Journal of Health and Social Behaviour* 16: 226-237.
- Gleeson-Kreig, J.A., Bernal, H. and Wooley, S. 2002. The role of social support in the self-management of diabetes mellitus among a Hispanic population. *Public Health Nursing* 19: 215-222.
- Gonder-Frederick, L.A., Cox, D.J. and Ritterband, L.M. 2002. Diabetes and behavioural medicine: The second decade. *Journal of Consulting Clinical Psychology* 70: 611-625.
- Gowers, S.G., Jones, J.C., Kiana, S., North, C.D. and Price, D.A. 1995. Family functioning: A correlate of diabetic control. *Journal of Child Psychology and Psychiatry* 993-1001.
- Hunt, L.M., Pugh, J. and Valenzuela, M. 1998. How patients adapt diabetes self-care recommendations in everyday life. *Journal of Family Practice* 46: 207-215.
- Kaplan, R.M. and Toshima, M.T. 1990. The functional effects of social relationship on chronic illnesses and disability, in Sarason, B.R., Sarason, I.G., Pierce, G.R (Eds): *Social support: An international view*. New York: John Wiley, pp. 427-453.
- Karlsen, B., Idose, T., Hanestad, B.R., Murberg, T. and Bru, E. 2004. Perceptions of support, diabetes-related coping and psychological well-being in adults with type 1 and type 2 diabetes. *Psychology of Health Medicine* 9: 53-70.
- Krause, N. 1990. Illness behaviour in later life, in Binstock, R., George, L. (Eds). *Handbook of aging and the social sciences*. San Diego, CA: Academic Press, pp. 227-244.
- Maclean, H. 1991. Patterns of diet-related self-care in diabetes. *Social Science and Medicine* 32(6): 689-96.
- Maillet, N.A., D'Eramo-Melkus, G. and Spollett, G. 1996. Using focus groups to characterize the health beliefs and practices of black women with non-insulin-dependent diabetes. *Diabetes Educator* 22: 39-45
- McKinlay, J.B. 1973. Social networks, lay consultation and help-seeking behaviour. *Social Forces* 51:275-291.
- Nwafor, A.E. and Owhoji, A. 2004. Prevalence of diabetes mellitus among Nigerians in Port-Harcourt correlates with socio-economic status. *Journal of applied sciences and Environmental management* (8) 16:27.

- Nyenwe, E.A., Odia, O.J., Ihekwaba, A.E., Ojule, A. and Babatunde, S. 2003. Type 2 diabetes in adult Nigerians: a study of its prevalence and risk factors in Port Harcourt, Nigeria. *Diabetes Research Clinical Practice* Dec; 62 (3): 177-85.
- Ogbera, A.O., Adedokun, A., Fasanmade, O., Ajani, M., Ohwovoriole, A.E. 2005. The foot at risk in Nigerians with DM: The Nigerian scenario. *International journal of Endocrinology and Metabolism*. 3(4): 165-173
- Owoage, E.E., Rotimi, C.N., Kautman, J.S., Tracy, J. and Cooper, R.S. 1997. Prevalence of adult diabetes in Ibadan, Nigeria, *East African Medical Journal* vol. 74, 5 pp299-302.
- Paul, B. 2004. Children and families living with diabetes; preface. *Diabetes spectrum* 17: 18-21
- Stoller, E.P. 1993. Interpretations of symptoms by older people. *Journal of Aging and Health* 5: 58 - 81.
- Suchman, E.A. 1965. Social patterns of illness and medical care. *Journal of Health and Human Behaviour* vol 6 No 1
- Tang, T.S., Brown, M.B., Funnell, M.M. and Anderson, R.M. 2008. Social Support, Quality of life, and Self-Care behaviours among African Americans with type 2 diabetes. *Diabetes Educator* 34: 266.
- Trief, P.M., Grant, W., Elbert, K. and Weinstock, R., 1998. Family environment, glycaemic control and the psychosocial adaptation of adults with diabetes. *Diabetes Care* 21: 241-245.
- Wallander, J.L. and Varni, J.W. 1998. Social support and adjustment in chronically ill and handicapped children. *American Journal of community Psychology* 17, 185-201.
- Wen, L.K., Parchman, M.L. and Shepherd, M. D. 2004. Family support and diet barriers among older Hispanic adults with type 2 diabetes. *Family Medicine* 36(6): 423-30.
- Wen, L.K., Shepard, M.D. and Parchman, M.L. 2004. Family support, diet and exercise among older Mexican Americans with type 2 Diabetes. *Diabetes Educator* 30: 980-993.
- World Bank Report, Appraisal of Anyigba Agricultural Development Project, Report No. 1369a- U.N.I., 1977, p. 1.
- Wortman, C.B. and Conway, T.L 1985. The role of social support in adaptation and recovery from physical illness, in Cohen, S., Syme, S.L (Eds): *Social support and health*. Orlando, FL. Academic Press, pp. 281-302.

## Doctors at Risk of Job Burnout, Diminishing Performance and Smoking Habits

**Abida Ellahi, Rabia Mushtaq**

International Islamic University,  
Islamabad, Pakistan

abida.phdtm5@iiu.edu.pk

### ABSTRACT

This study aims to explore the relationships among work-family conflict, workload, burnout (emotional exhaustion) and diminishing performance in a sample of doctors. The study also investigated how these indicators of psychosocial work climate influence respondents' frequency of smoking habits. A questionnaire survey has been carried out to explore these interrelationships. For testing the theoretical model, the structural equation modelling (SEM) technique was used. All hypotheses were supported and results appeared in the expected directions. Findings show that work-family conflict and heavy workload are strong predictors of emotional exhaustion and diminished performance of doctors. Emotional exhaustion and diminished performance were found to be strongly related to smoking habits. The findings draw the attention to the importance of improving the psychosocial work environment among doctors where examining burnout syndrome, diminishing performance and smoking habits have not yet received priority thus far.

### Practitioner Points

- In this study, a model is tested in which work-family conflict and workload caused burnout (emotional exhaustion) and diminishing performance, which ultimately influenced the smoking habits of doctors.
- The study reported that, as a result of changes in the hospital or duty tasks, the workload and work family conflict among doctors had increased, as a consequence they had more tendencies to experience emotional exhaustion, the central component of burnout and reduced work performance. In these situations, they tend to smoke more
- Our study helps in raising the issue of stress impact on smoking habits among doctors. Doctors are always aware of the adverse health effects of smoking and of beneficial health effects of giving up, but often they have to wrestle with work and psychological problems.
- The findings of this study could be used as a basis for developing human relation or human resource management programmes within the hospitals at national level

**Keywords:** Job burnout, Emotional exhaustion, Work-family conflict, Workload, Diminishing performance, Smoking habits, Pakistani doctors

## INTRODUCTION

The medical profession is an emotionally and physically demanding profession. The life of a doctor is very complex, as he/she has to work for long and irregular hours, dealing with life-and-death situations, carrying out a high volume of procedures, dealing with multiple simultaneous deadlines, never complaining and keeping emotions or personal problems from interfering with work as well as sacrificing their personal life to stay up-to-date in their field (Balch et al. 2009). In fact they are “doctors for others life”. They work in a dynamic and complex medical workplace environment; therefore, they have to face problems with their work, family or partners. According to researchers, the working conditions of the medical workplace leave many doctors under pressure. Sir William Osler (1849–1919), the most influential physician in history observed that only a few doctors were satisfied and happy in their professional lives (as cited in McManus et al. 2004). This dissatisfaction or unhappiness with their profession is due to the workload or work-family conflicts, which cause job burnout.

Burnout is a psychological term, which is characterised by overtiredness and its resultant effects. According to Freudenberger (1974) burnout is

*“a wearing down and wearing out of energy. It is an exhaustion born of excessive demands which may be self-imposed or externally imposed”.*

Maslach and Jackson (1984) identified that burnout is generally taken as a form of job stress, but in fact, it is a “syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do “people-work” of some kind”. Professionals experiencing the problem of burnout can face anxiety, depression, divorce or broken relationships, alcoholism, substance abuse, and suicide (Balch et al. 2009). It is a phenomenon that is of particular importance for both individuals and organisations because burnout affects individuals’ work performance, which ultimately affects organisational performance. These problems have been investigated among many professionals such as psychologists, physicians, teachers, nurses, policemen, and managers etc. (Schaufeli et al. 1993). Few studies conducted in Pakistan indicated the dissatisfaction of doctors with their jobs due to workload, stress, social status and other personal problems (Ghazali et al. 2007). Therefore, this research has made an attempt to examine job related psychological problems prevailing among doctors; these jobs related psychological problems include burnout caused by work family conflicts and work overload. The study has also examined the effects of resultant burnout on smoking habits among these doctors. In Pakistan, smoking is a commonly observed phenomenon in the general population; however, very little is known about the real patterns of smoking among doctors. Doctors were selected for this study because they are dealing with patients’ life and death matters, so their well-being is critical for the quality of care they provide.

## LITERATURE REVIEW

**Smoking habits** The stressors have two categories: one resides outside the person including economic pressures, rapid technological, social, or personal change, difficult work environments, and interpersonal conflicts; and the second resides within the person including personality patterns, patterns of thinking and acting, unrealistic expectations, unmet needs, and genetics. Individuals, who face stress also feel emotional exhaustion besides other stress symptoms and they seek help by smoking to cope with stress (Cleveland Clinic, 2008). Cigarettes contain nicotine which is an important element for mood altering. Tobacco users feel satisfaction and they possess a sensation of escaping from stress; in fact, smoking is actually a cruel illusion. Smoking may enhance the tendency for raised blood pressure, muscle stretching, blood vessels constricting and less availability of oxygen to the brain and

body which is actually necessary to facilitate healthy coping (Cleveland Clinic, 2008). Smoking is also a major cause of lifestyle-related diseases; hence, it is important to know the smoking habits and its causes among the doctors because of the impact on patients

**Work-family conflict** In today's competitive environment, doctors are facing multiple challenges while delivering high quality services to patients. Unfortunately, there is a lack of family-friendly policies for them. According to Spinks (2004) a long-hours culture is common among many organisations. In these circumstances, individuals are more likely to experience work-family conflict and emotional exhaustion (Karatepe and Tekinkus, 2006). Cooke and Rousseau, (1984) suggested that pressure from work or family roles enhances work-family conflict. Work-family conflict is defined as "a form of inter role conflict in which the general demands of time devoted to, and strain created by the job interfere with performing family-related responsibilities" (Netemeyer et al. 1996, p. 401). In these circumstances, individuals are subjected to the feelings of fatigue, loss of trust and emotional exhaustion (Gaines and Jermier, 1983). Job challenge and job variety, enriching work role characteristics are related to work-family conflict (Jones and Butler, 1980). These types of challenge are very obvious in the life of doctors. Thus, it is hypothesised that

*Hypothesis 1:* Work-family conflict has positive effect on emotional exhaustion among doctors

*Hypothesis 2:* Work-family conflict has positive effect on diminished performance capacity among doctors

**Workload** Workload is considered a common source of job burnout in 'helping' professionals like doctors (Janssen et al. 1999). According to Maslach et al. (2001: p.414), '*workload is most directly related to the exhaustion aspect of burnout*'. The study of Greenglass et al. (2001) confirmed the association of workload with emotional exhaustion in hospital nurses. Similarly, in a study of Cohen et al. (2004) significant associations between workload and burnout were also found in staff of a Canadian hospital. Alongside the high workload of doctors, makes them vulnerable to high levels of work-family conflict. This high workload and emotional pressure are more likely to increase the possibility of alcohol and drug abuse, problems in social relationships, depression and anxiety and suicide among doctors (Shapiro et al. 2000).

*Hypothesis 3:* Workload has positive effect on emotional exhaustion among doctors

*Hypothesis 4:* Workload has positive effect on diminished performance capacity among doctors

**Job burnout** Job burnout was first identified by a psychologist called Freudenberg in the early 1970's. He identified it as exhaustion by means of a result of hard working without interest and motivation. Maslach and her colleague Jackson developed a well-studied measurement of burnout known as Maslach Burnout Inventory. This measure has three dimensions of burnout which are confirmed to be empirically interrelated, but do not occur all the time in parallel and equal way (Farahbakhsh, 2009). These three dimensions are:

Emotional Exhaustion refers to a "feeling of excessive emotional stress and being drained by contact with other people" (Kowalski et al. 2010). Doctors are emotionally exhausted when they are not able to treat patients as human beings, rather as objects, and they feel emotionally depleted.

Depersonalisation refers to apathetic and insensate responses to people. Doctors experiencing depersonalisation show indifferent and harsh responses with co-workers or patients



Lack of personal accomplishment is expressed as a feeling of reduction in proficiency to carry out work tasks. Doctors feeling lack of personal accomplishment experience problems of poor judgment, pessimism and feelings of incompetence.

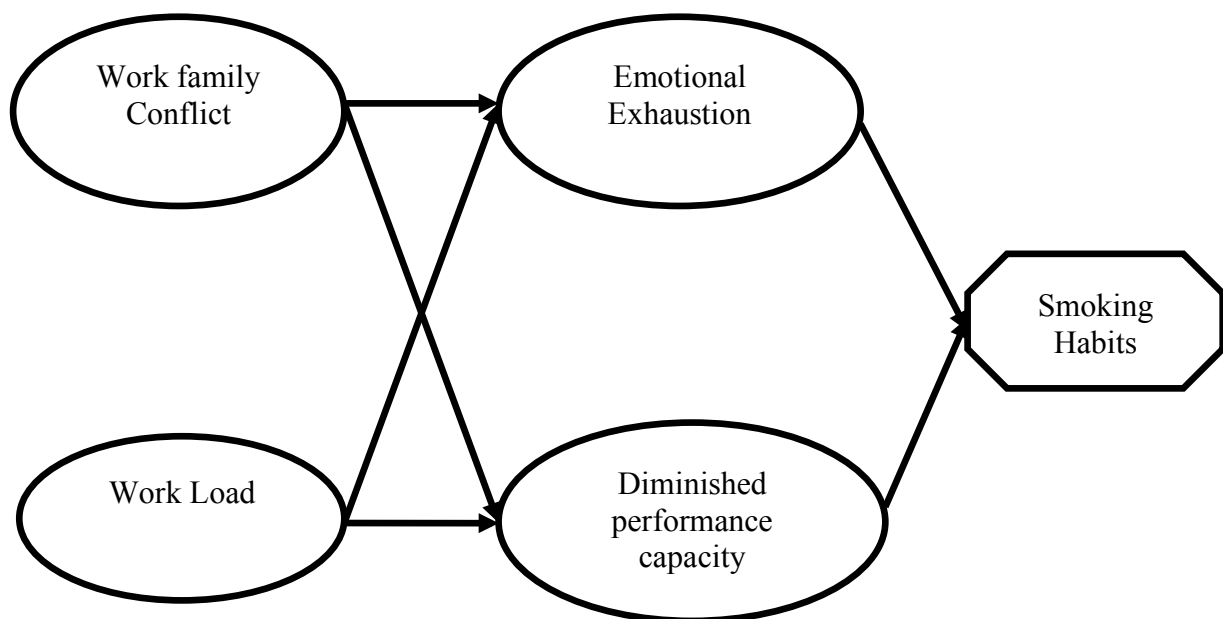
The phenomenon of job burnout is a syndrome that produces many side effects at the three levels of the personal, the family and the organisation. According to Farahbakhsh (2009), the frequent reported side effects of job burnout are physical tiredness, disability, frequent headaches, sleep disorders and anorexia. At the organisational level, these side effects include less work, absence from work, frequent delays, various complaints, conflict and strife in the work environment, change of position and job quitting. Assessing the syndrome of burnout among doctors is essential because the strength of the medical workforce is dependent on their wellbeing (Wu et al. 2008). Researchers confirmed that burnout among physicians can become harmful for patients' safety and quality of patient care, resulting in increased medical errors (Shanafelt, 2005; Shanafelt et al. 2002). Burnout among physicians may affect patients' satisfaction and treatment compliance (Williams et al. 2001). Researchers have identified several factors affecting job burnout. Some of these factors include long and hard working hours, age, gender, level of preparedness, type of personality, personal characteristics, lack of proper and desirable human relations in formal ranking position as well as the informal structure of the relations between personnel (Maslach and Jackson, 1981; Cherniss, 1992). The research confirmed that most smokers assumed smoking as an approach to cope with social anxieties rather than as divergent behaviour (Leventhal et al. 1991). Thus, it is hypothesised that

*Hypothesis 5:* Emotional exhaustion has positive effect on smoking habits among doctors

*Hypothesis 6:* Diminished performance capacity has positive effect on smoking habits among doctors

The proposed framework for the suggested theoretical relationships among variables is shown in Figure 1.

**Figure 1: Proposed Research Model**



## **METHOD**

### **Data Collection and Sample**

For the collection of data, a preliminary field survey was conducted using a close-ended questionnaire. By using a convenient sampling technique, a sample size of 300 staff doctors was selected from three hospitals of two major cities in Pakistan. The selected hospitals were medium sized private hospitals that have a limited number of specialised medical staff. Therefore, 300 doctors were initially targeted. As the study is a pilot, a convenient sampling technique was appropriate enabling us to obtain basic data and trends regarding this study without the complications of using a randomised sample.

The issues of precision and confidence, population size, time and cost constraints were taken into consideration in selecting the sample size. The respondents were drawn from various areas of specialisation. The questionnaires were randomly delivered to relevant hospitals during the duty hours and were collected back after two days. The doctors were sought out in hospital cafeterias, offices and wards and were asked to answer an anonymous questionnaire. The whole administration of this field survey was undertaken over a four-week period. Out of 300 questionnaires, 250 usable responses were received with a response rate of 83%. The high response rate may increase the generalisability of results.

### **Measures**

A well-structured and self-administered questionnaire was used as an instrument for data collection. The questionnaire was designed in English because English is the official professional language in Pakistan. This study adopted the measures used to operationalise the constructs included in the previous literature, making minor wording changes to tailor these measures to the current context. The questionnaire was refined through pre-testing. The pre-testing focused on instrument clarity, question wording and validity. During the pre-testing, 5 doctors were taken as subjects and were invited to comment on the questions and wording. The comments of these 5 subjects were taken as a basis for revisions to construct measures. The single copy of the questionnaire designed for this study was composed of two parts. The first part consists of information about demographic variables such as age, gender, marital status and work schedule. The second part of the questionnaire was about work related variables such as workload, work-family conflict, emotional exhaustion, diminished performance capacity and smoking habits. Emotional exhaustion and diminished performance capacity (e.g. "I feel emotionally drained from my work", "I deal with emotional problems very calmly") were measured using the Maslach Burnout Inventory (Maslach & Jackson, 1981), which has been widely used in existing literature. Smoking habits were measured by using the scale presented by Tolla et al. (2006) (e.g. "I would do almost anything for a cigarette right now", "I have a desire for a cigarette right now"). The variable of workload was measured with a subscale developed by Caplan et al. (1975) (e.g. "My job requires me to work very fast" and "My job leaves me with very little time to get everything done"). The variable Work-family conflict (e.g. "I often have to miss important family and social activities because of my job, "The demands of my work interfere with home, family, and social life") was adopted from the study of Karatepe and Uludag (2007). Each of the work related variables was measured on a five-point Likert Scale in which 1 indicated "strongly disagree", 2 indicated "disagree", 3 indicated "neutral", 4 indicated "agree" and 5 indicated "strongly agree". The respondents were required to express their opinion by selecting one of the options on the five-point Likert Scale.

## RESULTS

### Demographic Information

Table 1 presents data about the background information of respondents. The participants were 18.8% female and 81.2% male. The category marital status shows that 17.2% were single, 8% were divorced, 3.2% were widowed and 71.6% were married. Similarly, according to the status and timings of the job 21.6% have permanent morning shifts, 17.2% had permanent night shifts, 31.2% were on rotating day shifts and 30% were on rotating night shifts. Responses about age show that 1.2% were under 25 years, 21.6% were of age 25-45, 60% were of age 35-45 and 17.2% were aged above 45.

**Table 1. Demographic characteristics of sample**

| Demographic Variable  | N   | %    |
|-----------------------|-----|------|
| <b>Age</b>            |     |      |
| Under 25              | 3   | 1.2  |
| 25-35                 | 54  | 21.6 |
| 35-45                 | 150 | 60   |
| Above 45              | 43  | 17.2 |
| <b>Gender</b>         |     |      |
| Male                  | 203 | 81.2 |
| Female                | 47  | 18.8 |
| <b>Marital status</b> |     |      |
| Single                | 43  | 17.2 |
| Divorced              | 20  | 8    |
| Widowed               | 8   | 3.2  |
| Married               | 179 | 71.6 |
| <b>Work schedule</b>  |     |      |
| Permanent morning     | 54  | 21.6 |
| Permanent night       | 43  | 17.2 |
| Rotating day          | 78  | 31.2 |
| Rotating night        | 75  | 30   |

### Reliability

Reliability analysis depicts the internal consistency of scale items. It is used to ensure that the scale used is producing consistent results over time. Cronbach's alpha is a widely and commonly used measure for reliability analysis. Its value range is between 0 and 12. The value closer to 1.0 confirms significant reliability of scale (Khan and Ellahi, 2010). Table 2 shows Cronbach's alpha values of each factor. The first factor of the questionnaire, work-family conflict had a Cronbach's alpha of 0.90, factor workload had 0.94, factor emotional exhaustion had 0.90, factor diminished performance capacity had 0.88 and factor smoking habits had 0.83. All of the values of Cronbach's alpha were in an acceptable range, which delineates high internal consistency of subscales of factors.

**Table 2: Reliabilities, Means, Standard Deviations, and inter-correlation matrix of variables**

|                                   | 1     | 2      | 3       | 4       | 5       |
|-----------------------------------|-------|--------|---------|---------|---------|
| 1 Work family Conflict            | 1     | 0.205* | 0.35*   | 0.55*   | 0.85*   |
| 2 Work Load                       |       | 1      | 0.603** | 0.813** | 0.433** |
| 3 Emotional Exhaustion            |       |        | 1       | 0.637** | 0.377** |
| 4 Diminished performance capacity |       |        |         | 1       | 0.230*  |
| 5 Smoking Habits                  |       |        |         |         | 1       |
| <b><math>\alpha</math></b>        | 0.90  | 0.94   | 0.90    | 0.88    | 0.83    |
| <b><math>M</math></b>             | 15.67 | 3.87   | 4.16    | 2.84    | 19.54   |
| <b><math>SD</math></b>            | 1.56  | 0.48   | 1.65    | 3.03    | 4.68    |

\*\*p<0.01 and \*p<0.05 N=250

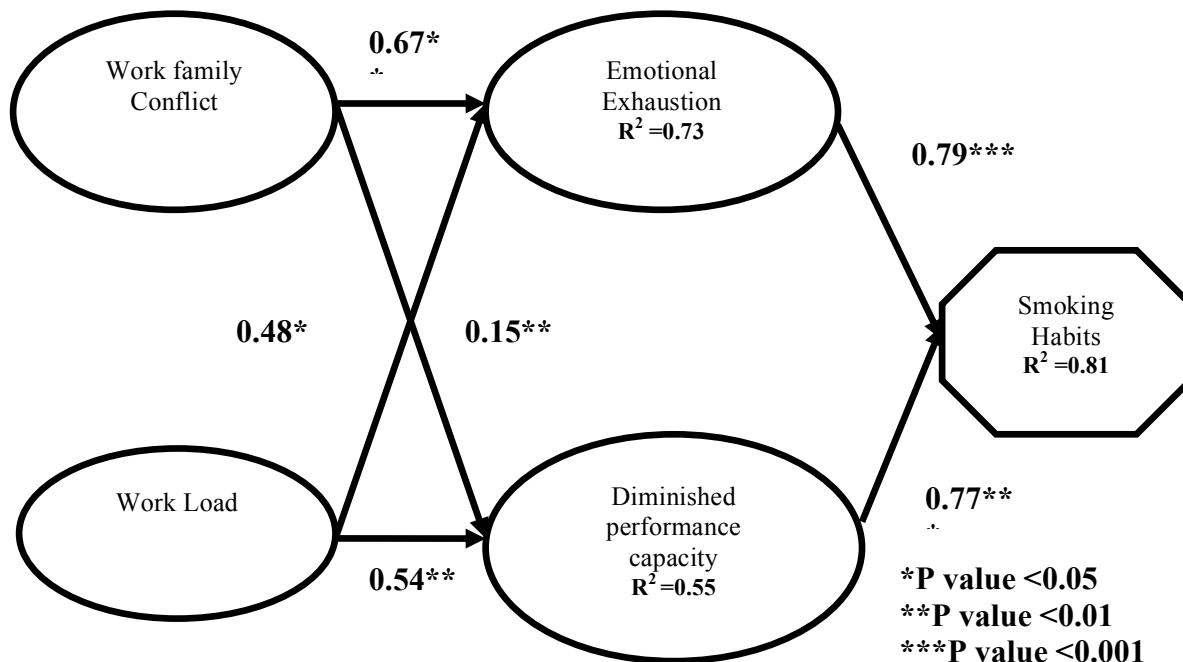
In order to evaluate the theoretical relationships among relevant constructs, the model presented in Figure 1 was tested through structural equation modelling, using AMOS. Figure 2 shows the values of testing theoretical relationships among relevant constructs. The values for path coefficients are showing hypotheses support for all of six hypotheses. The R2 values of dependent variables model are 0.73, 0.55 and 0.81, which show the explanatory power of the model. The value range of standardised coefficients of paths is ranged from 0.15 to 0.79 as shown in Figure 2. These values show that work family conflict, workload, emotional exhaustion and diminished performance capacity significantly affect the smoking habits of doctors. These results are consistent with suggested hypotheses.

The statistical results show that work-family conflict is positively related with emotional exhaustion among doctors. The highly significant path coefficient value of 0.67 (sig P<0.05) shows that one unit increase in work-family conflict will increase 0.67 units in emotional exhaustion. Thus H1 is supported.

The path coefficient value of work-family conflict and diminished performance capacity among doctors is 0.48 (sig p<0.05). This confirms that one unit change in work-family conflict brought about 48% variations in diminishing the performance capacity of the doctors. This confirms that work-family conflict significantly affects the diminishing performance capacity of doctors. Thus, H2 is also supported. The other results show that workload experienced by doctors is positively related to emotional exhaustion among doctors (0.15 sig p<0.01) supporting hypothesis H3. The positive relation of workload with performance capacity among doctors is confirmed by path coefficient value of 0.54 (P<0.01). It depicted that doctors who have high workload, feel a reduction in their proficiency to carry out work tasks. Thus H4 is also accepted. The statistical value of path coefficient for relation of emotional exhaustion and smoking habits is 0.79 (sig p< 0.001). It shows that doctors who experience emotional exhaustion are more inclined towards smoking; thus, providing support to

hypothesis H5. The statistical value of path coefficient for the relation of diminished performance capacity and smoking habits is 0.77 (sig  $p < 0.001$ ). It confirms that doctors who experience diminished performance capacity are more inclined towards smoking. Thus H6 is supported.

**Figure 2: Path Analysis of Research Variables**



The values of goodness-of-fit in Table 3 show how well the framework matches the observed data. The goodness-of-fit of the research model/framework developed may be determined by the GFI, AGFI, RMSR and the  $\chi^2/df$  ratio (Ellahi and Manarvi, 2010). The Goodness of Fit Index (GFI) which indicates the degree of similarity or of variance jointly explained by the model. The suggested values of GFI ranges between 0 and 1, higher values indicating better model fit. The GFI in this research model is 0.80, indicating a good fit of the model to the data. RMSR (Root Mean Square Residual) represents the average remaining value of the variance, which is left unexplained by the model. In a well-fitting model, the value should be small i.e. less than 0.5. The value of RMSR in this model is 0.17, signifying that only some of the variances were left unexplained by the proposed model.  $\chi^2$  is considered as classic goodness-of-fit measure to determine overall model fit. The  $\chi^2/df$  ratio is 1.79; a ratio of less than 2 is taken as indicator of good fit.

**Table 3: Goodness-of-Fit Statistics**

| Goodness of Fit | Values |
|-----------------|--------|
| GFI             | 0.80   |
| RMSR            | 0.17   |
| x2              | 140.19 |
| Df              | 78     |
| Prob            | 0.001  |
| x2/df           | 1.79   |

## DISCUSSION AND CONCLUSION

Job stressors like work-family conflict, workload and burnout have remained important constructs of inquiry in today's complex working environment. In this study, a model is tested in which work-family conflict and workload caused burnout (emotional exhaustion) and diminishing performance, which ultimately influenced the smoking habits of doctors. We tested these relationships in the cultural setting of Pakistan using a sample from different hospitals and found fairly good support for our hypotheses.

The results of the study demonstrated that work-family conflict and workload were associated positively with burnout (emotional exhaustion) and diminishing performance in hospital doctors. Both burnout (emotional exhaustion) and diminished performance of doctors are related to high smoking probability among these doctors. The doctors reported that, as a result of changes in the hospital or duty tasks, their workload and work family conflict had increased, as a result they had more tendencies to experience emotional exhaustion, the central component of burnout and reduced work performance. In these situations, they want to smoke more. The present findings are in line with the previous results reported by Leiter (1991) in which work overload and interpersonal conflict, increased emotional exhaustion in a sample of mental health hospital workers. All in all, the results clearly demonstrate that work-family conflict and work load have a capacity to manifest into burnout (emotional exhaustion) and diminish the performance of doctors which is much more detrimental, as it leads to negative consequences such as smoking or alcohol drinking to cope with work stress.

Moreover, our study helps to raise the issue of stress impact on smoking habits among doctors in the context of a developing country like Pakistan. Doctors are always aware of the adverse health effects of smoking and of the beneficial health effects of giving up, but often they have to deal with both work and other psychological problems. The findings of this study could be used as a basis for developing human relation or human resource management programmes within hospitals at a national level. Hospital management should pay special attention to the leading factors of job stress like work-family conflict and workload because of its harmful effects on outcomes. Its severity will lead to the burnout and diminishing performance of doctors, which in turn brings much more adverse effects on attitudinal and behavioural consequences. It is possible that early signs of stress such as low job performance and low satisfaction may not be evident to managers. By the time prolonged

stress leads to burnout it may be more difficult to counter the problem, particularly when it becomes chronic. A calm working environment for doctors is required for their work quality. Due to the stressful working environment, doctors' burnout level will be high and physician burnout can increase medical errors (Balch et al. 2009). Management should be cautious about these factors, that will create very negative impacts on the attitudinal and behavioural outcomes of the doctors that in turn can adversely affect patients' safety and quality of patient care. The findings also point to the need for health education programmes consisting of stress management, motivation management and smoking prevention or quitting strategies for doctors. The findings of this study provide a firm basis for such health education. The findings draw attention to the importance of improving the psychosocial work environment of Pakistani doctors where examining burnout syndrome, diminishing performance and smoking habits have not yet received priority thus far.

The limitations of the sampling strategy and research population size should be considered while considering the findings of this study. Despite these limitations, the findings have the potential to contribute to the development of health care reform by providing information on burnout, diminishing performance, work family conflict, workload and smoking habits among doctors. From an applied outlook, the concerns demonstrated in this study are vital to management practices in the hospitals of Pakistan.

## REFERENCES

- Balch, M.C., Freischlag, A.J. and Shanafelt, D.T. (2009). Stress and Burnout Among Surgeons Understanding and Managing the Syndrome and Avoiding the Adverse Consequences *Arch Surg*, 144,371-376.
- Caplan, RD., Cobb, S., French, JR., Harrison, RV. & Pinneau (1975). Job demands and worker health. *HEW Publication No. (NIOSH)*, 75-160.
- Cooke, R. A., and Rousseau, D. M. (1984). Stress and strain from family roles and work-role expectations. *Journal of Applied Psychology*, 69, 252-260.
- Freudenberger, H. J. (1974). Staff burnout. *Journal of Social Issues*, 30, 159-165.
- Gaines J. & Jermier J. (1983). Emotional exhaustion in a high stress organization. *Academy of Management Journal*, 26, 567-586.
- Ghazali, A. S., Shah, A. I., Zaidi, A. A., & Tahir, H.M. (2007). Job Satisfaction among Doctors Working at Teaching Hospital of Bahawalpur, Pakistan. *Journal of Ayub Medical College Abbottabad*, 19(3)
- Greenglass, E. R., Burke, R. J., & Fiksenbaum, L. (2001). Workload and burnout in nurses. *Journal of Community and Applied Social Psychology*, 11, 211-215.
- Jones, Allan P., and Mark C. Butler. (1980). A role transition approach to the stress of organizationally induced family role disruption. *Journal of Marriage and the Family* 42, 367-376.
- Karatepe, M.O., Uludag, O. (2007). Conflict, exhaustion, and motivation: a study of frontline employees in Northern Cyprus hotels. *International Journal of Hospitality Management*, 26,645-65.
- Karatepe, M. O., & Tekinkus, M. (2006). The effects of work-family conflict, emotional exhaustion and intrinsic motivation on job outcomes of front-line employees. *International Journal of Bank Marketing*, 24, 173-193.

- Kowalski C., Ommen O., Driller E., Ernstmann N., Wirtz M., Köhler T. & Pfaff, H. (2010) Burnout in nurses – the relationship between social capital in hospitals and emotional exhaustion. *Journal of Clinical Nursing*, 19, 1654–1663.
- Leiter, M.P. (1991). Coping patterns as predictors of burnout: the function of control and escapist coping patterns. *Journal of Organizational Behavior* 12: 1 23—1 44.
- Leventhal, H., Keeshan, P., Baker, T., Wetter, D., (1991) Smoking prevention: towards a process approach. *British Journal of Addiction*, 86 (5), 583–587
- Maslach, C., & Jackson, S.E. (1981). MBI: Maslach burnout inventory. *Palo Alto, CA: Consulting Psychologists Press*.
- McManus, I. C., Keeling, A., & Paice, E. (2004). Stress, burnout and doctors' attitudes to work are determined by personality and learning style: A twelve year longitudinal study of UK medical graduates. *BMC Medicine*, 2, 29–23.
- Netemeyer, R.G., Boles, J.S., & McMurrian, R. (1996). Development and validation of work family conflict and family-work conflict scales. *Journal of Applied Psychology*, 81,400- 10.
- Ralston, D.A. (2008). The crossvergence perspective: Reflections and projections. *Journal of International Business Studies*, 39,27-40.
- Schaufeli, W.B., Enzmann, D. & Girualt, N. (1993). Measurement of burnout: A review. *In W.B. Schaufeli, C. Maslach, & T. Marek (Eds.)*, 199-218.
- Shanafelt T, Bradley KA, Wipf J& Back A. (2002). Burnout and self-reported patient care in an internal medicine residency programme. *Ann Intern Med*, 136,358-367.
- Shapiro, S.L., Shapiro, D.E., & Schwartz, G.E.R. (2000). Stress management in medical education: A review of the literature. *Academic Medicine*, 75, 748-759.
- Spinks, N. (2004). Work life balance: achievable goal or pipe dream? *The Journal for Quality and Participation*, 27, 4-11.
- Tolla, A.B., Katulakb, A.N.& McKee, A.S. (2006). Investigating the factor structure of the Questionnaire on Smoking. *Addict Behav*, 31, 1231–1239.



## Questionnaire Items Used for Study

| Construct                              | Items  |
|--|--|
| <b>Work family conflict</b>            | <p>The demands of my work interfere with home, family, and social life</p> <p>Because of my job, I cannot involve myself as much as I would like in maintaining close relations with my family, spouse/partner, or friends.</p> <p>Things I want to do at home do not get done because of the demands my job puts on me</p> <p>I often have to miss important family and social activities because of my job.</p> <p>There is a conflict between my job and the commitments and responsibilities I have to my family, spouse/partner, or friends</p> |
| <b>Emotional exhaustion</b>            | <p>I feel emotionally drained from my work</p> <p>I feel used up at the end of the workday</p> <p>I feel fatigued when I get up in the morning and have to face another day</p> <p>Working with people all day is really a strain for me</p> <p>I feel burned out from my work</p> <p>I feel frustrated by my job</p> <p>I feel I am working too hard on my job</p>  |
| <b>Diminished performance capacity</b> | <p>I cannot easily understand how my recipients feel about things</p> <p>1 cannot deal very effectively with the problems of my recipients</p> <p>I feel I'm not positively influencing other people's lives through my work</p> <p>I cannot easily create a relaxed atmosphere with my recipients</p> <p>1 have not accomplished many worthwhile things in this job</p>   |
| <b>Smoking Habits</b>                  | <p>I have a desire for a cigarette right now</p> <p>Nothing would be better than smoking a cigarette right now.</p> <p>If it were possible, I probably would smoke right now.</p> <p>I have an urge for a cigarette.</p> <p>A cigarette would taste good right now.</p> <p>I would do almost anything for a cigarette right now.</p> <p>Smoking would make me less depressed.</p> <p>I am going to smoke as soon as possible.</p>  |
| <b>Work load</b>                       | <p>My job always requires me to work very fast</p> <p>My job always require me to work very hard</p> <p>My job very often leave me with little time to get things done</p> <p>I feel very little slowdown in the workload I do experience</p> <p>I feel a lot of workload while being on duty.</p> <p>I require a lot of time to do all your work</p> <p>I have a lot of projects, assignments, or tasks to do.</p>  |

## **‘Familiarity Bonds’: A Neglected Mechanism For Middle-Range Theories Of Health And Longevity**

**Graham Scambler**

University College London, UK

**Aksel Tjora**

Norwegian University of Science and Technology  
Trondheim, Norway

### **ABSTRACT**

This brief *conceptual note* introduces the idea of ‘familiarity bonds’. It is tentatively suggested that the existence of such bonds are likely to be protective of health. After outlining what is meant by familiarity bonds, an argument is advanced that that these may have more causal efficacy than has yet been recognised. A middle-range theory linking familiarity bonds to health and longevity is mooted/. This is succeeded by a series of theory-driven conjectures judged to be worthy of consideration and empirical investigation.

**Keywords:** Familiarity Bonds, Health and Longevity, Explanatory Models, Health Inequalities

### **INTRODUCTION**

The nitty-gritty of the mundane, routine or ‘familiar’ does not yet fit readily into either socio-epidemiological or sociological theories of the differential experience of health or longevity. In some ways this is surprising. Social capital has been enthusiastically studied post-Putnam, and it is widely accepted that density of network and intensity of belonging, strong and weak ties, possession of pets and attachment to ritual, carry a potential to buttress health and well-being, as can mid-morning shopping excursions, time-outs in cafes and cyber-friendships. It is tentatively suggested here that a Mertonian middle-range theory of bonds of familiarity holds promise not only to complement a worthwhile sociology of health inequalities but, more broadly, for a sociological theory of social integration.

The concept of ‘familiarity bonds’ is neither subsumed nor adequately reflected in that of social capital. It is self-evidently multidimensional. It denotes not only the often-rich variety of dyadic and group dynamics, but relations with non-humans, from dogs to goldfish, extending to ‘things’ and a multiplicity of representations of the routine and predictable. The hypothesis is that *the commitment and return on a person’s familiarity bonds are salient for health and longevity*. It is proffered cautiously and is consonant with rather than corroborated by extant research. It is cast as a meso- or middle-range theory with potential to help bridge the gap between the macro- and micro-sociology of health and health inequalities.

### **THE CONCEPT OF ‘FAMILIARITY BONDS’**

There has long been a case for asserting a positive associational, even causal, relationship between absorption into or engagement with community and health and longevity. Putnam’s (2000) pioneering studies leant both rationale and impetus to this relationship: they simultaneously informed psych-social models and (politically and conveniently) underwrote non- or post-materialist explanations of ‘the widening gap’ (between high and low-income families and health and longevity). They often also reflected a middle-class bias, rendering,

for example, more-or-less agential church attendance more significant and operational than on-the-whole less agential recruitment to neighbourhood or postcode youth gangs. They accentuated the positive health return on the likes of scout group membership while neglecting the fact that any positive effects of gang membership, surely also social capital, were likely to be cancelled out by deprivation, insecurity and symbolic or actual violence. (It is evident nonetheless that the variable 'flow' of social capital has implications for health and can contribute to our understanding of what has come to be called 'the social gradient': the poorer one's location on assorted socio-economic classifications, the poorer one's health and life-expectancy (Scambler, 2012)).

Familiarity bonds are not coincidental with those characterising possession of social capital, although they can be co-present and co-active. They have a number of core properties:

- they can be readily accessed;
- they can be actual, virtual or even imaginary;
- they are predictable and therefore reliable, affording a sense of permanence;
- they constitute a bulwark against what for Giddens (1990) refers to as a pervasive 'ontological insecurity';
- they are a by-product of what Archer (2004) terms people's 'projects';
- they are most salient for health and longevity at times of cultural relativity.

Each of these properties calls for elaboration.

(a) Ready accessibility

Familiarity is a necessary constituent of the social business of living. It is a precondition of our being in the world. This is not just a matter of later Wittgensteinian logic or of trains turning up on time. Familiarity underwrites getting by day-to-day and belonging *per se*. It provides for social order and offers a benchmark and reference group for self- and other-orientation. Moreover it is all around us: it comes not only with the acknowledging smile of a local *barista* or rickshaw-driver, what have been called 'subtle ties' (Tjora & Scambler, 2008), but with feeding the cat or glimpsing a van Gogh print on the wall, the shoes by the kitchen door, the herb patch, and the anticipation of a spell on *Facebook* or with the evening's TV soap. As Miller (2008) has eloquently shown, the familiar comprises non-living as well as living objects. The familiar is ubiquitous.

(b) Actual, virtual or imaginary

The familiar can be virtual as well as actual. It can be epitomised in the very act of communicating, in the charging of a mobile phone, let alone the checking for new texts. Our occupancy of cyber-realms is well researched, less so the yet more intimate kingdom of fantasy. There is calm and refuge in day-dreams and fantasies, replete with their actors, ego-centred relations and plots. 'Acquaintances' or 'significant others' need not be real to appear on these stages (Morgan, 2007; Hiscock, 2007). Health-bestowing potential might rest with such fictitious familiarity bonds, even if this potential fails to compensate for, is undone by, an actual world of disappointment, rejection and isolation.

(c) 'Ontological insecurity'

For Giddens (1990), the post-welfare statist culture is characterised by the threat or displacement of the *grand* narratives that formerly lent meaning, order and security to individual lives and projects. Identity-formation has seemingly become a matter of consumer 'choice' between *petit* narratives in a thoroughly relativised culture. If Marx's alienation and Durkheim's anomie intrude into the present, neither quite captures the causal power and impact or novelty of what we here call *ephemoralisation*. A Heraclitian state of permanent

flux prevails, tacitly encouraging fundamentalisms and nihilisms alike. Familiarity bonds stand in contradistinction to Bauman's (2000) 'liquid modernity'.

(d) Ongoing projects

Archer (2004) grounds people's projects in the 'internal conversations' that are informed but never determined by structure and culture: agency never entirely loses its causal power even as it never entirely escapes its structural and cultural contexts of influence. Familiarity bonds comprise items scattered in landscapes typically experienced – although *not* explained sociologically – in terms of *chosen* paths through everyday life. They are solid representations of past, present and future in the lifecourse and, as such, give tangibility also to putative directions of travel.

(e) Enduring markers

The predictability and reliability of familiarity bonds has special relevance in times of cultural relativity such as that associated with the 'postmodernisation' of the post-1970s. What counts as enduring depends on the background noise of the culture of the day. Complimenting the emphasis on ontology or 'being' under (c), bonds of familiarity give anchorage also to an otherwise volatile array of (epistemological) 'beliefs' and (moral and political) 'stances'. This is ephemoralisation again. It is not just that 'all that is solid melts into air', according to Marx an intrinsic feature of capitalism, but that contemporary class ideology has become *anti-* rather than post-Enlightenment, affording a culture of consumerist pick-and-mix as tolerant of extremisms as of 'difference'.

## THESES FOR EMPIRICAL INVESTIGATION

Social capital still tends to be used as what ordinary-language philosopher Ryle would have called a 'hurrah' as opposed to a 'boo' phrase: its connotations are obdurately positive. To the extent that this is so, it is defined and operationalised in terms of effects expected or predicted to be positive. Studies of bonds of familiarity could follow a similar flawed trajectory. It is evident, however, that such bonds can also be negative or pathogenic, as when a dependency develops on a 'familiar' like (bar, company, or time-specific) alcohol consumption, leading to diminished health and even reduced life-expectancy.

So *when* might *which* familiarity bonds serve positively personal and social agendas of health and longevity? And *why* and *how*? Crucial to the appeal of Granovetter's commendation of a distinction between 'strong' and 'weak ties' was his confident assertion that the latter had not only been neglected but under-valued: he documented in compellingly plausible detail the likely 'coercive power' of weak ties. In other words, it is not enough to timidly 'float' a notion of familiarity bonds. This injunction leads us to a research agenda for medical sociologists comprising the following steps:

1. a study of the prevalence and types of familiarity bonds of possible salience for health and longevity;
2. a consideration of the relative importance of *objective* versus *subjective* dimensions of (types of) familiarity bonds for health and longevity;
3. an empirical specification of those familiarity bonds identified under 2, defined objectively and/or subjectively, which are *most* salient for health and longevity;
4. an analysis of the relative contributions of the causal powers of the structural, cultural and agential to the familiarity bonds discerned under 3;
5. a review of the potential of familiarity bonds not only to help *explain* health inequalities but to inform policy interventions to reduce them.

1-5 require a qualification that one of us (GS) has always insisted on, namely, that between sociology oriented to (causal) explanation and sociology oriented to Popperian 'piecemeal social engineering'. Each has its place; but they are different projects and the latter can, and often does, obstruct the former.

In the spirit of Granovetter, and emergent from 1-5, we volunteer a hypothesis that carries a higher degree of testable specificity. We contend that *familiarity bonds are causally efficacious for health and longevity in inverse relation to the aggregate strength of flow of other forms of capital or asset known for their positive impact on health and longevity*. It is readily accepted that strong biological, psychological, social, cultural, spatial, symbolic and material asset flows each act positively for health and longevity (Scambler, 2012). It is our contention here that it is when these flows are weak 'across the board' that familiarity bonds come into play.

## REFERENCES

- Bauman,Z (2000) *Liquid Modernity*. Cambridge; Polity Press.
- Giddens,A (1990) *Consequences of Modernity*. Cambridge; Polity Press.
- Granovetter,M (1973) The strength of weak ties. *American Journal of Sociology* 78 1360-1380.
- Hiscock,J (2007) Acquaintances, friends and strangers – do they matter to medical sociology? *Medical Sociology Online* 2 23-25.
- Miller,D (2008) *The Comfort of Things*. Cambridge; Polity Press.
- Morgan,D (2007) Getting acquainted with acquaintanceship. *Medical Sociology Online* 2 21-22.
- Putnam,R (2000) *Bowling Alone: the Collapse and Revival of American Community*. New York; Simon & Schuster.
- Scambler,G (2007) Social structure and the production, reproduction and durability of health inequalities. *Social Theory and Health* 5 297-315.
- Scambler,G (2012) Review article: health inequalities. *Sociology of Health and Illness* 34 130-146.
- Tjora,A & Scambler,G (2008) Subtle ties: communal awareness in an urban café.

## Young Adults' Discursive Constructions of Chronic Illness Experience: Accounts of Type 1 Diabetes and Inflammatory Bowel Disease (IBD)

Benjamin Saunders

Cardiff University, UK

saundersbm@cardiff.ac.uk

### ABSTRACT

This thesis investigates the experiences of young adults living with either type 1 diabetes (T1DM) or Inflammatory Bowel Disease (IBD), two chronic conditions which are prevalent among this age-group. This is set against the long tradition of research into chronic illness experience; however, young adults are commonly underrepresented in this area, in spite of the contention that the new-found pressures and responsibilities associated with this life-stage may be especially difficult to manage alongside a chronic condition (Arber and Ginn,

In addressing the central research question – ‘how do young adults discursively construct their individual experiences of chronic illness?’, semi-structured interviews were carried out with respondents aged 18-29 ( $n = 30$ ). Transcribed interviews were subject to open-coding using qualitative software, which led to the systematic identification of predominant themes for analysis. Data was considered primarily as ‘accounts’ (Radley and Billig, 1996), with a focus on the moral-underpinnings of the respondents’ talk. These accounts were examined from a rhetorical discourse analysis perspective (Arribas-Ayllon et al., 2011), which entailed micro-investigation of the discursive devices drawn upon by the respondents in representing their experiences as part of situated identity-performances (Riessman, 1990). This approach of combining methods of coding to systematically identify predominant themes, with fine-grained discursive analysis of lengthy stretches of talk is unique in chronic illness experience research.

Across the predominant themes identified (self, other-orientation and control), some similar trends were identified, but also considerable variation, most significantly *across* the two conditions. In relation to *self*, accounts of T1DM showed greater evidence of ‘transformational’ experiences, and the *gaining* of positive self-images, with respondents constructing greater levels of agency regarding the *integration* or *distancing* of illness vis-à-vis selfhood, whereas in accounts of IBD ‘loss of self’ (Charmaz, 1983) was more prominent. In accounts of *other-orientation*, those with IBD more commonly constructed ‘felt stigma’ and ‘enacted stigma’ (Scambler and Hopkins, 1986) than T1DM-respondents, which had implications for reported disclosure practices vis-à-vis the two conditions. ‘Enacted deviance’ (Scambler, 2004) was also more commonly constructed by IBD-respondents, in reported cases where the signs and symptoms of their condition became outwardly perceptible. Within the theme of *control*, T1DM-respondents generally constructed greater *condition control* and *lifestyle control* than IBD-respondents. Variation was also observed in reported management-strategies, which reflected the respondents’ differing conceptions of their ‘healthy bodies’ (Balfe, 2009) – those with T1DM focused on future health concerns, their ‘longer-term’ healthy body, whereas IBD-respondents’ concerns centred primarily on more immediate health consequences, their ‘short-term’ healthy body. These differing conceptions of the ‘healthy body’ influenced how respondents accounted for their ‘risky’ social drinking

practices, with IBD-respondents producing 'justifications', and those with T1DM primarily constructing 'excuses' (Scott and Lyman, 1968).

In spite of this variation, a consistent thread running throughout the data was the constitution of the morally-driven self. A range of different moral figures were constructed by the respondents, allowing them to perform positive identities throughout. This eased the tension borne out of the conflict between the priorities, desires and demands of young adulthood and the complex considerations surrounding chronic illness, which often meant that the respondents' reported-behaviours conflicted with medical advice.

In addition to furthering knowledge within the research field, it is hoped that the findings presented in this thesis – especially the representations of different management-strategies, the construction of (lack of) stigma, and representations surrounding social drinking practices – can have implications regarding the advice given to young adults with type 1 diabetes and IBD, both inside the healthcare setting, and as online resources.

## REFERENCES

- Arber, S. & Ginn, J. (1998). Health and Illness in Later Life. In D. Field & S. Taylor (eds.) *Sociological Perspectives on Health, Illness and Health Care*, 134–151. Oxford: Blackwell Science.
- Arribas-Ayllon, M., Sarangi, S. & Clarke, A. (2011). *Genetic Testing: Accounts of Autonomy, Responsibility and Blame*. London: Routledge.
- Balfe, M. (2009). The Body Projects of University Students with Type 1 Diabetes. *Qualitative Health Research* 19 (1): 128–139.
- Charmaz, K. (1983). Loss of Self: A Fundamental Form of Suffering in the Chronically Ill. *Sociology of Health & Illness* 5 (2): 168–195.
- Radley, A. & Billig, M. (1996). Accounts of Health and Illness: Dilemmas and Representations. *Sociology of Health & Illness* 18 (2): 220–240.
- Riessman, C. K. (1990). Strategic Uses of Narrative in the Presentation of Self and Illness: A Research Note. *Social Science & Medicine* 30 (11): 1195–1200.
- Scambler, G. (2004). Re-Framing Stigma: Felt and Enacted Stigma and Challenges to the Sociology of Chronic and Disabling Conditions. *Social Theory & Health* 2 (1): 29–46.
- Scambler, G. & Hopkins, A. (1986). 'Being Epileptic': Coming to Terms with Stigma. *Sociology of Health & Illness* 8 (1): 26–43.
- Scott, M. & Lyman, S. (1968). Accounts. *American Sociological Review* 33 (1): 46–62.

## **Prison mental health: Context is crucial - A sociological exploration of male prisoners' mental health and the provision of mental healthcare in a prison setting**

**Melanie Jordan**

University of Nottingham

melanie.jordan@nottingham.ac.uk

### **ABSTRACT**

This thesis represents a sociological exploration of Her Majesty's Prison Service, male prisoners' mental health, and the provision of National Health Service mental healthcare in a prison setting. This qualitative social science study is conducted in one prison establishment. The work is characterised as a policy and practice orientated exploratory case study. The study implements an inductive approach to the datum–theory relationship, a constructionist ontological position, and an interpretivist epistemological orientation. Semi-structured interviews are conducted in a male category B prison with healthcare centre staff (e.g. registered general nurse, registered mental health nurse, health care assistant, plus varied administration and clinical management staff), the secondary mental health team (psychologist, psychiatrist, community psychiatric nurse), prison governors, prison psychologists, primary-level mental health service users/prisoners, and secondary-level mental health service users/prisoners.

The subject of place is salient when deliberating the mental health of prisoners as a social group. The prison setting can fashion or exacerbate mental illness. In comparison to the general population, the prevalence of mental distress experienced by the prison population is exceedingly high. In order to consider issues that concern the mental health of prisoners (i.e. aetiology, prevalence, severity, interventions, and outcomes), the prison setting as a communal and procedural place requires attention. Therefore, this medical sociology study devotes attention to social and institutional arrangements that permeate the prison locale. As examples, these include prisoner–staff relations and prison regimes.

The prison environment is not conducive to good mental health, and is not often a useful catalyst for mental healthcare for myriad reasons. Notably, the custodial treatment setting is important here. The provision of mental healthcare and the pursuit of good mental health in the prison milieu are challenging. Thus, the prison-based exceedingly complex three-way relationship between culture, mental health, and mental healthcare is addressed. As, if one wishes to provide appropriate healthcare in a prison, one also has to understand something about those for whom the healthcare exists. Knowledge of the specific patient group is important. Therefore, prison healthcare ought to be increasingly fashioned (i.e. commissioned, provided, managed, and practiced) in accordance with the prison social environment, the institutional set-up, and the specific health requirements of patients/prisoners. The proposition is that context is crucial to the provision of wholly apt prison mental healthcare.

Study data are analysed thematically. Resultant themes include: the nature of clinician–patient/prisoner rapport; the working environment of the healthcare setting; the notions of healthcare provision and receipt in a custodial setting; patients'/prisoners' perspectives regarding prison mental health; aspects concerning prison existence and mental healthcare users' experiences; prison staff mental health knowledge, roles, and responsibilities; prison



service and healthcare services collaborative working.

The penal milieu in relation to an extensive variety of issues impacts mental health and mental healthcare. These range from the overarching ethos of imprisonment right through to individual interactions in the setting. To précis, mental healthcare provision and receipt experiences and environments are important for clinicians and patients/prisoners alike.

## **Caring and working: a hermeneutic phenomenological study exploring the experiences of working-age male family carers**

**Linda Birt**

University of East Anglia

[linda.birt@uea.ac.uk](mailto:linda.birt@uea.ac.uk)

### **ABSTRACT**

#### **Research aims**

Over 1.25 million men in the UK are juggling employment with caregiving yet their experiences remain relatively unexplored. An in-depth knowledge of how working-age men experience the competing obligations of caregiving and employment is warranted as government initiatives encourage carers to remain in employment.

As male carers may experience caregiving in distinctly different ways to their female counterparts, this study aimed to capture how male carers experienced and gave meaning to a traditional feminine occupation, whilst also being of an age where their communities and the government might expect them to have a responsibility to be in paid employment.

#### **Method**

A purposive sample of thirteen working-age male carers participated in semi-structured interviews. All were the main carer for their wife, adult child or mother; seven were in paid employment.

A hermeneutic phenomenological design recognised that caregiving occurs within a complex web of social relationships with cultural norms shaping the meaning of experiences. The design enabled the phenomenon to be captured as perceived by participants, whilst also acknowledging the researcher brings subjectivities to the study. Recognising the potential limits of single-point conversational interviews, an innovative methodology was used where a first-person narrative was developed from the first interview. During a second interview, this narrative provided a platform to gain additive data and share emerging meanings, leading to richer, more experiential data.

#### **Results**

Thematic analysis led to three themes. Trustworthiness in the results was enhanced by participant and peer validation.

1. **Being a Carer**- explored the negotiated nature of family caregiving. On becoming carers participants made complex decisions about whether or not they should stay in the caregiving situation. These decisions were embedded within a sense of duty to care for family, but justified through a concept of being the 'best' person to provide such care. They reached junctures where they were faced with further decisions about whether to stay in or leave paid work. Decisions to leave employment were influenced by concerns for the safety of their relative, but tempered by concerns for their financial security.

2. **Obligated Time** - captured the meaning of time for these male carers. They structured their time in particular work-related ways with caregiving being framed as 'alternative work'. There was a sense of achievement from learning new skills, leading participants to value the domestic work they were obligated to undertake. All found their use of time constrained by the demands of their employment, and the needs of the care-receiver and health and social

care providers. They used strategies to manage their time and so discharge their obligations effectively, thereby promoting their physical and mental well-being. However, not all were able to take control of how their time was used and these men appeared engulfed by their carer role and also by their employment responsibilities.

**3. Self as Carer; Reworking Identities** - explored the unease and discontinuity between participants' identity as a father, son or husband and carer. The role of carer could become all-consuming leaving space for no other identity. Nonetheless some embraced the identity of carer, developing new identities within carer support groups. Others accepted they were carers, but still felt uneasy with this new identity and the way in which being a carer affected their relationship with their wife. Employment provided a defined identity of a man who could provide financially for his relative. However, concessions were made about the type of employment which could be undertaken, and these impacted on the participants' sense of being a man with a career. Those men who had left employment spoke of caregiving as a form of work and constructed an identity of a carer at work.

### **Discussion**

This thesis provides a range of evidence identifying that care work undertaken by men and their employed work is not necessarily a separate domain of experience, but is intertwined and purposefully informs each other.

Internally and externally imposed obligations and personal incentives arise at different stages of the carer career and have to be negotiated for care work to be experienced as manageable and acceptable. Perceived and structural disincentives to disclose a caregiver identity may constrain male carers' abilities to combine caregiving with employment.

By conceptualising care as legitimate work, a deeper understanding becomes possible of how men may make the transition from employee to carer whilst still maintaining a self-identity they find acceptable. The transfer of management and practical skills from employment into their unpaid carer work enables the utilisation of skills developed in paid work. Making this visible may support male carers to see some direct transference of skills, instilling a sense of greater expertise in their new care work. Through understanding the ways in which men experience care as work, service providers may be better equipped to support pre-retirement men as they undertake the new job of carer.

## Neurofibromatosis Type 1 (NF1) - Family Experiences and Healthcare Management of a Genetic Syndrome Characterised by a Highly Uncertain Phenotype

Daniele Carrieri

University of Exeter

d.carrieri@exeter.ac.uk

### ABSTRACT

Neurofibromatosis Type 1 (NF1) is a dominantly inherited disorder (births incidence: 1/3000) with a high spontaneous mutation rate. NF1 has been described as a *condition without parameters*; physical features, cognitive symptomatology, and complications such as malignancy, are highly variable, both within and between families, and over the lifetime of affected individuals. This thesis explores the significance of the recent classifications of NF1 as a 'genetic syndrome', in terms of the subjecthood of affected individuals, their family experiences and the way it is managed within the healthcare system. The research is based on qualitative semi-structured interviews of NF1 individuals, their families (n=30) and healthcare professionals who work with NF1 (n=11) and employs Grounded Theory and Narrative Analysis inspired methods of analysis. As such, it provides an empirical investigation of many of the sociological theories which have been developed in response to genetic disease, particularly genetic responsibility, biocitizenship and the medicalisation of the family.

NF1 was still experienced by patients and treated by the healthcare system, as a condition without parameters i.e., as a disparate set of symptoms with uncertain meaning, rather than as a 'whole'. The majority of the respondents - regardless of the severity of NF1 - rejected NF1 genetic identities, employing diverse downplaying strategies to normalise it. NF1 was salient at certain critical junctures in individuals' lifecourses, especially in relation to reproductive choices, disclosure and management of pressing symptoms. Family experiences with genetic conditions, the relations of family or kinship, health behaviours, familial surveillance and disclosure did not necessarily follow the lines of biomedical knowledge and genetic inheritance. The analysis also revealed a degree of mirroring between the structure of the healthcare provision for NF1 and patients' constructions of the condition, for example the lack of illness identity. The example of NF1 shows that the identification of the genetic basis of a condition does not necessarily provide patients and healthcare professionals with more parameters to manage it.

## **Who joins a UK right to die society and why? - A study of members of Friends at the End (FATE)**

**Marion Judd**

Queen Mary University of London

m.judd@qmul.ac.uk

### **ABSTRACT**

The thesis presents quantitative and qualitative thematic analyses of a postal survey and interview study of members of Friends at the End (FATE), a Glasgow-based right to die society. This is one of the first UK studies aimed toward filling a gap in knowledge about who joins a UK right to die society, and their reasons for doing so. The thesis attributes responsibility for the right to die movement's continuing existence to contemporary socio-cultural norms of individualism and self-determination in promoting desire for autonomy and choice surrounding dying and death. It shows how and why a distinct group of predominantly older and higher social class individuals, 22% of whom have health and social care professional backgrounds, have decided to join FATE. The right to die movement is shown to be a new social movement concerned with health, ageing and death activism that challenges contemporary biomedical models of managing dying and death. The thesis shows how ageing, social class, religiosity, socio-medical constructs of dying, risk management and altruism toward others all contribute toward the ongoing existence of pro-right to die attitudes and beliefs. It also shows how personal fears about the manner of future dying, both physical and existential are frequently informed by personal experiences, identified as critical factors in decisions made to join the movement. FATE exists in a culture in which assessing risk has become very pervasive, and joining FATE is, for many members, a risk-avoidance strategy, given their concerns that future dying and death may be unpleasant. Conditional desire for hastened death is also shown to be informed by desire to avoid placing burden on others, a form of reciprocal altruism in which hastened death benefits both the dying person and family members as well as society as a whole.

## Care closer to home - what does it offer?

**Charlotte Overgaard**

Aalborg University, Denmark / King's College London, UK

co@hst.aau.dk

### ABSTRACT

This thesis represents an empirical study of safety and quality of maternity care in freestanding midwifery units in Denmark. It is publication-based and consists of a thesis overview and three peer-reviewed publications. A multidisciplinary and mixed-methods approach is applied and the work is informed by sociological theories of childbirth, medicine, midwifery and health.

At the same time as it is both a biological and a cultural phenomenon, childbirth is a significant personal life event shaped by the historical, social and political context in which it takes place. In most high- and middle-income countries, obstetric units (OU) have become the primary setting for birth, also for low risk women. This model of care is dominated by a medical and technological perspective that has led some to question the ability of OUs to meet the needs of all birthing women. While OUs have given increased attention to women's autonomy and the "humanisation" of care, midwifery units have emerged as an alternative to OU care for low-risk women, offering low-technological, individualised, and patient-centred care.

The aims of this study were:

- To compare perinatal and maternal morbidity, birth complications, interventions, use of pain relief as well as women's birth experiences, care satisfaction and perceptions of care in two freestanding midwifery units (FMU) and two obstetric units in northern Denmark, all pursuing an ideal of high-quality, humanistic and patient-centred care
- To investigate whether the effect of birthplace on perinatal and maternal morbidity and birth complications and interventions correlates with women's level of social disadvantage
- To investigate the influence of social disadvantage on women's birth experience and care perceptions

Overall, the study was designed as a cohort study with a matched control group. A postal questionnaire survey was undertaken as part of this study.

The study included 839 low-risk women intending FMU birth between March 2004 and October 2008. The women were prospectively and individually matched on nine selected obstetric/socio-economic factors to 839 low-risk women intending OU birth. A sub-group of 218 FMU women and their 218 matched controls were invited to participate in a questionnaire survey one month after birth.

No significant differences in perinatal morbidity were observed between groups. Significantly fewer birth complications and birth interventions, including caesarean section, instrumental delivery, and epidural analgesia occurred among women in the FMU group.

Of the 436 women invited to participate in the survey, 375 women (86 %) responded. Birth experience and satisfaction with care were rated significantly more positively by FMU than by OU women. Significantly better results for FMU care were also found for patient-centred care

elements such as support, participation in decision-making, information, and women's feeling of being listened to.

The FMUs' location in community hospitals in predominantly rural areas offered women a choice of low-technology patient-centred care relatively close to home, an offer which was accepted by women from a far wider range of social backgrounds than seen in most studies of out-of-OU birth.

Subgroup analysis revealed a significant, negative effect of low education and employment levels on birth experience. This effect was found only for the OU group; showing the potential of FMU care to mitigate the effects of social disadvantage on women's birth experience.

A similar effect of FMU care was not found on clinical birth outcomes. In all cases, socially disadvantaged women in the FMU group had comparable and, in some respects, favourable clinical outcomes when compared to OU women with the same level of disadvantage.

Overall, this study provides strong support for FMU care, even in settings where all frontline care in OUs is provided by midwives and where the humanistic paradigm of childbirth and patient-centred care is prevalent, as was the case in the North Denmark Region.

FMU care appears to offer important benefits for birthing women in terms of improved birth experience and reduced maternal morbidity with no additional risk to the infant. In a public health perspective, FMU care holds great potential for the improvement of maternal health and well-being in populations of low-risk women. Policy makers may consider increasing the availability of FMU care and information about different care models in order to support women in making an informed decision about their preferred place of birth.

## REFERENCES

Overgaard C, Møller AM, Fenger-Grøn M, Knudsen LB, Sandall J. Freestanding midwifery unit versus obstetric unit: a matched cohort study of outcomes in low-risk women. *BMJ Open* 2011;2:e000262.doi:10.1136/bmjopen-2011-000262

Overgaard C, Fenger-Grøn M, Sandall J. Freestanding midwifery units versus obstetric units: does the effect of place of birth differ with level of social disadvantage? *BMC Public Health* 2012, 12:478 doi:10.1186/1471-2458-12-478

Overgaard C, Fenger-Grøn M, Sandall J. The impact of birthplace on women's birth experiences and perceptions of care. *Social Science & Medicine* 2012; 74: 973 - 981.Doi.org/10.1016/j.socscimed.2011.12.023

## **Involvement in practice: an examination of the multiple influences on the construction of service user involvement in mental health care planning**

**Sarah Robens**

Peninsula College of Medicine and Dentistry  
Plymouth, UK

sarah.robens@nhs.net

### **ABSTRACT**

The involvement of mental health service users and their carers plays a central role in the policy behind the Care Programme Approach, the system for the management of care for people with mental illness. Since the 1990s there has been a shift in health and social care towards increasing the control service users have over their care. This is done through the use of different care planning mechanisms in particular. Within the Care Programme Approach, care plans define the package of care, and this care is monitored through six monthly reviews of the care plan. Care planning and reviewing is a process in which service users and carers are supposed to be fully involved but evidence shows that this involvement is not happening.

This evidence was reflected in the concerns of a mental health service user group in Devon, who designed this study with a steering group made up of mental health service users, carers and mental health professionals. The study seeks to fill the gap in the literature, which highlights that there are problems with mental health service user involvement in care planning but fails to explain the nature of the problems. Through the use of non-participant observation and in-depth interviewing, this study examined involvement in practice, outlining how it is created and what influences it, both positively and negatively.

The observational data pointed towards involvement as dynamic in nature and further analysis outlined the detail of how involvement changes during a review. In so doing, what emerged was analysis of how involvement is created through the interaction of different stakeholders at the review. A number of different methods are identified through which involvement is enabled, restricted and self-created. The interview data outlined people's experiences of involvement, and identified key bridges and barriers to involvement that relate to structural and interactional issues. Through both sets of data, the importance of the care coordinator in enabling involvement is emphasised, acting as they do within a set of structures that restrict service user involvement. Further discussion of this data used the theory of Giddens to outline how involvement is the product of structuration, being produced when structure is put into practice through the actions of individuals.

Coming out of these findings is the implication that for service user involvement to become meaningful requires a re-working of care planning systems to move away from a professionally-led system to one which is truly centred in service user needs and wishes. The other implication is that care coordinators need a greater understanding of how they can enable or restrict involvement through their actions, and this thesis provides the evidence on which to build this knowledge.



## **Chronic illness and self-management in primary care: characterising the 'work' of older people with coronary heart disease**

**Lucy Moore**

Peninsula School of Medicine and Dentistry  
Plymouth, UK

lucy.moore@pms.ac.uk

This abstract summarises a PhD in medical studies entitled, Chronic illness and self-management in primary care: characterising the 'work' of older people with coronary heart disease. Professor Nicky Britten and Dr Charlotte Paterson supervised this research. Three contrasting primary care practice sites were recruited including a town practice with a high deprivation score, a rural practice and a general practice with a low deprivation score.

A review of the literature on self-management employed an iterative process leading to an exploration of the ideology, assumptions and attributes associated with self-management policy. The analysis for this study drew on features of grounded theory and the work of Schutz and social phenomenology, Foucault, governmentality and the reflexive self and Giddens's modernity and self-identity.

Detailed findings of the study are divided into three areas namely:

- Context and complexity: the meaning of self-management for patient participants
- The 'occupational' model of self-management, drawing on the metaphor of work
- The professional perspective: the successful and unsuccessful self-manager.

In conclusion, the study identified the tension for policy makers and professionals who need to consider how to meet the needs of a diverse group of patients. Some patients had the skills, attributes and understanding to align themselves with self-management policy and improve their outcome. Other patients lacked the skills, attributes and personal circumstances for optimum self-management and were more likely to follow a lifestyle incongruent with an improved outcome for the heart and their health. These patients were either restricted or constrained physically and socially, fatalistic or anxious with a negated sense of self, disengaged or distanced from professionals or distracted by competing priorities in the form of co-morbidities or caring roles. There were a higher number of these patients in areas of high deprivation.

### **ABSTRACT**

Self-management policy has presented opportunities for patients with long-term conditions to improve their health and wellbeing by becoming active agents in their care. However, the 'work' of self-management for patients appears to need certain essential and desirable skills and attributes for improved health outcomes. A literature review and mind mapping analysis of policy literature produced a 'policy' model identifying 4 concepts described as active, competent, efficacious and responsible. The aim of this research was to characterise the self-management 'work' of older patients with coronary heart disease (CHD) in primary care and to identify the skills and attributes required for participation. This study was qualitative in design employing longitudinal diary-interviews with 21 patients, and interviews with 8

professionals, in three contrasting socio-economic general practice areas in the South West of England.

The analysis for this study drew on concepts of governmentality and the reflexive self. It produced an alternative 'occupational' model of self-management with 5 dominant occupational roles and 3 levels of occupational status. This occupational model identified the breadth and depth of self-management practices by older patients with CHD. It incorporated the diversity of self-management strategies seen in relation to the everyday management of health problems, life and illness perspectives and challenges associated with bereavement, retirement and parallel responsibilities as carers and sufferers of co-morbidities. It clearly demonstrated where patients have the interest, knowledge and confidence to modify their behaviour for an improved health outcome. It also highlighted the struggles associated with social, physical and emotional circumstances as well as the spectrum of relationships with health care professionals and significant others that improved or impacted upon optimum self-management. This occupational model provides a sociologically sensitive method of describing the older person's experience of living with CHD. This thesis outlines recommendations for primary care professionals based on this occupational model.

## **An Ethnography of Changes In The Giving Relationship**

**Patricia Mahon-Daly**

Bucks New University, UK

pmahon01@bucks.ac.uk

### **ABSTRACT**

Commentary about solid or whole body part transplantation, transfusion and donation is well documented and has added to discourse about who gives and receives and how. Commentary about another body part – blood – is, it is argued here, less well developed (Sanner, 2001; Lock, 2004; Scheper-Hughes and Wacquant, 2006; Shaw, 2009). Blood and its modern-day sociology and anthropology is understood and limited by its links with both Titmuss' altruism and gift exchange theories. This thesis, using a qualitative ethnographic approach, re-examines and introduces new discourse about blood, challenging the orthodoxy of altruism and seeking new understanding and justification for blood donation. It uses testimony from 80 blood donors to elicit real-time ideas about blood as a source of risk rather than a gift from strangers. It also argues that donors "give to get back" their donations rather than give as a form of altruistic behaviour, thus introducing the concept that blood donating is a form of covenant between society and the individual or a form of deposit.

Issues of trust are examined via the lens of deferment as increasingly it is not good enough to just donate blood without stringent societal, as well as techno-medical, surveillance. Donating blood is shown to be a form of active citizenship, and to be deferred from doing so has a direct impact on individuals' freedom to donate and thus community membership. The emotional labour of giving is revealed by the testimonies of "able" donors, which evidence that not only do donors perceive their blood to be special, but also the act of giving is a labour carried out by the few who can do it for the majority, in contrast to those donors who regard giving blood to be a mundane, functional practice. Lastly, an emerging hierarchy of self in relation to the body is uncovered here revealing hints at its' inalienable status. The thesis charts the journey of blood from being a mystical part of the body, linked to goodness, to blood being the new "master tool" of modern society, imbued with risk and therefore entrusted to society via scrutinising blood management systems. The methodological framework is centred on an interpretative approach, using data gathered from interviews and questionnaires from active blood donors in sessions at the National Blood Service (NHSBT) as well as testimony gathered from individual one-to-one interviews. It refers to theories by Foucault, Mauss and Douglas to interpret the qualitative data revealing blood as a target of bio-power, risk management and social exchange and a shifting dislocated new body part, and it sets out to challenge the orthodoxy of altruism as the rationale and justification for blood donation in modern Britain.

## **Heart Transplantation: Its Risks, the Expectations, and Cultural Negotiations in Japan**

**Ikuko Tomomatsu**

Queen Mary, University of London, UK

ikuko.tomomatsu@gmail.com

### **ABSTRACT**

The aim of this thesis is to facilitate an understanding of the experiences of Japanese heart transplant recipients in terms of how their identities are transformed. The thesis contributes to the discipline of medical sociology by providing an understanding of issues relating to the surgical procedure of heart transplants, the labelling of the recipients by the Japanese government and Japanese cultural factors. This is a qualitative study based on semi-structured interviews, which have been analysed thematically. The thesis sheds light on two major aspects of heart transplantation. One is the experiences of heart transplant recipients, from diagnosis through surgery to recovery. The other is the influence of Japanese cultural expectations about the body and the custom of reciprocal gift-exchange on recipients' experiences. In so doing, this thesis argues that heart transplant recipients face an issue of identity crisis when making a decision to have transplant surgery, and that identity is reconstructed in the post-operational period. In this process, the recipients face social stigma as the result of having a heart transplant. Considering heart transplants as they are viewed by Japanese people in everyday life, the use of an organ for this medical purpose is in conflict with conventional attitudes towards the treatment of the dead body in Japan. In addition, it is difficult for the practice of altruistic organ donation to take root in the modern consumer culture of Japan, where gift-giving has become a quasi-commercial transaction. As a result of these phenomena, anonymous relationships between heart transplant recipients and donors are varied in terms of the gift relationship. It is key how Japanese heart transplant recipients repay their donor. The repayment strategies are impacted by cultural factors.

## **Towards the Camisation of Health? The Countervailing Power of CAM in Relation to the Portuguese Mainstream Health-Care System**

**Joana Almeida**

Royal Holloway, University of London, UK

joana\_a\_almeida@btinternet.com

### **ABSTRACT**

The aim of my PhD research was to answer the following primary research questions: Is the relationship between complementary and alternative medicine (CAM), the medical profession and the State changing in Portugal? If there has been a change, how and why has such a change occurred? Two CAM therapies, acupuncture and homeopathy, were chosen as case studies. The main sources of data were in-depth individual interviews and documents. The research sample (n=41) was made of three groups of interviewees: (1) 20 traditional CAM practitioners, (2) 10 orthodox medical doctors not committed to CAM and (3) 11 orthodox medical doctors committed to CAM.

My PhD research drew on a neo-Weberian perspective of professions which emphasises the power relations between related occupational groups who seek to gain or maintain power and status in their field of work. This research also made extensive use of the concept of 'countervailing powers' (Light, 2010), as it attempted to illuminate the influence of CAM practitioners in the attitude of powerful players within Portuguese health-care, such as the State and health corporations (e.g. pharmaceutical companies), towards CAM.

On the basis of my PhD research, I argued that the relationship between CAM, the medical profession and the State has changed in Portugal over the last 16 years. I introduced a concept that helps to explain CAM practitioners' recent countervailing actions within the Portuguese mainstream health-care. This concept is 'camisation', a process through which everyday human problems are transformed into health problems which are treated in CAM terms and within a CAM framework. Although the main driver of camisation has been CAM practitioners, I also show how the Portuguese State, the medical profession and the pharmaceutical industry have all been active collaborators in this process, whilst maintaining different interests and constantly bargaining and negotiating to maximise their power and status within the field of health-care.

## **Empowerment and HIV Prevention among Women in Nigeria: The Relative Significance of Behavioural and Structural Determinants**

**Oluwatosin Alo**

University of Warwick, UK

alotosinige@yahoo.com

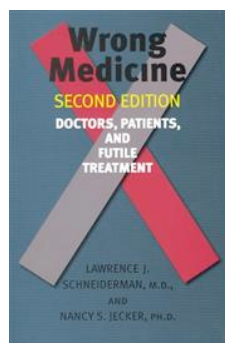
### **ABSTRACT**

**Aims:** To explore why women in long-term heterosexual relationships in Nigeria are constrained in negotiating safe-sex and how the current interventions are limited. As the dominant ideology in HIV prevention, behavioural models support individual-level interventions and public health communications, drawing on the assumptions that lack of knowledge and individual's attitudes to HIV are the main problems. However, as underpinned by social determinants theories, the key question raised is whether behavioural models adequately uncover the experiences of vulnerable women, given that they fail to take account of how contextual forces limit women's ability to undertake safe-sex practices.

**Methods:** This qualitative research was conducted with low and high socio-economic status women, low and high socio-economic status men, and local HIV/AIDS agencies. There were six focus group discussions and 29 in-depth interviews, involving 91 participants who were chosen purposively. **Results:** First, this study reveals that the women's inability to negotiate safe-sex was significantly conditioned by their social environments. In spite of their knowledge of HIV prevention, they were constrained by the fears of relationships breakup, economic insecurity, violence, and the difficulties in justifying why they feel the need to insist on condom use, especially since initiating condom use is antithetical to trust. Second, evidence suggests that women's access to life opportunities (i.e. higher education and economic power) might be instrumental. However, it does not automatically constitute a direct means of empowering them to negotiate safe sex because of widespread culture of patriarchy.

**Conclusions:** Policy and strategy on HIV prevention in Nigeria should not be confined to narrow mechanistic individual-level interventions underpinned by behavioural models, but should take a combination approach, focusing on how social, behavioural and biomedical factors overlap in promoting women's disempowerments which run-counter to safe sex practices.

## Book Review



Schneiderman, L. J. and Jecker, N. S.

### **Wrong Medicine: Doctors, Patients and Futile Treatment**

Baltimore: The Johns Hopkins University Press, 2011 second edition, paperback

ISBN: 978-0-8018-9851-8

230pp

### **Reviewer: Jacqueline Watts**

The Open University, UK

The quantity versus quality of life debate in respect of those facing life-limiting illness continues to take centre stage within both academic and public discourses. This is so particularly in the countries of the west where advances in medical and drug treatments in recent years have offered up the possibility of deferring death to extend biological life. The economic, social and ethical issues that frame medical and family decision-making in this area, are of interest to medical sociologists on a number of levels. The issue of resource distribution and the contentious questions of what are the goals of medicine and how these are determined are topics that have been widely debated in the medical sociology literature. *Wrong Medicine*, focusing on the US context and jointly authored by a medic and a humanities professor, makes a significant contribution to developing understanding of the complex nature of medical ethics in an era of growing public expectation that medicine will provide a cure for all kinds of ill health. Specifically, the book asks two questions in its quest to explore the concept of medical futility that is central to the narrative. The first is: can we as a society agree when treatment fails to achieve the goals of medicine? The second is: what are physicians supposed to do and not do when treatment fails to achieve the goals we set for medicine? The stated impetus for the book is a desire on the part of the authors to restore a vision of medicine's proper ends and reform medical practice that is accountable to society.

In seeking to address these key questions, the authors invoke material and ethical understandings of both life and death to mobilise a critical awareness for readers that these constructs are negotiated and highly dependent on cultural frameworks. So, the issue of individuals being not fully alive but not quite dead (an interim status that is the outcome of modern medical treatment) is an underpinning theme of the discussion. A further theme is that of the patient's best interests, not just those as defined by the patient, but a wider sense on the part of health professionals about which treatments and interventions bring benefit to patients. The interplay of these two themes, illuminated through a number of case studies, provides a fascinating and powerful lens through which the concepts of personhood, capacity and care are explored highlighting the centrality of the harm/benefit model that informs medical futility.

The book is organised into eleven chapters, each of which focuses on a specific aspect of the way in which medical treatment is considered, evaluated and delivered. Topics covered include family influence, litigation and the ethical implications of medical futility. Chapters

eight and nine are particularly engaging; they discuss 'the way it is now/the way it ought to be' for patients and for health professionals, drawing out how maintaining life at all costs and medics 'doing everything' (usually supported by patients and families), has been at the core of treatment decision-making for a very long time. An alternative approach, that frames the 'ought to be' aspect of these two chapters, is a participatory model of healthcare that privileges patient-centeredness and care, as well as cure, in an attempt to improve the humanity within medicine. The arguments presented by the authors are eloquently made and very persuasive, highlighting that modern medical treatments, often highly technology intensive, convey not only benefits but also significant psychological, spiritual and economic burdens. The concluding chapter of the volume offers the reader a useful succinct summary discussion of the key points in the form of objections/responses. This technique enables the reader to have a clear sense of the controversial nature of the debate that surrounds medical futility in relation to optimising outcomes that serve the best interests of patients, families and society.

I enjoyed this book because of its accessible style and clarity of purpose. As I began reading I wondered whether the volume's focus on the USA might limit its value for a wider readership, particularly in respect of litigious concerns and the insurance model of healthcare that underpins US healthcare delivery. This ambivalence turned out to be unfounded because the ethical, economic, theoretical and philosophical issues discussed in the US context also apply in other settings. This second edition of an earlier volume published in 1995, reads as cutting edge in its appropriate and thoughtful use of a number of high profile case studies with which to engage the reader in 'real life' values practices and standards facing both the medical profession and society. The book should be recommended reading for healthcare professionals, healthcare managers, medical social workers and medical educators.