Containing acute childhood illness within family life: a substantive grounded theory

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Abstract
Acute childhood illness is a universal experience for children and families. This paper presents the central process of a Glaserian grounded theory study which explored family management of acute childhood illness at home. Twenty-nine interviews were conducted with 15 families of children 0–9 years of age. Constant comparative analysis generated the substantive grounded theory ‘Containing acute childhood illness within family life’. This informal social rule was identified from families’ persistent desire to do the right thing, for their child and in the eyes of others in social life. Families perceived that they were expected to contain illnesses which are defined as minor and to seek medical help for ‘real’ illnesses. Considerable uncertainty was evident around defining the illness and the legitimacy of seeking medical help. Their concern with the latter indicates doctors’ role as moral agents for parents’ behaviour, directing the containment of acute childhood illness.

Keywords
acute illness, central process, childhood, containment, core category, family, Glaserian, grounded theory, moral agents, uncertainty

Introduction
Acute childhood illness is a universal experience for children and families. These are the common childhood illnesses which all children experience, such as coughs, colds, ear infections, viral rashes, chickenpox, vomiting and diarrhoea. These illnesses touch the lives of almost everyone in society, through experiences as parents, grandparents, friends, work colleagues, child care workers, teachers or health care professionals. Families look after children without professional help for between 59 and 99 percent of episodes of acute illness at home (Bruijnzeels et al., 1998; Holme,
1995; Mayall, 1986; Saunders et al., 2003). Those that decide to consult constitute a significant proportion of the workload in primary care. The General Household Survey 2006 found that 15 percent of 0–4 year olds and six percent of 5–15 year olds consulted a General Practitioner (GP) in the two weeks prior to interview, whilst five percent had seen a Health Visitor and four percent had seen a Practice Nurse (Ali et al., 2008). The Royal College of General Practitioners (RCGP) continue to report that children under 4 years consult most frequently, with the exception only of the over 75 year age group (RCGP, 2007).

The very commonality of acute childhood illness seems to have rendered it almost invisible in research terms. Yet it is this very commonality which makes it such an important area to investigate in the absence of theoretical knowledge in the area. The research findings reported here make a contribution to the development of this theory.

**Aim of the study**

The aim of the research was to discover the psychosocial processes which take place in families when a child is acutely ill at home, and the influence of these processes on families’ responses to such episodes of illness.

Acute childhood illness was defined, for the purposes of the project, as those common childhood illnesses which are of short duration and are wholly managed at home. Beyond this families decided for themselves what constituted acute childhood illness. The core category or central process of the resulting grounded theory is presented in this paper. Other publications have, and will, explore further the method and the detail within the grounded theory (Neill, 2000, 2005, 2006, 2007, 2008). Reporting the core category in depth is not common in grounded theory papers, usually due to journal word limits. Consequently readers are often given only a summary of the content of such theory as writers attempt to provide a flavour of the whole theory in one paper. The approach taken here is to present the core category, variously described as the core variable or central process (Stern, 2009), so that readers can assess, in this initial report, its detailed composition. It is hoped that it will also provide a much needed example for others learning the process. Readers are referred to Neill (2008) for a full report.

**Methodology**

Glaserian grounded theory methodology was chosen as it ensures that the analysis stays close to the data, facilitating the inductive emergence of an explanatory grounded theory (Glaser, 1992, 2001). Glaser’s approach to grounded theory was selected because it is less fractured and formulaic than that of Strauss and Corbin, keeping the analytical process close to the data. Analytical questions emerge from the data itself, as opposed to Strauss and Corbin’s (1990, 1998) use of speculative questions not indicated by the data.

An initial literature review was conducted (Neill, 2000) to establish the need for the research (Glaser, 1998; McGhee et al., 2007). This literature was then put aside and not revisited until the core category was established, to prevent any foreclosure of the analysis created by preconceived ideas from prior research (Heath, 2006; McGhee et al., 2007). Thereafter, the usual tenets of Glaserian grounded theory were followed, evolving from initial purposeful to later theoretical sampling, using theoretical sensitivity and constant comparative analysis to achieve theoretical saturation around a core category (Glaser, 1978, 1992, 1998). A core category is central to the data as it accounts for a large proportion of variation in behaviour and, therefore, most of the other
categories are related to it (Glaser, 1992, 1998). Variables which do not fit are not included in the theory (Glaser, 1978). Once the core category had been identified different areas of the literature relevant to the emerging theory were reviewed and subjected to the constant comparative process to establish their fit with the emergent theory. It was then possible to identify new contributions to prior theory. The findings reported here concentrate on the core category. Data analysis was assisted by QRS NVivo 2.0 (Richards, 2002), a computer software package for qualitative data analysis. Throughout the process supervision provided checks on the rigour of the grounded theory process. On completion the grounded theory was assessed against Glaser’s (1998) evaluation criteria of fit, work, relevance and modifiability.

Four sets of data generated 29 tape recorded interviews in the home with 15 families with children aged 0–9 years (see Table 1 for the characteristics of the sample participants). Sampling sites were identified in two towns with socioeconomic profiles close to the national average. Purposeful sampling initially directed sampling through primary health care. This was followed by theoretical sampling through sites not directly connected to health care, in a Sure Start Programme, a junior school, a private nursery and an infants school (see Neill, 2007 for further detail). The final data set was selectively sampled, from within the families already in the study, to check out the emerging theory and confirm category saturation.

Ethical approval was received from the local research ethics committee prior to each of these sets of data collection. Adults were provided with written and verbal explanations about the project and an opportunity to ask questions prior to completing consent forms. Where families were involved in additional interviews consent was reviewed. Consent for children’s participation was initially sought from parents, following which the researcher met with the children in each family to develop trust and rapport, prior to seeking consent verbally and in writing, in an age appropriate manner, at the beginning of the interview.

In the first three sets of data collection interviews took place as soon as practically possible following family experiences of acute childhood illness managed at home. Families had agreed to contact the researcher when one of their children had experienced an acute childhood illness. In this way families were able to define, within the broad definition given for the study (see above), what constituted an acute childhood illness. This approach facilitated recall of the event of the child’s illness which, itself, often triggered recollections of prior experiences.

Family interviews, using an unstructured in-depth interviewing technique were conducted with adults, as these interviews enable the exploration of family beliefs and experiences (Astedt-Kurki and Hopia, 1996). Adult family members were asked the starter question: ‘What was it like when ... was ill the other day/last week?’ Neutral prompts and probes where then used to help research participants to tell more about their experiences, giving the necessary depth to the data (Chenitz and Swanson, 1986; Rubin and Rubin, 1995). A draw, write and/or tell technique (Pridmore and Bendelow, 1995; Williams et al., 1989) was used with children over 5 years of age. Each child was able to choose how they would like to tell the story of their illness. All interviews were tape-recorded, transcribed verbatim and returned to participants to check for accuracy. Interviews later in the process of theoretical sampling, all with parents, continued to use the same open starter question and conversational style with added questions about emerging categories, if these areas had not been mentioned spontaneously. The final set of interviews was devoted to discussion of the emerging theory to confirm category saturation. Inherent within this process is the assessment by participants of the credibility or ‘fit’ (in Glaser’s [1998] terms) of the emerging theory.
<table>
<thead>
<tr>
<th>Data set</th>
<th>Family code</th>
<th>Family composition within household</th>
<th>Parents’ occupation</th>
<th>Family members interviewed</th>
<th>Presenting acute illness</th>
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<tr>
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<td>F111: Mother &amp; Father</td>
<td>Conjunctivitis, Ear infection</td>
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<td>Mother 33, Daughter 12 years, Son 7 years</td>
<td>Mother: Occupational therapy assistant</td>
<td>F211: Mother, F212: Daughter, F213: Son (Drawing only)</td>
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<td>Mother: Teacher (6th form)</td>
<td>F311: Mother</td>
<td>Vomiting, Chesty cough</td>
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<td>Mother: Classroom assistant (PT), Father: HGV vehicle fitter</td>
<td>F411: Mother &amp; Father, F412: Daughter</td>
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<td>F511: Mother, father &amp; paternal grandmother, F512: Daughter (son present)</td>
<td>Vomiting</td>
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<td>6</td>
<td>Mother 22, Father 23, Son 2 years, Daughter 2 months</td>
<td>Mother: Housewife, Father: Unemployed</td>
<td>F611: Mother</td>
<td>Rash</td>
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<td>7</td>
<td>Mother 30+, Father 30+, Son 2½ years, Son 13 months</td>
<td>Mother: Accountant (PT), Father: Carpenter</td>
<td>F711: Mother</td>
<td>Gastroenteritis</td>
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Table 1. (continued)

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<thead>
<tr>
<th>Data set</th>
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<td>8</td>
<td>F8I1</td>
<td>Mother &amp; Father</td>
<td>Mother: Shop assistant (PT) Father: Factory shift worker</td>
<td>F8I1: Mother &amp; Father</td>
<td>Chicken pox</td>
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<tr>
<td>8</td>
<td>F8I2</td>
<td>Mother &amp; Father</td>
<td>Mother: Shop assistant (PT) Father: Factory shift worker</td>
<td>F8I2: Mother &amp; Father</td>
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<tr>
<td>9</td>
<td>F9I1</td>
<td>Mother &amp; step-father</td>
<td>Mother: School assistant (PT) Father: Motorbike journalist</td>
<td>F9I1: Mother &amp; step-father</td>
<td>Ear infection</td>
</tr>
<tr>
<td>9</td>
<td>F9I2</td>
<td>Daughter &amp; son</td>
<td>Mother: Shop assistant (PT) Father: Motorbike journalist</td>
<td>F9I2: Daughter &amp; son</td>
<td>Sore throat</td>
</tr>
<tr>
<td>9</td>
<td>F9I3</td>
<td>Mother &amp; step-father</td>
<td>Mother: School assistant (PT) Father: Motorbike journalist</td>
<td>F9I3: Mother &amp; step-father</td>
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<td>10</td>
<td>F10I1</td>
<td>Mother &amp; father</td>
<td>Mother: Secretary (PT) Father: Unemployed driving instructor</td>
<td>F10I1: Mother &amp; father</td>
<td>Croup</td>
</tr>
<tr>
<td>10</td>
<td>F10I2</td>
<td>Maternal grandmother (regular carer for grandson)</td>
<td>Mother: Secretary (PT) Father: Unemployed driving instructor</td>
<td>F10I2: Maternal grandmother (regular carer for grandson)</td>
<td>Chest infections</td>
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<tr>
<td>10</td>
<td>F10I3</td>
<td>Mother &amp; father</td>
<td>Mother: Secretary (PT) Father: Unemployed driving instructor</td>
<td>F10I3: Mother &amp; father</td>
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<tr>
<td>11</td>
<td>F11I1</td>
<td>Mother &amp; Father</td>
<td>Mother: Medical secretary (PT – on maternity leave for Interview 1) Father: Boat builder</td>
<td>F11I1: Mother &amp; Father</td>
<td>Gastroenteritis</td>
</tr>
<tr>
<td>11</td>
<td>F11I2</td>
<td>Mother &amp; Father</td>
<td>Mother: Medical secretary (PT – on maternity leave for Interview 1) Father: Boat builder</td>
<td>F11I2: Mother &amp; Father</td>
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<tr>
<td>12</td>
<td>F12I1</td>
<td>Mother &amp; father</td>
<td>Mother: Childminder Father: Telecommunications engineer</td>
<td>F12I1: Mother &amp; father</td>
<td>Conjunctivitis</td>
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<td>12</td>
<td>F12I2</td>
<td>Mother &amp; father</td>
<td>Mother: Childminder Father: Telecommunications engineer</td>
<td>F12I2: Mother &amp; father</td>
<td>Cold</td>
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<td>CM1I1</td>
<td>Mother in her childminder capacity</td>
<td>Mother: Childminder Father: Telecommunications engineer</td>
<td>CM1I1: Mother in her childminder capacity</td>
<td>Sore throat</td>
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<td>13</td>
<td>F13I1</td>
<td>Son 5½ years</td>
<td>Mother: Business assistant (PT from home) Father: Teacher (11–16 science)</td>
<td>F13I1: Son 5½ years</td>
<td>Chicken pox</td>
</tr>
<tr>
<td>13</td>
<td>F13I2</td>
<td>Mother &amp; father</td>
<td>Mother: Business assistant (PT from home) Father: Teacher (11–16 science)</td>
<td>F13I2: Mother &amp; father</td>
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<td></td>
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<td>Son 5½ years</td>
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<td>14</td>
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<td>Son 20 years</td>
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<td></td>
<td></td>
<td>Mother 31</td>
<td>Mother: Own business (PT from home)</td>
<td>F14I1: Daughter 6 years</td>
<td>Head cold</td>
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<td></td>
<td>Father 37</td>
<td>Father: Parts manager for car sales</td>
<td>F14I2: Mother &amp; father</td>
<td>Croup</td>
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<td></td>
<td>Daughter 6 years</td>
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<td>Daughter 4 years</td>
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<td>Daughter 3 years</td>
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<tr>
<td>15</td>
<td></td>
<td>Mother 30</td>
<td>Mother: Student nurse</td>
<td>F15I1: Mother &amp; father</td>
<td>Chicken pox</td>
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<td></td>
<td>Father 35</td>
<td>Father: Surgical implants sales officer</td>
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<td></td>
<td></td>
<td>Son 4 years</td>
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<td></td>
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<td>Daughter 2 years</td>
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Findings

The core category: containing family life

‘Containing acute childhood illness within family life’ emerged as the core category, from analysis of families’ desire ‘to do the right thing’. This core category integrated categories representing informal social rules (unwritten social expectations) for parents when their child(ren) have an acute childhood illness at home. Central to all of these social rules was the expectation that families will contain such illnesses within family life. Three interrelated categories constitute the core or central process as follows:

- Doing the right thing, including defining family and containing the illness
- Parents’ roles in acute childhood illness: the persistence of the traditional model
- Family identification and definition of childhood illness: the rule frame for seeking help.

These categories are reported here. Other findings, which will be reported elsewhere, explored how families learn to contain childhood illness, and the strategies families use to present an appearance of conformity with this informal social rule. Figure 1 depicts the basic process of containing childhood illness.

‘Doing the right thing’. Repeatedly parents were found to strive ‘to do the right thing’, for their child and in the eyes of others, by attempting to conform to informal social rules (ISRs) for the management of common acute childhood illness. Previous research also identified a desire to do the right thing for the child (Ehrich, 2000; Houston and Pickering, 2000; Neill, 2000; Polyzoi et al., 2003). It is evident that this is an expectation of families, which, given the desire to be seen to do the right thing – to manage the impressions created for their audience (the researcher) – might be expected in conversations about parenting. Families appear to be conforming to perceived informal social rules, which, Denzin (1970) suggests, specify appropriate and inappropriate ways of behaving. This first quote illustrates this mother’s anxiety to do the right thing for her child.

He was a very hungry baby and I think we were very anxious to do the right thing by him. (Family 1 Int. 1, Mum)

The second shows another mother’s multiple sources of concern regarding the right thing for her child.

Sometimes I feel sorry for them because they say ‘oh I’ve got a cold and so and so stays off school for a cold’ and I said ‘Yes but we’ve got to go to work, if it’s that serious the teachers will send you home’. Sometimes I feel as if, am I doing the right thing there? (Family 5 Int. 1, Mum)

This mother, like many others reflected in broader research concerned with mother’s roles (Cunningham-Burley et al., 2006; Elvin-Nowak, 1999; Hochschild and Machung, 2003; Kostiainen et al., 2009), is juggling different sets of expectations – those of her employer, her child’s teachers and more general social expectations of a mother of a sick child. These last expectations, or ISRs, are difficult for parents to identify, creating a situation of some uncertainty about ‘the right thing to do’.
Families concern to do the right thing for the child was focused around protecting the child’s health status, which they sought to manage in such a way as to present the family as conforming to informal social rules of behaviour. Families appear to perceive and respond to ISRs governing the expectations of families when a child is ill in three ways: containing the illness within family life; identifying and defining the illness to determine whether it should be contained; and consequently, seeking to be seen to use services ‘appropriately’. Families’ definition of ‘family’ for the purposes of caring for an acutely ill child, and their perception of expected roles for mothers and fathers, shape the way in which they respond to these informal social rules. These are, in Glaser’s (1978) terms, the conditions for containing the illness.

*Defining family.* When families were invited to participate in the research they were asked to identify the people in their family who were involved in the care of their child(ren) when they are...
ill at home. Almost exclusively the individuals identified were resident parents and children. This was also supported by the interview data within which most of the parents seem to define family in these circumstances as consisting of their children and themselves. The mother quoted below kept her concerns within the parental dyad.

I don’t really ask anybody else, no . . . I say to M (her partner) ‘What do you think?’ (Family 9 Int. 1, Mum)

The children in the study also referred almost exclusively to their parents and siblings when talking about being ill at home. Many of the families in the study mapped out an extensive network of family members with whom they are in touch, often with several local relatives, but they did not call on them for help or advice with childhood illness, although they might ask them for help with practical tasks such as shopping. One father commented, when this emerged during the interview ‘How mad is that? We should do’ (Family 9 Int. 1, Dad)

Multiple forms of contemporary family structure have been identified (Allan, 2005; Finch, 2007; Finch and Mason, 1993; Mitchell and Green, 2002; Ribbens et al. 2003), consequently it might be expected that such diversity would be identified in the data. However there was little variation from the nuclear format of resident parents and dependent children. One exception involved support from people parents defined as close family members. For example: Family 6 sought help from a grandmother.

I took him up to my mum’s and he was sick on the way to my mum’s . . . My mum’s just there . . . five minutes away . . . (Family 6 Int. 1, Mum)

Grandmothers have been identified as commonly included in the nuclear family inner circle (Firth et al., 1970), and an accepted part of family lives in research findings from the 19th century onwards (Mitchell and Green, 2002). Here it was the younger mothers who chose to seek advice from their mothers (usually in addition to their partners) about illness identification or management. This definition of grandmothers as a part of the immediate family group may reflect a developmental continuum where young parents in a relatively new relationship are still developing their sense of independence as a family.

Although contemporary sociological theory has shown diversity and fluidity in family structures (Allan, 2005; Finch, 2007; Finch and Mason, 1993; Mitchell and Green, 2002; Ribbens et al., 2003), when children are ill at home families appear to define themselves in very traditional ways as parents and dependent children, extending beyond this group only when the resources available, within this core unit, have been exceeded. It is within this family unit that parents appear to feel they are expected to contain acute childhood illnesses.

**Containing the illness.** Families strive to contain the child’s illness within family life without recourse to help from others outside the immediate family, particularly for the direct care of the sick child. This desire, to remain independent, is based on family perceptions of the social expectations of families with young children, mostly illustrated in the data in the ways in which management of minor childhood illness at home is reported by family members. One mother (Family 9) did comment directly on her desire to be self-sufficient in the care of her children with minor childhood illness:
I never once thought oh we need to ring the doctor. I quite like to manage it myself . . . I’m reluctant to go to the doctor’s because I can manage it myself, it’s not life threatening and I know that in a day or two it’ll pass . . . (Family 9 Int. 1, Mum)

This quote clearly illustrates her desire for independence whilst also alluding to her knowledge of childhood illness. Other parents talked about the things they would do when their children’s were ill. It was implicit in this talk that they wanted to manage the child’s illness within the family unit. This is illustrated in data extracts from the sub-categories: ‘Treating it myself first’, ‘Wait and see’, ‘Being prepared’ (see Figure 1).

**Treating it myself first.**

. . . you get the thermometer out . . . and if you think it’s higher than it should be and that’s when you get the good old faithful Calpol out or whatever and dose him up with that sort of thing (Family 11 Int. 1, Mum)

Calpol was referred to by all the families as a universally accepted over the counter (OTC) medication. The data generated a long list of other OTCs, non-drug treatments and behavioural responses reported by the families in the study. These strategies enabled families to manage their child’s distress and contain the illness. Where they were unable to do so, feelings of uncertainty and loss of control were the result.

**Wait and see.**

Dad: See what it’s like in the morning
Mum: See what it’s like and see how he is
Dad: He seemed pretty much himself, didn’t he? (Family 1 Int. 1)

Many of the parents gave considerable detail on the ways in which they assessed their children’s health. These parents had both the resources with which they could assess and manage the child’s illness whilst ‘waiting and seeing’, and knowledge of what they perceived was expected of them.

**Being prepared.**

But because I know it [the illness] I sort of don’t really like to be without my Phenergan . . . You know? My Phenergan syrup must be in the cupboard. So that I know if they need it, even if they wake up at sort of 2 o’clock in the morning I give them a dose of Phenergan. (Family 4 Int. 1, Mum)

Being prepared included having OTCs in the house and, for another mother, doing a first aid course when she first discovered she was pregnant.

All of the above sub-categories demonstrate parents’ desire to remain independent and contain the illness within the family where possible. In so doing families are managing the impression they make on others by presenting themselves as able to cope with the illness without help. Much earlier research from the 1980s and 1990s around parenting roles also identified that parents desire to be self-sufficient and to resolve problems within the nuclear family (Backett, 1982; Ribbens, 1994). Families appear to perceive childhood illness management as ‘back stage’ work in Goffman’s (1959) dramaturgical analysis terms, keeping it concealed within family life, echoing the private nature of suffering identified in research around chronic illness (Charles and Harris, 2007; Charmaz, 1983, 2000, 2002; Williams 1993, 2000).
Parents’ roles in acute childhood illness

Within the expectation that families will contain childhood illness the expectations of mothers and fathers were found to differ. Mothers are seen as having primary responsibility for the care of sick children, emotionally and practically, in this study, as in other contemporary research (Cunningham-Burley et al., 2006; Gatrell, 2005; Guendouzi, 2005; Hochschild and Machung, 2003). Practical responsibility had consequences for the pattern of mothers’ days and their employment, for example ‘It’s usually me that stays off work . . . have to work it round’ (Family 1 Int. 1, Mum).

Mothers talk about taking time off work, staying up with them in the night and delaying housework until later: ‘It’s usually their Mum they want anyway, isn’t it?’ (Family 5 Int. 1, Dad). Families seem to accept this as the normal expected pattern. They justify the mother’s role in several ways: through talking about mothers’ greater sensitivity and responsiveness to the children; with an expressed belief that fathers don’t really know what to do with children when they are ill anyway; talking about ‘mothers’ instincts’; and making reference to children expressing a preference for their mothers when they are ill.

Not only is it mothers who have the primary responsibility for the physical care of the child and the practical arrangements necessary to accomplish it, but mothers also carry the emotional responsibility. This is represented in the data in the form of ‘mothers’ worry’ and ‘mothers’ guilt’. In terms of mothers’ worry:

... if you’d said to my mother who rang when say A had a . . . whatever, it would be me . . . even though you’re working, there’s still a part of your brain that’s still thinking about your children . . . (Family 11 Int. 2, Mum)

And for mothers’ guilt:

Nobody tells you whether they’re faking or whether they’re real and the amount of times you kind of think they’re playing up . . . and then they are really poorly and you feel so bad because you think I made her do this or told her to do that and they are really, really poorly. (Family 14 Int. 2, Mum)

When fathers talk about responsibility, it is in terms of their responsibilities to their employment and as a breadwinner for the family. However when children are ill, fathers talked about the inflexibility of their employers, providing support for the expectation that fathers will continue to work, leaving mothers or other women in the family, to provide the necessary care.

Mum: I think they [the father’s employers] just feel, don’t they, that you should be at work and that we should find other support, help, i.e. parents or . . .

Dad: What’s wrong with mum, why can’t my mum come round and like . . . (Family 14 Int. 2)

Fathers in this study were involved in the process when a child is ill, usually at the level of decision making about seeking help and providing some direct care when they are not at work.

I think it’s a mutual thing [decision making] . . . And we’ve always said well perhaps we should do such or what do you think? (Family 4 Int. 1, Dad)

Mothers sought reassurance from their partners that they were ‘doing the right thing’ when their partners were present.
Although people may say that they reject traditional patterns of social roles (Park et al., 2003), in practice these patterns of behaviour continue to persist for a significant proportion of the population. Fathers did report involvement when they are present in the home, although mothers appear to continue to be seen as having the major responsibility for child care when the child is ill.

I think it [conventional view of parents’ roles] persists stronger, I think there’s a level of acceptance now that in a lot of cases both parents choose or need to work but whatever acceptance you have then comes crashing down when a child is not well... no matter how far forward we think we’ve come in, say, the last 30 years particularly, there are certain situations where that gets all undone remarkably quickly. (Family 12 Int. 2, Mum)

When children are ill traditional gendered roles are reinforced as it is women who care for the ill child, although fathers contribute to the decision making process and may help out with caring around their commitments to work. Therefore is it mothers who experience conflicting expectations between their obligations to work and to their child(ren).

**Identifying and defining the illness: the rule frame for seeking help**

Parents appear to have been adept at identifying illness as they were able to report a wide range of symptoms and behavioural changes which indicated their child was ill. They learnt about each individual child over time, gradually accumulating knowledge and experience of acute childhood illness. Once they had identified illness in their child, parents’ perception of the illness emerged as pivotal to their responses. Two broad categories of illness were identified: minor/normal illness for people generally or for children and/or for the individual child; and ‘real illness’ requiring medical help. These categories reflect those of Cornwell’s (1984) research, although her definition of ‘real illness’ was of illness of greater severity as it was viewed as presenting a challenge to medicine. This may simply be related to the focus of Cornwell’s research on adult illness. Children are seen as vulnerable in Western society (Alderson, 2000; Christensen, 1998; Mayall, 2002), consequently parents may interpret illness in their child(ren) as more serious than in themselves.

**Minor/normal illness.** Minor illnesses were those which seemed trivial, were understood, created little or no uncertainty and could be easily accommodated within normal family life.

I’m lucky coz I’ve never been in hospital or anything really seriously ill or anything, just like colds and that. But that don’t really bother me. (Family 2 Int. 2, Child)

Normal illness included illness normal for anyone of any age such as colds, those which are normal for an individual child and those which are an expected part of childhood such as chickenpox. In categorizing illness in this way families indicated that they feel competent to manage these illnesses themselves and see it as part of their role to do so.

Dad: Yes, just like having breakfast everyday, it’s...

Mum: Yes, it’s not considered an illness.

Dad: ... when they’ve got a cold you just deal with it ... (Family 10 Int. 3)

Some parents also referred to using common sense knowledge to manage these illnesses. In doing so they infer that these are illnesses which they consider parents should be able to manage.
independently. This has a judgemental quality as if parents do not have this knowledge they are somehow viewed as lesser parents. Drawing from Goffman’s (1963) theory of stigma, lack of such knowledge could be interpreted as a discrediting attribute. This interpretation is supported by Ehrich’s (2000) finding that GPs and nurses in an out of hours service constructed parents as unreasonable, ignorant or incompetent. Health care professionals may be acting as agents of ‘official morality’ (in Voysey’s 1975 terms) – setting informal social rules for parents when their children are ill.

‘Real illness’ requiring medical help. Parents seemed to define a child’s illness as real when the illness is unknown to them, when it persists or severity increases, when symptoms recur or when symptoms of concern are identified such as a rash. In all of these situations parents viewed the illness as beyond their ability to manage or feel that it is about to become so.

It’s hard to know really, isn’t it sometimes? It’s like meningitis and stuff and you just don’t know do you? ... Like we had that rash and I was like ... oooowh. (Family 2 Int. 1, Mum)

These situations reflect varying forms of uncertainty – diagnostic uncertainty around identifying the illness and therefore the severity of the illness, trajectory uncertainty concerning the expected duration of the illness and its impact on family life, and symbolic uncertainty concerning how their actions in response to the illness will be viewed by others, particularly health care professionals. These forms of uncertainty have also been reported in chronic illness, although the latter relates to Bury’s (1991) symbolic meaning of the illness. Here it is the symbolic significance of consulting, usually a doctor, which contributes to the meaning of illness for families. Uncertainty about the legitimacy of seeking medical help led some parents to check it out in books, with NHS Direct (the UK national health telephone helpline).

But, no, I think we use NHS Direct before taking them to the doctor just so that we don’t waste the doctor’s time and just to see if there is anything to be worried about but ... (Family 10 Int. 3, Mum)

Or through contacting a family health care professional.

Dad: We do talk to my mother or sister who are both ex-nurses ...
Mum: ... if you are a little bit unsure is just to ring somebody to say I’m not a hundred percent sure about this, what do you think, you know, just to, you know, to get confirmation that you are doing the right thing as well ... (Family 11 Int. 1)

In seeking to validate their need to contact a doctor parents were checking out others’ perceptions of informal social rules. Their intention was to ‘do the right thing’ for their child and to act in accordance with these rules.

Influences on family definitions of illness. Several sub-categories were identified as having an influence on perception of the illness. These are the characteristics of the ill child, knowledge and experience of childhood illness, parents’ state of health, and the family’s social circumstances. As can be seen from the data extracts below, each of these can affect families’ ability to assess childhood illness and to differentiate between normal/minor and ‘real’ illness in need of medical treatment.
Children’s characteristics.

M . . . will tell us, won’t she, whether she’s really poorly and when she says she’s poorly we normally believe her . . . T is, she’s a bit of a drama queen, a bit of a hypochondriac so when she says my tummy hurts, MY TUMMY REALLY HURTS, and I’m like OK T . . . (Family 14 Int. 2, Mum)

Children’s characteristics which could impact on the definition of the illness also included the vulnerability of a young baby and the child’s level of distress.

Parents’ health.

... the times when you’re feeling worn out, rundown, exhausted, you take on a lot of other people’s comments which can then be very confusing . . . (Family 14 Int. 2, Mum)

This mother was unusually open as very few parents were willing to discuss the impact of their own health status on their ability to cope with their child’s illness, reflecting their desire to be seen as morally worthy parents.

Social circumstances.

... it’s that feeling that you’re not going to get help . . . because everyone else has gone to bed. So I think it’s that critical point. (Family 12 Int. 1, Mum)

Influential social circumstances all related to the perception of access to support from another person, even if, in the event of illness, it was not used.

Experience.

... and the first time it happened, yes, we were both really frightened, but then, once you know what it is it’s like you just deal with it then. (Family 10 Int. 3, Mum)

Identifying illness can be difficult for professionals due to the ambiguity of symptoms. Not only is this also difficult for parents, but their resources with which to define their child’s illness may be affected by all of the above. Clearly uncertainty is a feature of many childhood acute illnesses, leading parents to define illness as ‘real’ in their desire to do the right thing for their child. Seeking help, however, is fraught with uncertainty of its own – symbolic uncertainty about how those consulted will view their competence as parents.

Using services ‘appropriately’: the rule frame for seeking help

Parents attempt to conform to the informal social rule that they should manage normal/minor illness independently whilst ensuring that they seek help for ‘real’ illness. This is their rule frame for seeking help, yet determining ‘real’ from normal or minor illnesses is far from easy. Consequently parents are often exposed to criticism for either seeking help too soon or too late.

Families reported situations where they sought help from a doctor only to be made to feel silly for doing so, emphasizing the expectation that this is not desired behaviour, and that they should have dealt with it themselves – reinforcing family containment of the illness.

We’ve all taken a sick child to the doctor only to be pooh poohed away, you know . . . and then you feel silly . . . So I think you get a reluctance that builds up. (Family 12 Int. 2, Mum)
Doctors appear to be acting as ‘agents of control officially empowered to legitimate family behaviour’ (Voysey, 1975: 52), creating informal social rules for parents’ use of health services for their children.

There has been much discussion in the health professional literature concerning the (in)appropriateness of patients use of services, largely led by the medical professions concerns with managing demand. More recent research (Ehrich, 2003; Houston and Pickering, 2000; Liggins, 1993; Watson, 1991) has focused on examining the underlying reasons for patterns of service use, rather than demonizing service users for failing to behave as professionals believe they should. There is some evidence in that research (Ehrich, 2003; Houston and Pickering, 2000) and in this study (albeit based on the families’ perspective) that professionals’ behaviour during consultations is shaped by these expectations of appropriate service use, illustrated in accounts of consultations which have resulted in families feeling ‘silly’ for having sought a doctor’s opinion. Findings in this area generated the concept of felt or enacted criticism from which experiences parents learn the informal social rules for the management of acute childhood illness. A later publication will explore felt or enacted criticism in greater depth.

**Conclusion**

Families appear to be expected to manage minor, normal childhood illness at home without recourse to health care professionals – to contain acute childhood illness within family life. They are also expected to define the severity of the illness and use services ‘appropriately’ as a result (see Figure 1). Families define themselves as the immediate family of parents and children, sometimes including grandparents, for the purposes of caring for the ill child. Containing the illness within this small family group enables them to control exposure to scrutiny and manage the impression they make as parents on others outside this group.

Gender emerged as an important construct within parental responsibility for children. Older social attitudes about parents’ roles re-emerge with the child’s illness – newer ways of thinking about family life ‘all come crashing down’. Social attitudes are slow to change when compared to demographic change (Gatrell, 2005) and changes in social policy (McKie et al., 2001). As a result, parents, particularly mothers with whom responsibility for children still resides, face conflicting expectations.

Parents want to be seen to be doing their best for their children, and it is this which motivates parents to respond to their child(ren)’s illness in a way which manages the impressions others have of them. Seeking legitimation, for their perceptions of their child’s illness and the ‘appropriateness’ of seeking help, is one strategy used by parents in an attempt to check their conformity to informal social rules, or the ‘official morality’ as defined by those from whom they seek help.

The containing family life theory appears to offer a new way to look at family processes focusing on containing family processes rather than on the boundary management which has featured in other sociological research (McKie and Cunningham-Burley, 2005; McKie et al., 2005; Wyness, 1997). The theory of family containment presents opportunities for further research to establish whether or not, or to what extent, it operates in other areas of family life. In a society where individualism appears to be in the ascendant there are likely to be increasing pressures to manage family life independently.

This is a substantive grounded theory whose scope or workability is restricted to the area of family management of acute childhood illness at home. It is also limited by the characteristics of its sample. The predictive ‘work’ of the theory is, therefore, restricted to containing acute
childhood illness at home in the dominant white population. Further research is needed to explore in what ways, if any, the containing family life theory needs to be modified for other ethnic and cultural groups, different family structures such as those headed by lone fathers, and in different social environments such as inner city or remote rural communities.

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