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Emotional encounters in health care: an investigation into the experiences of health visitors when working across cultures

Fiona Cuthill

A thesis submitted in partial fulfilment of the requirements of the University of Sunderland for the degree of Doctor of Philosophy

October 2011

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Abstract

Background: A substantial body of research evidence suggests that inequalities in health linked to ethnicity exist. People from minority ethnic groups suffer discrimination and have poorer access to health care services, however, the influence of health professionals in relation to these health inequalities is under researched. Health professionals are expected to deliver a high standard of culturally appropriate health care to a diverse, changing and complex population. Educational packages in the area of cultural care have flourished, but there is a paucity of research that seeks to explore the experience of health professionals themselves. This research explores the opportunities and barriers experienced by health visitors in the North East of England when working with clients who are from another culture. The findings from the study are developed into a substantial theory which conceptualises this work.

Methodology: Grounded Theory methodology was used and 21 semi-structured interviews were conducted with practicing health visitors in the North East of England between May 2008 and September 2009. All participants described themselves as white.

Findings and conceptual theory: When health visitors talk about their work with people from cultures they identify as different to their own, there are three areas which are important to them. These are, first, in

relation to relationship building; second, a metaphorical ‘cross cultural terrain’; and finally, and most importantly, in managing emotions. The complex ways in which these three areas intersect with each other is what shapes professional engagement across cultures. The theory ‘emotional encounters through cross cultural terrain: shaping relational journeys through culture’ was developed to conceptualise this work.

Conclusion: Emotions have the power to shape professional practice in health care, influencing (dis)engagement with clients across cultures. The ways in which this happens have implications for practice, theory and education.

Table of contents **Page number**

Acknowledgements …….. ..2

Abstract……... 3

Table of contents……. ….5

List of appendices……9

List of tables……..12

List of figures……13

Chapter 1 Introduction……16

1.1 Background to the study…….16

1.2 The title of the research……....18

1.3 Context of health visiting practice……18

1.4 Aims and scope of the research……27

1.5 Summary of research findings and construction of theory……30

1.5.1 Findings……..32

1.5.2 Construction of theory……..33

1.6 Implications for theory, practice and education……..36

1.7 Presentation of thesis……38

Chapter 2 Literature review……...40

2.1 Introduction……...40

2.2 The context of health visiting……42

2.3 'Race', ethnicity, culture and health care……53

2.4 Cultural competency……...72

Chapter 3 Methodology – data collection, analysis and development of conceptual theory……87

3.1 Introduction……...87

3.2 Research problem and opening research questions……90

3.3 Data collection and analysis……..92

3.3.1 Interviews……..94

3.3.2 Forcing data……95

3.3.3 Situational analysis……96

3.3.4 Sensitising concepts and general disciplinary perspectives……104

3.3.4.1 Theoretical sensitivity……104

3.3.4.2 Research diaries……105

3.3.5 Initial coding and data collection……..108

3.3.5.1 Study sample……..108

3.3.5.2 Analytic coding and categorisation of the data – micro analysis……113

3.3.6 Initial memos and raising codes to tentative categories……131

3.3.6.1 Theoretical memos……131

3.3.6.2 Theoretical sampling……..145

3.3.7 Data collection and axial (focused) coding……170

3.3.7.1 Axial coding……170

3.3.7.2 Emergent categories leading to secondary literature review……...193

3.3.8 Advanced memos – refining conceptual categories (Selective coding)……196

3.3.9 Theoretical sampling and seeking specific new data…208

3.3.10 Adopting certain categories as theoretical concepts…212

3.3.11 Sorting memos……215

3.3.12 Integrating memos and diagramming concepts…….216

3.4 Summary of findings and construction of conceptual theory…….221

3.4.1 Relationship building……..221

3.4.2 'Envisioning the journey'…….223

3.4.3 'Cross cultural terrain'…….224

3.4.4 Managing emotions…….225

3.5 Research criteria and limitations……231

3.6 Summary……233

Chapter 4: Secondary literature review……..235

4.1 Introduction……235

4.2 Professional-client relationships across cultures…….236

4.2.1 Communication across cultures……... 239

4.2.2 Trust in professional-client relationships……. 242

4.3 'Cross cultural terrain'…….. 249

4.4 Summary…….. ..251

Chapter 5: Discussion……253

5.1 Introduction……253

5.2 Managing emotions through cross cultural terrain……256

5.2.1 Introduction……256

5.2.2 Uncertainty and ambiguity in health and social care discourse……257

5.2.3 Strategies to manage uncertainty……265

5.2.3.1 Managing uncertainty through avoidance: travelling to the perimeter fence of culture……265

5.2.3.2 Managing uncertainty through stereotyping. Fixing a culture: unchanging throughout time……274

5.2.3.3 Managing uncertainty through equality. Re-working an equality agenda: the same throughout time……..277

5.2.3.4 Managing uncertainty through 'positioning self'. Asserting a professional identity: undermined over time…….285

5.2.2.5 Managing uncertainty with a toolkit. Developing a toolkit: strengthening over time……290
5.2.4 Emotional flexibility: treading lightly on cultural terrain……291
5.3 Theoretical conceptualisations of 'emotional engagement'……296
5.3.1 Erving Goffman and the health visitor self……296
5.3.2 Pierre Bourdieu and cross cultural terrain……303
5.3.3 Conceptual development: emotional capital, emotional *habitus*……...320
5.3.4 Summary……327
5.4 Emotional engagement through culture: the hidden work of health visitors……329
5.4.1 Introduction……329
5.4.2 Cultural 'competence': science or 'art'?.....331
5.4.3 The 'art' of culture within current health care……...335
5.5 Summary……345
Chapter 6: Conclusion and implications for theory, practice and education……347
6.1 Conclusion……..347
6.2 Implications for theory……..349
6.3 Implications for practice……350
6.4 Implications for education……353
6.5 Strengths and weaknesses of the study……357
6.5.1 Strengths……357
6.5.2 Weaknesses……358
6.6 Suggestions for future research……360
References……..410

List of appendices

Appendix A Initial theoretical memos…….363

A1 Summary memo: Joy 29 July 2008……363

A2 Theoretical memo: learning to ask 2 August 2008……...364

A3 Theoretical memo: interpreter as barrier 25 October 2008…….365

A4 Theoretical memo: stumbling over the vocabulary of 'race' 28 March 2009…….366

A5 Theoretical memo: Helen 4 July 2008……367

A6 Theoretical memo: empowering clients 10 July 2008……..368

A7 Theoretical memo: feeling comfortable and relaxed 11 July 2008……...369

A8 Theoretical memo: importance of extended families 11 July 2008……...370

A9 Theoretical memo: culture as fluid 12 July 2008……..371

Appendix B Interview schedules……...372

B1 Initial interview questions……..372

B2 Interviews 5-8: guided interview questions……373

Appendix C Ethical approval documentation……374

C1 Ethical approval University of Sunderland Ethics Committee……374

C2 Ethical approval NHS Ethics Committee……375

C3 Primary Care Trust approval……378

C4 Letter of invitation……..379

C5 Information sheet……...380

C6 Consent form……..383

Appendix D Initial open coding…….381

D1 Open codes following interview 5 (Alice)……...384

D2 Open codes following interview 7 (Emma)……385

Appendix E Situational analysis maps……386

E1 Initial situational messy map……386

E2 Situational map – relational analysis: white health visitors and culture……387

E3 Situational map - relational analysis: health visitors and the NHS.388

E4 Situational map – relational analysis: NHS policies…….389

E5 Situational map – historical discourses of 'race'……...390

Appendix F Social worlds map……..391

F1 Social worlds – health visitors in the UK context……..391

Appendix G Positional maps……..392

G1 Positional map – discourses of cultural fluidity and cultural (dis)engagement……392

G2 Positional map – discourses of culture and policy framework……392

G3 Positional map – discourses of cultural competency and professional (un)certainty……393

G4 Positional map – discourses of the Westernised 'other' and knowing the cultural 'other'……394

Appendix H Advanced theoretical memos…….394

H1 Advanced theoretical memo: cross cultural terrain 26 March 2009……...394

H2 Advanced theoretical memo: emotional encounters through culture 10 September 2009……395

H3 Advanced theoretical memo: taking and leaving 17 January 2009……396

H4 Advanced theoretical memo: taking a toolkit 20 April 2009……398

H5 Advanced theoretical memo: tools of knowledge 20 July 2009….399

H6 Summary memo: strategies to stabilise uncertain terrain 10 October

2009……401

H7 Advanced theoretical memo: fixing a culture throughout time

26 September 2009……..401

H8 Advanced theoretical memo: emotional flexibility

26 September 2009……..403

H9 Advanced theoretical memo: re-writing an equality agenda

26 September 2009……..404

H10 Advanced theoretical memo: asserting a professional identity

26 September 2009…….405

H11 Advanced theoretical memo: hidden work 20 October 2009……406

H12 Advanced theoretical memo: relational journeys

25 October 2009……...407

H13 Advanced theoretical memo: taking bearings

27 November 2009……..408

List of tables

Table 3.1 Ordered situational map……100

Table 3.2 Participant profile table.....110

Table 3.3 Tentative categories and related open codes:

interviews 1-7……167

Table 3.4 Axial codes and related open codes:

interviews 1-11……..183

List of figures

Figure 3.1 – Research diary: Jane 18 June 2008……..106

Figure 3.2 - Research diary: competency 2 October 2009……...107

Figure 3.3 – Supervision meeting 20 October 2009……..116

Figure 3.4 – Theoretical memo: anxiety 19 June 2008……127

Figure 3.5 – Summary memo: Jane 23 June 2008……130

Figure 3.6 – Theoretical memo: common ground 6 July 2008…… 132

Figure 3.7 – Research diary: Helen 24 June 2008……134

Figure 3.8 – Theoretical memo: marrying it up 21 July 2008……136

Figure 3.9 – Summary memo: skidding on ice 3 September 2008…..140

Figure 3.10 –Theoretical memo: opening up…closing down
12 September 2008……142

Figure 3.11 – Conceptual map: tentative themes
interviews 1-4……..144

Figure 3.12 - Research diary: Alice 20 September 2008……..149

Figure 3.13 – Theoretical memo: universal provision
19 September 2008……152

Figure 3.14 – Theoretical memo: professional status devalued
24 September 2008……...154

Figure 3.15 – Theoretical memo: playing the ‘race’ card
21 September 2008……156

Figure 3.16 – Theoretical memo: not pushing forward
27 September 2008……157

Figure 3.17 – Theoretical memo: take it or leave it menu
10 October 2008……160

Figure 3.18 – Research diary: Emma 29 September 2008……..162

Figure 3.19 – Theoretical memo: taking a toolkit
4 November 2008……...172
Figure 3.20 – Theoretical memo: treading lightly on cultural terrain
4 January 2009……...174
Figure 3.21 – Research diary: difficulty getting through
12 January 2009…….178
Figure 3.22 – Research diary: supervision support meeting
19 May 2009…….179
Figure 3.23 – Theoretical memo: universal provision…specialist
intervention 17 February 2009……181
Figure 3.24 – Theoretical memo: barriers to moving forward
9 March 2009……..188
Figure 3.25 – Research diary: Leah 2 October 2008……..190
Figure 3.26 - Conceptual map: main categories following
Interviews 1-13…….192
Figure 3.27 – Advanced theoretical memo:
moving forward…retreating back 2 April 2009……195
Figure 3.28 – Theoretical memo: changing over time 4 June 2009…199
Figure 3.29 – Advanced theoretical memo: approaching the
perimeter fence 10 April 2009……...201
Figure 3.30 – Advanced theoretical memo: preparing for the journey
8 June 2009……..203
Figure 3.31 – Advanced theoretical memo: envisioning the journey
20 June 2009……..205
Figure 3.32 - Advanced theoretical memo: emotional dimensions
27 June 2009……209

Figure 3.33 – Theoretical memo: health visitor self

25 June 2009……..211

Chapter 1: Introduction

1.1 Background to the study

The development of the research question was the result of several inter-related factors, which became the impetus for this research. Interest in the subject of cultural care developed over many years, through my experience of working as a community nurse and community development worker in several socio-economically deprived areas of the North East of England. My experience, and anecdotally that of many of my colleagues, was that any 'cultural education' packages we had experienced, as part of our continuing professional development, failed to address the problems we experienced in our day-to-day work with clients who were from cultures different to our own. Theoretical conceptualisations of the cultural 'other' within health discourses presented issues of 'race'[1], culture and ethnicity as essentialised and fixed, thereby simplifying the complexity of cross cultural work as experienced by health professionals in their daily work. Educational packages in 'cultural care' appeared to have developed without reference to the lived experiences of health professionals in their daily working lives.

My research primarily sought to ask health professionals their experiences of working across cultures, as a starting point to explore

[1] 'Race' is used throughout this thesis within parenthesis to denote the difficulty of naming a concept which does not exist (although it is acknowledged that racism does exist in the lived experience of many people in the UK). The difficulty of naming 'race' without reifying it is discussed in detail in chapter 2.

issues of ‘race’, culture and health and to thereby contribute not only to the body of research into cultural care, but also to extend scholarly inquiry into educational discourses of cultural ‘competency’ and nursing practice itself. Theoretical interrogation of the results of the study explore the boundaries of cultural theory, using the work of Pierre Bourdieu (1977, 1989, 1993; Bourdieu and Wacquant, 1992) to conceptualise culture and in particular the notion of emotional capital and emotional *habitus*.

In this chapter, the study is introduced, including the background and rationale for the study. An overview of the conceptualisation of the problem of interest is presented and the aims and main research questions are outlined. Theoretical and methodological approaches are described and questions are raised in relation to cultural education and practice. A summary of the research findings are outlined and the final substantial theory is introduced.

Broadly framed, my research began with an interest in understanding the experiences of health visitors in the North of England in their daily work with clients from cultures different to their own. The first three chapters take the reader through the research process as it unfolded. The remaining three chapters primarily explore the ways in which emotion can be a powerful force in influencing practice in cross cultural work. Ultimately the study arrived at a destination where cross cultural work is conceptualised as **‘emotional encounters through cross cultural terrain: shaping relational journeys through culture’** and, in doing so, this research has crossed many disciplinary borders. In

presenting this work, I have sought to present a clear account of the daily experiences of health visitors, while using theoretical insights to inform and extend current conceptualisations of cross cultural working practices. The study provides support for a consideration of emotion within cultural education and indicates further research is required to understand the role of emotional flexibility in cross cultural engagement.

1.2 The title of the research:

Emotional encounters in health care: an investigation into the experiences of health visitors when working across cultures.

1.3 Context of health visiting practice

In this contemporary moment, health professionals are working in a rapidly changing world, where practice is being challenged by a plethora of competing influences. Contemporary nursing discourses draw our attention to the shifting of professional roles and responsibilities foregrounding health visitors as negotiating the competing demands of 'care' and 'value for money' (Marcellus, 2004; Drennan and Joseph, 2005; Hamill and Bigger, 2005; Cohen and Reutter, 2006 and Lowe, 2007). Health visiting has followed a trajectory in recent years towards a recognised professional status but the path has not been smooth, as change has become a 'constant' within the British NHS. Health visiting and wider nursing practice cannot be extricated either from the multilayered socio-political context of health care, nor from its history. The delivery of health care is being shaped

and remoulded, according to pressures in the scientific, technological, political and pharmaceutical spheres.

Arguably, none of this is new and health professionals have always worked within such a contested context, but what is new is the rapid rate of change and the increasing political significance of health care practice. Never before have health care professionals been under such scrutiny; the political lens is focused sharply on the working lives of individual practitioners and the populations they serve. Health visitors, along with social workers, are brought into sharp focus by the inward turn of this political lens and working practice is being examined, investigated and interrogated by the media in a new light (Lister, 2009; Greenhill, Cohen and Schlesinger, 2010).

A community nurse or health visitor working within the British NHS might be forgiven for believing that the daily pressures he or she faces are a symptom of a struggling National Health Service, but many of the issues facing nursing today are internationally felt (Garrosa et al., 2008; Kingma, 2008). The changing landscape of health care policy and practice cannot be contained within national boundaries and the context within which health care is delivered is also changing. Global pressures are not only altering the world ‘out there’, but distant events are shaping our communities and impacting individual lives (Giddens, 1999, 2003; Naples and Desai, 2002; Finn et al., 2010).

While acknowledging that globalisation is a richly textured and fluctuating process, its impact spans political, scholarly and popular

thought, challenging global institutions, national governments and health care organisations (Klein, 2001; Held, 2009). Held and McGrew (2000) point to the complexity of this changing world, by framing globalisation as:

> a process (or set of processes) which embodies a transformation in the spatial organisation of social relations and transactions – assessed in terms of their extensity, intensity, velocity and impact – generating transcontinental or interregional flows and networks of activity, interaction and the exercise of power (p.348).

Information technology is creating network societies of interconnectedness, which are divorced from the geographical localities in which people live. Social relations are becoming more stretched while simultaneously becoming more intensively interconnected (Martinelli, 2003). Networks and flows of people and information are being generated (Castells, 1989, 2010). Communities are increasingly changing in diversity and established social landscapes are being replaced and remoulded to reflect a new cultural diversity, which has never previously been experienced.

> As social relations stretch there is an increasing interpenetration of economic and social practices, bringing apparent distant cultures and societies face-to-face with each other at a local level, as well as on the global stage (Held, 2004, p.16).

Local communities are becoming spaces of both resistance and negotiation. The North East of England is one such region, where economic, social, political and cultural transformations are impacting upon established and multi-layered community formations that are already in existence (Renton, 2007). The inward migration of people into the region in search of work, to study or to seek sanctuary has impacted on local communities, as they adapt to a changing physical and socio-cultural landscape (Nayak, 2003). Local communities reflect the changing contours of post-industrialisation, which has seen the region move away from a reliance on coal mining and steel manufacturing towards new economies. Globalisation and economic restructuring has impacted communities left by the legacy of post-industrialisation, and these communities are in turn responding to these changes through the ebb and flow of cultural relations, negotiated identities and, at times, conflicting perspectives (Bradford and Burdett, 1989; Hudson, 2000; Nayak, 2003).

The last decade has witnessed insecure times (Vail, Wheelock and Hill, 1999) and the fluidity, flux and a growing sense of uncertainty of this modern life is described by Bauman (2005), as a 'Liquid Life'. Community transitions have held a long and firm sociological gaze, concerned with the formations and negotiated identities of individuals and groups. Although the migration of people in search of peace, security and prosperity is nothing new, over the last two decades immigration has taken on a new and unprecedented political and social significance (Castles and Miller, 1998; Watters, 2007; Castles, 2010).

The rise of the British National Party and the English Defence League in many communities in England has turned the political lens toward the cultural 'other', in ways which reinforce a specific historical positioning. The tabloid press regularly run sensational stories on issues of asylum, terrorism and Islam and discourses of 'the threat within' are widespread. Health care professionals are themselves enmeshed in these interwoven social relations.

It is within this complex and contested landscape that health visitors are required to provide culturally 'competent' care to those who are from other cultures. Health care professionals must meet the challenge of delivering a high standard of health care to diverse populations and changing communities. Professional bodies require that care is culturally appropriate (NMC, 2006; GMC, 2007) and, yet, research suggests that problems persist (Gerrish, 2001; Curtis, 2004; Drennan and Joseph, 2005; While et al., 2005). Scholarly activity investigating the perspective of people from those identified as from Black Minority Ethnic groups has uncovered discrimination and a lack of trust (Gunaratnum, 2001). A substantial body of research evidence suggests that inequalities in health linked to ethnicity exist (Nazroo and Dvely, 2001; Nazroo, 2003; Lorant and Bhopal, 2010), that people from minority ethnic groups have suffered discrimination (Marmot, 2005; Bhopal, 2001, 2007), and that they have poorer access to health care services than those from the majority population (Davey Smith et al., 2000). The influence of health care professionals in relation to care outcomes for people from other cultures is under researched (Van Ryn,

2002), and there is a paucity of research investigating the experiences of health professionals themselves.

Cultural 'competency' educational programmes [2]have flourished across the Western world over the last 30 years, since nurse theorist Madeline Leininger first introduced the concept of transcultural nursing care (Leininger, 1991a, 1994, 2002). This has become a normalised discourse in many countries (Maier-Lorentz, 2008), but has recently been challenged and critiqued for its essentialist nature (Duffy, 2001; Gustafson, 2005; Culley, 2001, 2006). Non-essentialised approaches to cultural education have been developed in response to these criticisms, most notably the concept of 'cultural safety' first developed in New Zealand in a response to the discourse of power relations in professional and client interactions (Ramsden, 1989). Cultural education programmes that deconstruct 'race' and culture have been adopted widely across the disciplines of education, sociology and cultural studies, but have been slow to be adopted within health.

Cross cultural education is a fascinating, though polarised, area of investigation within health care discourse. Historically, health and culture bear the hallmarks of an essentialised discourse, arguably reflecting the bio-medical model of health care, which remains strong in the British NHS today (Hippilsey-Cox et al., 2008). Ethnicity is constructed as fixed, solid and static, and a substantial amount of research has been devoted to the investigation of specific ethnic groups

[2] 'Competency' is within parenthesis to highlight to the reader one of the central contentions of this thesis; that culture cannot be measured within health care as a 'competency' but rather it should be conceptualised as an art or a craft, something to be practised and honed. This is discussed in length in chapter 5.5.3.

and individual disease processes (Dundas et al., 2001; Taylor et al., 2006). This has served to reify 'race', ethnicity and cultural boundaries as static and fixed. This discourse is strong and powerful within health care today in the UK, despite an extensive body of research into the dynamic, fluid and changing nature of 'race', culture and identity, which has emerged in the fields of sociology, feminist studies, education and geography in recent years (Reay, 2004c; Crozier, 2005; Clayton, 2008; Dwyer and Bressey, 2008). Health care discourse has been slow, and reluctant, to interrogate non-essentialised notions of 'race', culture and identity, preferring to frame cultural groups as bounded and fixed.

Nonetheless, there are encouraging signs that health care researchers are beginning to look beyond these bounded spaces of 'race' , culture and identity to work within feminist, critical, post colonial and cultural analysis to examine power relations within health care practice, structural inequalities in health care provision and cultural education (Chevannes, 2002; Anderson, 2003, 2007; Gustafson, 2005; Culley, 2001, 2006). Although social researchers may talk in terms of tiredness and discuss the over worn concepts of 'race' and culture (Nayak, 2008), this is only beginning to be explored within health discourse. New and exciting theoretical perspectives are being interrogated within health care to examine how Bourdieu and his theories of *habitus* and *field* can help us explain culture and health (Lynam, 2004; Lynam et al., 2006). Feminist scholars in health care are examining the notion of 'cultural safety' (Anderson et. al., 2003, 2007), and a critical eye within nursing is being turned on the power relationships, which exist between health

professionals and clients (Aranda, 2005; Bradbury-Jones and Sambrook, 2008; Kagan and Chinn, 2010).

In response to these new theoretical interrogations of 'race', culture and health care, education is also changing and is being challenged to re-examine the essentialised nature of cultural 'competency' education in health (Duffy, 2001; Gustafson, 2005; Pon, 2009). At this present time, cultural 'competency' education is caught in a split, between those who continue to view culture as traditional, bounded and fixed and new forms of research endeavour, which traverse the boundaries of disciplines, exploring a non-essentialised discourse. Situated in the middle, somewhere between these polarised positions are cultural competency courses, which are unable to leave some 'essential' characteristics of culture behind, but are influenced by the fluidity and dynamic changing nature of culture (Dogra et al., 2005; Dorga and Karim, 2005; Papadopoulos, 2006). This is an exciting field of enquiry, caught between new modes of enquiry and bounded cultural spaces, but there appears to be a push towards developing non-essentialised educational packages, without a thorough investigation of what health care practitioners themselves are discussing as the problems they face.

While excited at the prospect of new modes of enquiry into a non-essentialised perspective on 'race', culture and identity, there is a danger in developing such courses in a vacuum of evidence from practitioners themselves. While embracing critical insights into the well researched field of 'race', culture and identity across many other disciplines, and acknowledging the theoretical value of this type of

interrogation, there appears to be a rush in health care to put the theoretical horse before the practical cart. Cross cultural education is built on several assumptions, which should be clarified. Those who postulate that health care practitioners need to increase their skills and knowledge have developed essentailsed educational packages (Campigha-Bacote, 1999, 2002; Purnell and Paulawka, 2003). Non-essentialised educational packages assume that health care practitioners all view culture as stereotyped, fixed and static, and argue for the de-construction of 'race', culture and identity within educational packages. The popular notion of cultural safety has been developed in New Zealand (Ramsden, 1989) and widely adopted in both Australian and Canadian contexts. Cultural safety builds on the assumption that nurses are able to provide 'safety' in cultural issues for their clients. The recognition of power imbalances is central to the concept of cultural safety (Walker et al., 2009).

There are many assumptions built in to these educational programmes about what health care practitioners are, or should feel, but little research which investigates what they actually say they feel or need in relation to their everyday working practice. Kathy Charmaz (2006) describes theorising as 'stopping, pondering, and rethinking anew. We stop the flow of studied experience and take it apart' (p.135). This study was an attempt to stop and ponder anew, to explore established approaches to cultural education within health care, and nursing in particular, to ask if anything has been missed in our rush to 'educate'. In the following interview extract, Alice expressed similar concerns:

Fiona: What training do you get to help you with this situation [working across cultures]?

Alice: We had no help at all. We just have annual diversity training, which is a one day session.

Fiona: Did you find that helpful?

Alice: Yes, I think it was a really good awareness session but I think for the day-to-day working it doesn't help you solve the problems you are coming up against, you know (Alice: 45-49)[sic].

The experience of Alice was supported by many of the research participants, and this study sought at the outset to ask health visitors the questions, which would give insight into both the problems health visitors experience and the solutions to those problems.

1.4 Aims and scope of the research

The aims of this research are:

a) To explore with practising health visitors in the North East of England their experiences of working with clients who are from cultures different to their own.

b) To build a theory in relation to how health visitors work with people who are from cultures the health visitors identify as different to their own.

c) To use this theory to support, or to challenge, current educational practices in the area of ‘cultural competency’ in health care.

This study sought to investigate how health visitors in the North East of England engaged with the challenges of working with people from other cultures, by examining the expressed narrative of their day-to-day working lives. Grounded theory methodology was used, as it seeks to investigate the views of the research participants from the ground level upwards. The inductive nature of grounded theory methodology, and the development of new epistemological perspectives (Clarke, 2005; Charmaz, 2006; Corbin and Strauss, 2008) ensured that the methodology was appropriate to investigate the views and perspectives of health visitors. Epistemological consistency was adhered to, in that, broadly, a social constructionist approach was used across all areas of the research process, from data analysis to conceptual development. The study was situated primarily within the fields of health and sociology but crossed disciplinary borders, to include theoretical insights from cultural studies, psychology, postcolonial studies and geography.

In linking their clearly expressed experiences of providing family health care with the social and political context of health care in the UK today, the experiences of the health visitors were explored and analysed. Twenty one health visitors were interviewed to explore their views and perspectives on working with clients who they perceived as being from another culture. Although all health visitors in the region were invited to take part in this study, the health visitors who agreed to participate

described themselves as white, British and from the majority culture. This is reflective of the demography of the North East of England, where 96% of the population describe themselves as white (NEPHO, 2008). The researcher and the participating health visitors worked together through varying accounts of their professional experience, to explore how they work with and relate to clients who are from a culture other than their own and, in doing so, developed a conceptual theory, which was recognisable by both the academic community and the health visitors themselves.

It is important to note that all of the health visitors who volunteered to participate in this study did so because they were interested in cross cultural working and wanted to improve their practice. The initial purposeful sample of participants does not represent all health visitors in the North East of England but a sub-set of interested health practitioners, who volunteered to be involved in the research following a general letter of invitation.

The purpose of this study was to answer two research questions:

1. What are the most important issues health visitors express, when considering their work with clients who are from cultures different to their own?

2. What concerns do health visitors experience when they are working with clients who are from a culture different to their own?

1.5 Summary of research findings and construction of theory

Kathy Charmaz (2006) asserts that when you theorise you:

> Reach down to fundamentals, up to abstractions and probe into experience. The content of theorizing cuts to the core of studied life and poses new questions about it (p.135).

The excitement of grounded theory rests in my ability to take my experience as a community nurse and to pose practical questions generated by that experience. New questions can be asked by generating a theory from the lived experience of the health visitors involved in this study and, by constant comparison and concurrent analysis of the data, generate a theory which reaches up to the abstract. Theorising in this way takes everyday experiences to a conceptual level and then, most importantly, brings it back to the practical, so that the theory makes sense for those practicing at ground level. In this way, grounded theory enables old practices to be thought of in a new way, conceptualised through novel understandings and new methods of practice may emerge, which nudge us towards better understandings and enhanced practice.

In generating a conceptual theory, **'emotional encounters through cross cultural terrain: shaping relational journeys through culture'**, I was then able to feedback a summary of the overall findings of the study to the participating health visitors. All of the health visitors were

given the opportunity to comment on the relevance of the conceptual theory for their practice, and the health visitors who responded concurred with the overall research findings and resulting conceptual theory. In this way, the data generated at ground level was taken to a conceptual level and then brought back to the ground level to help inform practice.

Using Norman Denzin's analogy of a *bricoleur* (Denzin, 2007), this research has sought to take fragments from the experience, feelings and actions of the participating health visitors, and sew these together to create a theoretical framework, which is both reflective of their experience and relevant to their practice. This is an interpretation of their stories, pieced together with theoretical sociological, philosophical and cultural insights within the recognised methodological framework of grounded theory.

As stated, this study set out to investigate the opportunities and barriers experienced by health visitors in the North East of England when working with clients who are from another culture. Adhering to constructionist grounded theory methodology, data was analysed and concurrently coded and categorised. Coding, categorisation and constant comparison of the data resulted in the conceptualisation of a theory in relation to the participating health visitors.

1.5.1 Findings

When health visitors talk about their work with people from cultures they identify as different to their own, there are three areas which are important to them. These were categorised as:

1. Relationship building
2. Metaphorical ‘cross cultural terrain’
3. Managing emotions

The complex ways in which these three areas intersect with each other is what shapes professional engagement across cultures. Relationship building was described by all of the health visitors as central to their work across cultures. Issues of communication, interpretation and trust were the most frequently raised issues. Conceptually, the health visitors entered a **‘relational journey’** with their clients across cultures.

Most importantly, the **‘relational journey’** was shaped by:

1. The ways in which the health visitors **‘envisioned the journey’.**
2. The perceptions held by the health visitors of **‘cross cultural terrain’.**
3. The ability of health visitors to manage their emotions when working on **‘cross cultural terrain’.**

The health visitors **'envisioned the journey'** in several ways, but the most important aspects of this were in **'positioning self'** and **'taking a toolbox'** of knowledge, experience and assessment tools with them on their **'relational journey'** (Section 3.3.7.2). .

'Cross cultural terrain' was metaphorically described by many of the health visitors as a cultural space, within which cultural engagement occurred. This was often described as **'common ground'** or **'meeting in the middle'** and was a space of compromise, uncertainty and negotiation. **'Cross cultural terrain'** was most commonly described as a place of **'mistrusting terrain'** and the health visitors were **'scared to offend'**.

In '**managing their emotions'**, the health visitors all spoke of the powerful way emotions influenced their practice across cultures. The most common emotion described was anxiety, but fear, anger and empathy also drove practice. The ways in which the health visitors managed their emotions had a profound impact on their practice, and this is what informs the central thesis of this research.

1.5.2 Construction of theory

These three broad categories of **'relationship building'**, **'cross cultural terrain'** and **'managing emotions'** were subsequently developed in line with grounded theory, and using situational mapping (Clarke, 2006), into the conceptual theory:

‘Emotional encounters through cross cultural terrain: shaping relational journeys through culture’.

‘Relational journeys through culture’ conceptualised the experience of cross cultural working of the majority of the health visitors interviewed. Issues most frequently raised were in relation to relationship building, communication, language, interpretation and trust. This supports a plethora of research within the field of health care over the last two decades, but does not bring any new insights to the field of study. What is new and particularly interesting in this study is the conceptual category **‘emotional encounters through cross cultural terrain’**, and the ways in which these emotional encounters shape professional practice. It is the exploration of this conceptual category which informs the direction of the thesis from chapter 4 onwards.

‘**Emotional encounters through cross cultural terrain’** conceptualises the experiences of the health visitors into three different groups. These are core theoretical categories and relate to the key findings of this study. They are conceptualised as:

a) **Emotional flexibility: treading lightly on cultural terrain.**
b) **Emotional hesitation: stabilising uncertain cultural terrain.**
c) **Emotional avoidance: travelling to the perimeter fence of culture.**

The conceptualisation **'emotional flexibility: treading lightly on cultural terrain'** related to only two of the health visitors in the study, and was identified as the most positive form of engagement across cultures. These two health visitors were confident and emotionally flexible to adapt to the complexity and fluidity of culture. In **'treading lightly on cultural terrain'**, they were not hindered by culture as a barrier, although recognised culture as an element of cross cultural working.

The majority of health visitors in the study were conceptualised as working with '**emotional hesitation: stabilising uncertain cultural terrain'**. Engagement across culture was fraught with anxiety, apprehension and, for some, even fear. The work of the health visitors across cultures was to **'stabilise uncertain cultural terrain'** and in doing so, their emotions shaped their practice in four important ways. These were conceptualised and described as:

1. Fixing a culture: unchanging throughout time (see Appendix H7). The health visitors fixed clients into rigid cultural categories, which led to stereotyping and prejudice.

2. Re-writing an equality agenda: the same throughout time (see Appendix H9). Several of the health visitors in this study tried to **'stabilise uncertain cultural terrain'** by conceptualising everyone as **'all are equal…all are the same'**. In this way, they negated cultural difference and ignored the need for cultural adaptation to individual needs.

3. Asserting a professional identity: undermined over time (see Appendix H10). Some of the health visitors attempted to **'stabilise uncertain cultural terrain'**, especially when their advice was challenged by traditional or cultural practices, by **'asserting the professional self'**. They positioned themselves in terms of professional knowledge and expertise.

4. Developing a toolkit: strengthened over time (see Appendix H4 and H5). All of the health visitors who were conceptualised in the category of **'emotional hesitation'** sought to increase their cultural knowledge and experience over time, as a way of **'stabilising uncertain terrain'**.

Interestingly, although building up the **'toolkit of experience'** increased knowledge, it did not produce emotional flexibility for health visitors working across cultures. This is important, as emotional flexibility was identified as an important aspect of effective engagement across cultures.

Finally, a minority of health visitors were conceptualised as using **'emotional avoidance: travelling to the perimeter fence of culture'**, as a way of avoiding **'uncertain cross cultural terrain'**. These few health visitors did not engage across cultures, but delivered the necessary information and left.

1.6 Implications for theory, practice and education

The findings generated by this research have implications for theory, practice and education and, although all three are intrinsically connected within the research process and subsequent discussion, they are presented separately in chapter 6. The implications for theory are situated within the wider scholarly discussions currently taking place in relation to the work of the French sociologist Pierre Bourdieu and his complex work on capital, *field* and *habitus.* Emotional flexibility is explored as both part of emotional capital and as part of emotional *habitus*, although further research is required to understand the role of emotional flexibility in cross cultural work.

The implications of this research for practice are to challenge current cultural 'competency' agendas. Firstly, to acknowledge the power of emotion to shape practice in cross cultural work and, secondly, to recognise uncertainty and anxiety as common emotions in cross cultural work. I suggest that cultural practice should be recognised as an 'art' rather than a 'science' and, therefore, rather than being subjected to 'competency' measures, health care practice should create a space where uncertainty and ambiguity are acknowledged. It is only then that health professionals can begin to practice the 'craft' of cultural engagement and, in doing so, to engage effectively across cultures. When emotion is negated as a powerful force to shape practice, then health professionals risk low quality engagement with clients across cultures.

Finally, the implications for cultural education are to present evidence, which identifies uncertainty as a powerful emotion in cross cultural education and which has the power to shape practice. Cultural education, while presenting a diversity of perspectives including anti-racism education, cultural knowledge, cultural sensitivity and approaches which deconstruct the self, must also develop spaces to acknowledge the power of emotions to shape practice. It is suggested that by acknowledging the power of emotions to shape practice, and by helping health professionals to identify strategies which they employ to **'stabilise uncertain cultural terrain'**, new strategies can be developed to enhance cross cultural engagement. It is only then that the 'art' of cultural engagement can be developed and practiced for the benefit of all clients.

1.7 Presentation of thesis

The presentation of the thesis does not follow a conventional format, but rather follows the process of the research investigation itself. This is to clearly demonstrate an audit trail in relation to the collection and analysis of the data, and to give the reader a clear understanding of the ways in which secondary literature is only used within grounded theory methodology only after the data analysis has begun. The theoretical work of Pierre Bourdieu is included in the discussion chapter near the end of this study, as his work was only considered after the categories of 'emotional flexibility' had begun to emerge and were considered within the theoretical framework of 'emotional capital' and *habitus*.

In Chapter 1, a brief outline of the research project is given, including the research title, aims and the methodology used.

In Chapter 2, the research question is examined in the context of the current literature around culture, health care and cultural competency in the world in general and the UK in particular.

In Chapter 3, the methodology used for collecting data is explained, including the rationale for the use of grounded theory and the strengths and weaknesses of this approach. A detailed description of the analysis of the data is given, including the process of open, axial and selective coding using the comparison of textual data from the interviews, and the theoretical memos which accompany that analysis. Issues of validity and reliability in relation to qualitative research are also discussed in this chapter. The research findings are identified, and the conceptual theory is explained and discussed in relation to current literature.

Chapter 4 details the secondary literature reviews, which were carried out in response to the emerging theoretical categories, as the research progressed through the data analysis stage.

Chapter 5 discusses the implications of this research in the context of current health care discourse. These implications have the potential to inform theory, practice and education and are explained in detail in chapter 6. The strengths and weaknesses of the study are highlighted and suggestions for future research draw the thesis to a conclusion.

Chapter 2 Literature review

2.1 Introduction

The place of a literature review within grounded theory methodology is contested by contemporary scholars (McCallin, 2003; McGhee, Marland and Atkinson, 2007), and is a departure from the original conceptualisation of grounded theory by Glaser and Strauss (1967). For Glaser and Strauss (1976), the researcher is framed within a positivist epistemology and stands outside of the research process, a detached observer and a *tabula rasa.* Researchers working within this tradition assert the necessity of the detached researcher in order to maintain an objective distance from the research participants (Kennedy and Lingard, 2006). Nonetheless, in the four decades since Glaser and Strauss (1967) first developed grounded theory, scholarly activity across all areas of social enquiry has exploded (McCallin, 2003). The rigours of University Ethics Committees and doctorate programmes now require, and acknowledge, the wealth of scholarly knowledge, which researchers bring to the research process. Interpretivist epistemologies make the role, experience and knowledge of the researcher explicit (Charmaz, 2006), and the researcher is situated within the research process itself (Charmaz and Mitchell, 1996). An initial literature review is required to set the context and explore the current concept of the study. A secondary literature review is necessary within constructivist and post modern epistemologies, as both a tool to explore emerging themes and as an additional form of data to incorporate into the data

analysis (Mills, Bonner and Francis, 2006). This is presented in chapter 4.

The initial literature review is presented here in chapter 2. Section 2.2 examines the literature in relation to health visiting practice today, with a particular focus on the UK context. The scholarly literature around the contested use of ‘race’, culture and ethnicity is interrogated in section 2.3, with particular attention to health care discourse. Finally, section 2.4 outlines the historical development of cross cultural education and examines differing scholarly perspectives in cross cultural education up until the present time.

2.2 The context of health visiting

Complexity surrounds health care delivery at this present time and health care practitioners stand at the centre of competing and complementary discourses, which impact day-to-day practice. In order to contextualise the working practice of health visitors in the North East of England, a literature review was undertaken to explore the political, social and organisational context the health visitors interviewed were working within. The picture is both complex and contested, but a strong and recurrent theme running throughout the literature is one of continual and turbulent change. Competing global, national and local forces operate at both policy and practice levels, so that health visitors find themselves caught in the eye of the storm, but the experience is anything but calm (Malone et al., 2003).

Health visitors are public health nurses who predominantly work with families and children under the age of five, although their role is being expanded to include all children under the age of 16 years old. The health visiting service in the UK is a universal service, with health visitors being notified of a new birth by the midwifery service. Health visitors are required to visit new mothers before the 14th post natal day in order to identify and help with any health issues. Health visitors arrange subsequent visits either at the client's home or in a clinic setting, depending on the needs of the client and availability of the health visitor. The role of health visiting is being strengthened in the area of public health, and new guidelines in relation to this are currently being written by the Nursing and Midwifery Council (NMC, due for

publication April 2011). There is increasing support for public health nurses internationally to address child and family poverty (Cohen and Rutter, 2007), and in the UK, nursing in all forms is being challenged to take up a more active public health role (Craig, 2000; Appleby and Frost, 2006)

The historical construction of the community health visitor is as looking after new parents and their babies, visiting at home and giving advice and health care. The literature suggests that the experience of health visiting has not only changed over time, but the political significance of the role has also increased. Global pressures, national health care agendas and changing local communities have all converged to impact those who work in the day-to-day delivery of health care. One health visitor interviewed in this research described it as 'working in the coal face in the dark'. The way ahead for many health visitors is not clear – the 'map' has altered beyond all recognition. Roles, responsibilities and the delivery of community care have all altered in line with divergent national agendas and global pressures are altering local communities (Derrett and Burke, 2006; Hoskins, 2009). Health visitors are caught within the maelstrom where global change intersects with national policy (Hoskins, 2009), and turbulent waters swirl around individual professional and client interactions (McIntosh and Shute, 2007).

A review of the literature has identified several areas where health visiting is changing and continues to change. Some global changes in health care delivery do not appear to have impacted health visitors in the North East of England, while other changes leave health visitors

feeling as if they are working within a storm, and the future does not point to calmer seas. There is a large body of literature that points to a global nursing shortage and the increase of overseas nurses into the British health care system (Buchan, 2005; Mensah, Mackintosh and Henry, 2005). This has happened within the North East of England, but the majority of health visitors in the North East of England remain white and British, as defined by ethnicity.

Nonetheless, the North East of England is being impacted by globalisation and health care change on several fronts and each of these will be considered in detail. Firstly, the impact of global health care pressures on health visitors in relation to public health care will be considered. Secondly, a review of the literature in relation to the changing role of the health visitors will be explored. Thirdly, this literature review will consider the changing shape of child health surveillance in the UK. The final discussion will be into the changing nature of local communities themselves, cohesion and convergences within a globalising world. The impact of immigration and diversity will also be considered within communities, which have themselves moved from traditional employment patterns to new and emerging communities.

Health promotion and public health have become increasingly important over the last two decades. The World Health Organisation (2010) places health professionals at the centre of health promotion, stating that:

> Health professionals – particularly in primary health care – have an important role in nurturing and enabling health promotion. Health professionals should work towards developing their special contributions in education and health advocacy (WHO, 2010).

Prevention has been pushed to the top of the political agenda and public health strategies are targeted towards tackling the primary causes of morbidity, in particular coronary heart disease, cancers and mental health. Child health promotion has become increasingly more important, and child health promotion programmes are in place in most of the industrialised nations around the world (Kuo et al., 2006). The focus of these strategies is immunization programmes, child health surveillance, universal assessments and medical interventions. In the UK, these functions are largely delivered by health visitors (DH, 2007) who are registered nurses holding an additional health visiting qualification.

Global health prevention agendas are translated into national policy in the UK by the Department of Health. In relation to health promotion, community health practitioners are all expected to deliver on a public health agenda, but the roles and responsibilities remain unclear. Health visitors have an important role to play in bringing about social change to reduce child poverty (Cohen and Reutter, 2006), and the International Council of Nurses (2004) states that nurses have a clear role in reducing poverty and its impact on health. Nonetheless, the question as to ‘who’ carries out health promotion within the UK remains unclear, as

existing health professionals find their roles challenged to incorporate health promotion into already busy schedules. New health promotion and public health roles are being developed in the UK, but existing practitioners disagree on how these public health roles should be exercised in practice. Health visitors find themselves pulled into the general public health and health promotion agendas, involved in the delivery of smoking cessation services and obesity clinics. This pushes the traditional role of the health visitor in a trajectory, which many see as heading in a completely different direction to that of developing an understanding of parent-child relationships (Wilson et al., 2008) and child health surveillance (Bloor and McIntosh, 1990; Wilson, 2001).

Health visiting, today, in the UK is strongly positioned within child health care prevention policy, but even away from the general health promotion/ population health agenda, health visiting is moving in competing directions. This has not always been the case and health visiting has been extensively revised in the UK over the last decade. Historically, health visiting began in Britain with middle class philanthropy. There has been extensive critique of this, but it has remained largely unchanged until the last two decades, when health visiting services have been moved from offering a largely universal preventative service for preschool children, towards recommendations for increased targeting of services to those with identified needs (Hamill and Bigger, 2005; Hall and Elliman, 2003). The last two decades have witnessed increasing concerns in the UK around practice, which is not evidence based (Hendrickse, 1982) and inequity in the provision of services (McFarlane and Pillay, 1984). This has contributed to a review

of health visitor services in the UK. Recent high profile child abuse cases have also resulted in an increased focus on health visitors working within the child protection arena (Laming Report, 2003; DfES, 2004), and multi-agency working to coordinate complex health care needs in the community (Watson et al., 2002). Researchers have, over the last decade, questioned the effectiveness of child protection work, which health visitors engage in, when contact time with families is reduced (Kelsey and Robinson, 1999), and asserted the benefits of home visits to at risk families in early childhood (Barnes-Boyd, 2001; Kemp et al., 2005). Media interest has sensationalised and demonised health and social care professionals working within the child protection arena, particularly in the areas of social work, but health visitors have not remained unscathed in the turn of the popular lens towards their working practices. The Laming enquiry (2002) triggered directives for integrated working and for integrated teams, especially across child protection arenas. Improved technology has allowed for this to happen but there are problems with integrated teams.

Health visitors are torn between competing discourses of health prevention and child protection, of universal provision versus targeted need (Malone et al., 2003; Hoskins, 2009). Time constraints and public sector cuts result in the concentration of services to those in greatest need, but the discourse of ‘greatest need’ remains complex and contested. Health promotion and public health agendas demand universal health promotion, and the remit of health visiting has broadened out to include the elderly and older children. Turner et al. (2003) found that health visitors were the professionals most active in

health promotion activity in communities, but their activity in the development of healthy public policy was low. Simultaneously, health visitors are also expected to narrow down their practice, to target areas of high need and the most vulnerable of families. Time pressures and competing agendas leave health visitors feeling compromised and confused (Hamill and Bigger, 2005). Lupton et al. (2001) describe how health visitors have responded to these pressures by either fighting for the continuation of their child surveillance role, or by moving to support a less family centred, more generic public health role. The debate has become polarised, as have working practices. The National Service Framework for Children, Young People and Maternity Services (DH, 2004) recommended a move towards the protection of children across all health work. The tensions between competing agendas of surveillance and support have been highlighted extensively in the public health literature (Liaschenko, 2002; Marcellus, 2005). Condon (2008) also found that there was a policy-practice gap in the UK, which was created by many health visitors who did not adhere to policy directives, as they viewed them as being imposed from 'above' and not as in line with their own values and beliefs about what is good practice in relation to child health promotion.

Health visitors not only find themselves caught between general health promotion agendas and specific child health promotion, between universal surveillance and targeted interventions, but they also find themselves caught up within the wider professionalization of nurses agenda. Although a recent government review of the role of health visitors sets out clear responsibilities of health visitors (Lowe, 2007), the

practical application of this remains complex and contested. Health visitors are part of an ongoing debate into the professional role and responsibilities of qualified nurses in the UK. In line with many other industrialised nations, nursing care in the UK is moving towards increasing technical and medical status; the most recent manifestations of this being the implementation of global advanced practice agendas (Betts, 2007) and the introduction of nurse prescribers in the UK. After nearly half a century of theorising, Clarke (2006) suggests that in the middle of these conflicting agendas, nursing still does not know what it is. As health services respond to drivers such as evidence based practice (Elkan, Blair and Robinson, 2000), rising consumer demand and increased requirements for value for money (Derrett and Burke, 2006). Forsyth and McKenzie (2005) report economic constraints and the conflicting expectations of nurses and management within a market driven health care economy, as the focus of nursing discontent. As all nurses become more medically driven and technically qualified, one implication for health visitors is that many are now nurse prescribers and run clinics that offer therapeutic drug interventions. This shifts the focus from the health visitor in preventative services to curative services, from surveillance to therapy. Health visitors must allocate their time, and community care managers their resources, to competing agendas. Traditionally health visitors have been relatively autonomous in the management of their time and the allocation of their professional judgement (White, 1985), but the management of time, direction and frequency of visits have become much more closely managed, and health visitors are now held accountable for visit frequency and identification of needs requiring intervention. Condon (2008) highlights

how this now creates further tension between policy makers and the implementation of that policy (or not) at practice level. In practice, asserts Condon (2008), health visitors implement policies according to their own priorities, rather than those of policy makers.

Health visitors do not only work within a changing and complex professional and political landscape, but also within diverse communities. The final area to consider in this part of the literature review is a consideration of the changing nature of the communities within which child health preventative programmes are delivered. The North East of England is a region built on the industrial back bone of coal mining, ship building and heavy engineering. Nayak (2003) asserts that the:

> Northeast once contained the oldest coal mining district, which acted as a piston powering international economic and commercial success in Britain, before the last remaining pit closed in 1994 (p.307).

The heavy industry and coal mining of the North East built a thriving economy, despite periods of biting economic recession in the inter war years. Nonetheless, the last two decades have seen a rapid decline in these traditional industries and the North East of England has experienced a painful transition to a new economy. Belt et al. (2002) note that the workforce has become ‘feminized’ with the rise of telephone call centres, although this too has declined in recent years. The region does benefit from multinational organisations in both the car

and chemical industries, but employment is largely located within the public sector and is particularly vulnerable to current economic austerity measures by the coalition government. Recent public sector protests indicate a rise in unemployment in the region, as a result of the government cuts and local council leaders are currently hitting out at the government through the media to protest at these cuts (BBC, 2011). The North East of England is an area of poor health outcomes (Marmot, 2011) and suffers from pockets of high level socio-economic deprivation. Daiski (2005) states that:

> As nurses and health care practitioners in the frontlines…we need to advocate for social equity, adequate welfare and disability payments, wages that people can live on, affordable housing as a right, and social inclusion of the poor (p. 37).

Scholarly discourse challenges nursing to expand from individual care to a broader socio-political context, including communities (McDonald, 2002; VanderPlaat, 2002; Falk-Rafael, 2005; Cohen and Rutter, 2006). Although the historical development of public health nursing is grounded on social justice (Drevdahl, 2001; Falk-Rafael, 2005), this is less evident within health visiting policy and practice in the UK.

The demographic makeup of the North East of England is based on the 2001 census (ONS, 2001), which showed that only 0.051% of the region are residents born with a non-British nationality and, overall, the North East of England has less than 4% of non-white groups (ONS,

2001). Inward migration is largely focused around students to the area's five universities, and a small, but focused, dispersal of people seeking asylum to the region. The needs of people seeking asylum have been the focus of media attention including the health visiting literature (Drennan and Joseph, 2005). It is with this moving background that health professionals must practice to meet the multifaceted needs of changing communities.

2.3 ‘Race’, ethnicity, culture and health care

In recent years, a large amount of scholarly attention has been drawn to the shared and contested dimensions of ethnicity and health (Ahmad, 1993, 1996; Smaje, 1996; Gerrish, 2000; Bhopal, 2001; Porter and Barbee, 2004; Culley, 2006; Ahmad and Bradby, 2007). Accounts of inequality in health care suggest that in the UK, along with other Westernised nations, those who are not from the majority culture experience poorer health outcomes across many indicators, compared to the majority population (Davey-Smith et al., 2000; Erens et al., 2001; Nazroo, 2002, 2007; Knight et al., 2009). Inequalities in health care outcomes are attributed to difficulty in accessing services, cultural barriers, racism, prejudice and cultural incompetency by health care providers (Anderson, 2000; Bhopal, 2001; Gunaratnum, 2001; Lynam, 2004). Recent research has also highlighted the ways in which these inequalities persist across generations (Smith, Kelly and Nazroo, 2009). Service users continue to experience inequalities and discrimination (Annandale and Hunt, 2000; Browne and Fiske, 2001). Over the last 15 years in the UK, there has been a growing body of evidence and increasing concern that the health care needs of minority ethnic groups in the UK are not being adequately met (Gerrish et al., 1996; Fletcher, 1997; Papadopoulos et al., 1998; Gerrish and Papadopoulos, 1999; Bhopal, 2001, 2008). The picture is similar in other economically developed countries (Reijneveld, 2010). In the USA, disparities in health care in relation to ethnicity are well documented (Smedley, Stith and Nelson, 2002) and multifactorial (Jove, Trivedi and Ayanian, 2010). Policy makers have put forward a variety of interventions at health care

systems level to try to tackle these inequalities. These include more systematic collection of BME data, enhanced training and education of professionals in cultural care, improvements in interpreting services and information dissemination, and the introduction of lay community health workers (Kai, Spencer and Woodward, 2001; Gerrish, 2002; Gill et al., 2007). While considerable evidence of inequality exists, there is a paucity of research into practitioner behaviour in relation to people from other cultures (Van Ryn, 2002). Gerrish et al. (1996) demonstrated that nurses frequently fall short of providing culturally appropriate care to people from minority ethnic communities. In a study of 126 registered nurses, Narayanasamy (2003) found that nurses recognised cultural needs as relating to religious practices, diets, communication, dying, prayer and culture. In doing so, culture is equated with static cultural practices and physical markers, rendering it fixed and unchanging. Taking a Scandanavian perspective, Roland (2002) argues that the health care system has failed to adequately prepare registered nurses to meet the cultural needs of their clients and, consequently, they feel impotent to provide culturally appropriate care.

Research into the influence of health and social care practitioners in shaping health in relation to ethnicity, culture and 'race' largely looks at issues of attitudes and bias (Smedley et al., 2002; van Ryn and Fu, 2003). A large body of research is focused around the skills and knowledge, which health care professionals require to deliver culturally 'competent' care. Cultural competence is represented as:

> A quantifiable set of individual attitudes and communication and practice skills that enables the nurse to work effectively within the cultural context of the individuals and families from diverse backgrounds (Gustafson, 2005, p.2).

In the UK, as in other Western countries, the primary responsibility of nurses is to meet clients' health care needs while respecting and supporting their values (NMC,2009). The Australian Nursing Council Incorporated (2001) promoted cultural sensitivity, as a fundamental principle of nursing within a health care system, which values structural equality as a moral imperative. A limited amount of research evidence exists, which has interrogated the relationship between the cultural skills and knowledge employed by health professionals, and measurable health care outcomes for clients. Nonetheless, there has been an explosion of programmes over the last two decades to address these competencies in relation to the cultural skills and knowledge required by health professionals (Leininger, 1994, 2002; Campinha-Bacote, 2003; Lipson and DeSantis, 2007; Omeri, 2008). A review of the literature uncovers a plethora of research, which seeks to assess and evaluate nursing competencies (Purnell and Paulanka, 2003; Park et al., 2005; Kardong-Edgren et al., 2005; Campigna-Bacote, 2010), but educational programmes have flourished largely without due attention to the voice of the health care practitioners themselves. While these efforts are not without value, there have been concerns expressed that they potentially reify cultural stereotypes and essentialised discourse.

In response to these critiques, and incorporating discursive practice across disciplinary boundaries, scholars within health and sociology have begun to move beyond a knowledge/skills framework, using critical cultural perspectives to interrogate structural inequalities, racism, power and oppressive practice (Bradby, 2007; Williams and Sternthal, 2010). These perspectives are interrogated in section 2.4, but in order to develop a theoretical and political approach to researching 'race', ethnicity and culture, there are several tensions and contradictions that must be tackled at the outset. Not only do the terms themselves provoke fierce debate (Solomos and Black, 1994), but they shape the lived experience, identities and relationships of individuals, groups and society in general.

'Race', ethnicity and culture are categories, which are interconnected through complex historical and political threads (Hall, 2000), and have been socially constructed through dynamic processes over time (Brah, 1996; Gunaratnam, 2003). This socially constructed, non-essentialised view conceptualises 'race' and ethnicity as fluid, dynamic and changing (Dein, 2006). Postcolonial and feminist insights have challenged researchers to situate research within the social worlds of both the researcher and the research participant (Bhaba, 1994, 1996; Haraway, 1988; Spivak, 1998, 1999; Mohanti, 1984; Nayak, 2003; Gilroy, 2005). Guanratnam (2003) urges researchers to 'examine and trace how research is entangled with wider social and historical relations' (p.7) in order for these relationships and formations to be exposed. Our current understandings of 'race', ethnicity and culture have been shaped by history, and are being vigorously interrogated by social researchers,

feminist writers, postcolonial studies and critical ‘race’ theorists today. Central to these discussions are questions of how we produce knowledge about difference and how this knowledge is related to histories of power (Foucault, 1980).

‘Race’, ethnicity and culture are terms commonly used in health care literature, often interchangeably and without clear definition and explanation. There are thick and complex interactions between the categories (Hall, 2000; Bradby, 2003). Ahmad and Bradby (2007) draw our attention to the view that:

> Contemporary notions of ‘ethnicity’ show it as a marker of identity, a vehicle for community mobilisation and a possible indicator of disadvantage, discrimination or privilege (p.796).

Although Yasmin Gunaratnam (2003), taking a social constructionist approach, argues convincingly that they are interchangeable, and that definition only serves to reify difference and that the terms require exploration to understand the historical and political processes, which have shaped the debate.

‘Race’ and ethnicity originated in the global expansion of the 19th century, as European expansion and imperialism sought to dominate new lands and peoples. The term ‘race’ generally refers to a set of physical characteristics, which are attributed to a defined and fixed set of criteria. The origins of the concept of ‘race’ are controversial, but Malik (1996) gives a convincing argument that the discourse of ‘race’

did not arise out of the categories of Enlightenment discourse, but arose out of the relationship between European thought and the social organisation of capitalism. He asserts that the bourgeoisie still excluded other classes in the 19th century and, as social problems were not overcome despite the rhetoric of the Enlightenment and the belief in the universality of man, inequality became to be seen as the natural order of society. It was, he argues, the disparity between a belief in equality and the reality of an unequal society, which slowly gave rise to the idea that differences were natural, not social. Banton (1987) supports this view by asserting that the word 'race' was rarely used either to describe peoples, or in accounts of difference between them in an examination of the literature of the 17th and 18th centuries. The Victorian era embedded these 'natural' inequalities within scientific theory. Charles Darwin's 'Origin of the Species', published in 1859, placed the black man at the bottom of the evolutionary scale. Colonial literature took on a moralising responsibility of the West toward Africa, as personified in Rudyard's poem, 'White Man's Burden' [1866](Jones, 2008). Joseph Conrad perpetuated the ideology of the African man as a 'savage' in 'Heart of Darkness' (Conrad, [1902]1989), and Phillipa Lavine (2003) explores in her research how prostitution by Indian women was constructed by the colonisers as a 'natural' condition.

This construction of the 'other' continued into the 20th century, but following the atrocities of the Nazi concentration camps, the concept of biological 'race' was left to drop from political and popular rhetoric, as the Holocaust, Bauman's 'dark side of modernity' (1989), was left to die. The sixty years since then have led to differing accounts as to

whether the concept of ‘race’ has disappeared, or merely been redefined as a political or social construct. ‘Race’ has slipped from the academic lexicon, but the experience of racism is still a daily lived experience of many in the UK. New Commonwealth immigration in the 1950s and 1960s in Britain saw the issues of ‘race’ re-emerge, and the political climate of the 1970s supported the immigration-host model, which favoured assimilation and the integration of cultural groups into the dominant white culture. Since that time a plethora of Race Relation Acts (1962, 1966, 1976, 2000) have been introduced to tackle inequalities and discrimination. Riots on the streets of Britain’s cities in the 1970s and early 1980s were constructed as ‘race riots’, and neo-Marxist writers assert that the immigrant-host assimilation model reflected and reinforced racist assumptions by defining immigrants as social problems, and ignoring the part played by structural inequality in shaping the immigrant experience (Sivanandan, 1982). Social theorist Stuart Hall (1987) joined in the debate by taking as his central concern the processes by which ‘race’ came to be defined as a ‘social problem’, and the construction of ‘race’ as a political problem requiring stated intervention. Hall’s work focused on the construction of identity as a social process. Barber and Wallerstein (1991) and Solomos (1993) highlighted in their research how the use of public order measures was used to deflect attention from socio-economic problems experienced by the threatening ‘other’. John Rex (1991) asserted that ethnic groups sometimes have identities imposed on them to restrict mobility and increase exploitation. Research by Rex and Tomlinson (1979) preceding the riots, taking a neomarxist stance, found that the position

of many black people in the UK can be understood in terms of an underclass occupying a:

> systematically disadvantaged position in comparison to the bulk of the white working class in respect of housing, education, politics and employment (p.89).

Post colonial writers have highlighted the resistance by the cultural 'other' to this oppression as a struggle for:

> freedom, self-determination and dignity against contingent, ideologically biased and oppressive views and practices claiming false objectivity and universal validity (Parekh, 2000, p.2).

Researching in the 1990s into social disadvantage and ethnic groups, Ginsberg (1992) identified three areas of disadvantage, namely subjective (individual), institutional and structural (state) racism.

In his work on police institutional racism in the 1990s, Stuart Hall (2000) found that:

> black and Asian people have been subjected to racialised attacks, had grievances largely ignored by police and been subject to racially inflicted policing practices (p.4).

Sivanandan (2000) cautioned that ‘if institutional racism is the litmus test of a society’s democracy, we have surely failed’ (p.73). Institutional racism has been widely documented in the police service in the UK, in the wake of the Stephen Lawrence enquiry (Macpherson, 1999) but less so within the National Health Service.

Racist practices in the NHS have been explored over the last 15 years (Porter, 1993; Ahmed, 1993; Bhopal, 2001; McKenzie, 2003) but difficulties remain in collecting data and the political volatility of the subject in society in general. In their discussion around the benefits of multicultural or anti-racist approaches to nurse education, Nairn et al. (2004) note that difficulties exist in:

> exploring attitudes that respondents know do not conform to what it is to be a professional nurse and so avoid the risk of simply producing socially desirable responses from students and lecturers (p.192).

Studying 194 white student nurses, they concluded that although no significant negative attitudes towards those from other cultures were observed, however:

> as awareness of racial and ethnic group oppression increases, students are less likely to voice publicly an opinion that might be construed as racist (p.193).

‘Political correctness’ has been demonstrated to act as an inhibitor in the expression of certain attitudes in relation to ‘race’ (Eliason and Raheim, 2000). Research by Mazzei (2007) into the teaching of race and diversity to predominantly white students was characterised by ‘silence’ and the ’absence of voice’ as a means of resisting the challenges of anti-racist teaching. Scholars of critical race theory would go further and argue that students may resist breaking the silence but to do so may challenge the structural privilege they hold as being white (Mazzai, 2007; Gillborn, 2005; Jowallah, 2007; Sullivan, 2006). The danger is that, since racism is professionally unacceptable, it becomes invisible behind the discourse of equity. Wienorka (2000) puts this very succinctly by arguing that the issue of ‘race’ can be ‘both everywhere and nowhere’ (p.143). New research methodologies are being called for to explore these paradoxes (Hagey and Mackay, 2000):

‘Race’ has largely been constructed as a social category, but debate rages as to whether the term ‘race’ should continue to be used, or whether its continued use reifies the category.

Solomos and Black (1996) argue that racism is alive and well in the UK, and that to deny that ‘race’ exists is to deny the experience of racism. Modood, Berthoud and Nazroo (2002), while not explicitly arguing for the category of ‘race’, do emphasise the social divisions that exist in Britain and are perpetuated by racism and racialisation. They conclude that these categories, therefore, need to be maintained in order to be challenged. Smith (2002) argues that to continue to use the category of ‘race’ is to perpetuate the division of people according to physical

characteristics, while simultaneously ignoring the extent to which other factors can influence outcomes.

In health care, ‘race’ has been replaced by ethnicity as a more politically acceptable term to use, in order to define people by social group and shared culture. Ahmad and Bradby (2007) warn that:

> Notions of biology and culture mingle in a messy but complementary mortar, cementing inferiority of some, while conveniently absolving powerful groups and states from responsibility. Such thinking has seriously influenced definitions of health and care needs of minority ethnic groups in Britain, and elsewhere (p.798).

Bhopal (2001) argues that differences in disease experience, which are attributed to ethnicity fail to explore how it might be racism, rather than ‘race’ or ethnicity, which defines and perpetuates difference. He further argues that if ‘race’ is denied then racism can also be denied and rendered invisible. The cultural theorist Stuart Hall asserts that the categories of ‘race’ and ethnicity are ‘racism’s two registers’ (Hall, 2000, p.223) rather than two different discourses:

> Biological racism privileges markers like skin colour, but those signifiers that have always also been used, by discursive extension, to denote social and cultural differences...the biological reference is therefore never

> wholly absent from discourses of ethnicity, though it is more direct (p.223).

Racism within the National Health Service has been uncovered and interrogated within scholarly research and, although legislative frameworks operate to prevent racism (Equality Act, 2010), racism and discrimination have been shown to be denied and hidden (Aranda, 2004). Bhopal (2001) points to a failure within health care discourse to consider that it is racism, which contributes to differences in disease, rather than 'race' or ethnicity.

Ethnicity is used within health care policy, practice and research arenas to define people by shared origins or social background, but defies a consensual definition. In much health, social care and educational research, ethnicity is essentialised into a discourse of a fixed cultural distinctiveness of a defined group. Nonetheless, scholars writing from critical and postmodern perspectives alert us to the dangers of constructing ethnicity and culture as the root of health problems (Ahmad, 1993, 1996). Whiteness has been normalised as undifferentiated and non-racialised (Frankenberg, 1993). Whiteness is rendered invisible and ethnicity is attributed to the minority 'other' (Nayak, 2003). White and black identities are posed in relation to each other, with the 'white norm' as dominant (Hooks, 1989; Nayak, 2003). Crozier (2007), writing from the field of education, explores the ways in which token gestures of multi-culturalism are designed for the 'ethnic other', rather than for the 'white self'. Exploring the ways in which whiteness intersects with class, researchers (Reay et al., 2007) have

interrogated both the ways in which whiteness has ‘subtle shades’ (Nayak, 2003) and also has multiple subjectivities (Hall, 1997). Smaje (1995) alerts scholars within health care research to look at the silence in the constructions of ‘white’ ethnicities. These critical researchers challenge the plethora of research in health care which essentialises ethnicity (Anderson, 2005; Grant and Luxford, 2008). Differences in health outcomes are investigated between ethnic groups in relation to identified ethnic groups as having higher rates of diabetes, thalassaemic, sickle cell and tuberculosis (Chandra, 1996; Smaje, 1995). This is perpetuated in policy by the requirement of the UK Department of Health that all hospitals since 1995, and now all GP practices must collect data on the ethnicity of patients. Culley (2006) asserts that:

> Ethnicity is not merely symbolic; it is also materially constituted in structures of power and wealth (p. 140).

The influence of ‘race’ or ethnicity within this essentialised discourse has been critiqued for its focus on one category of identification without consideration of the complexity of factors influencing health outcomes for individuals. Lynam and Cowley (2007) highlight marginalisation as a social determinant of health, and Anderson (2000) has been exploring the intersection of ‘race’, health, class and gender over the last decade. McClintock (1995) reminds us that:

> Race, gender, and class are not distinct realms of experience, existing in splendid isolation from each

> other…they come into existence in and through relations to each other (p. 5).

Nazroo and Davey-Smith (2001) present a convincing argument of how ethnicity has been the focus of much research into health and inequalities without recognition for the influence of other important determinants of health, in particular socio-economic influences. Arguments for the elevation of ethnicity in determining health outcomes above other factors are strong (Smaje, 1996; Wild and McKeigue, 1997) but vigorously contested (Ahmad, 1996; Anderson et al., 2003). The oversimplification of the complexity of culture has come from many different quarters and has been slow to be interrogated in health. The boundaries between health and the discourses of feminism, postmodernism and post-colonial writings have become porous, and scholarly activity in health research has begun to explore a non-essentilaised view of culture and ethnicity (Francis, 1999; Anderson, 2000; Reimer Kirkham and Anderson, 2002; Gibb, Forsyth and Anderson, 2005; Dein, 2006; Grant and Luxford, 2008).

A critical cultural approach has interrogated the bounded nature of ethnic and cultural boundaries of much health care research (Ahmad, 1996), and explored the ways in which culture is fluid, flexible and a dynamic concept (Lynam et al., 2000). A social constructionist approach to culture and health has been a very welcome development in recent years and is challenging both policy and practice across many health care areas (Brah, 1996; Gunaratnam, 2003; Culley, 2006). Social constructionist accounts of ‘race’, ethnicity and culture see these

categories as historically constructed over time and social context, influenced by issues of power and knowledge (Dein, 2005). Werbner (1997), writing from a feminist epistemology, articulates this in the quote below, where she challenges theorising on essentialising and essentialism:

> To essentialise is to impute a fundamental, basic absolutely necessary constitutive quality to a person, social category, ethnic group, religious community, or nation. It is to posit a timeless continuity, a discreteness or boundedness in space, and an organic unity. It is to imply an internal sameness external difference or otherness (p.228).

Power relations both within and outwith health discourse are being examined in relation to cultural practices. Brah (1996) explores how a social constructionist approach to 'race', ethnicity and culture must interrogate these categories as dynamic heterogeneous processes, which have been socially produced over time:

> Race is more than a category, it is a lived experience. Different people experience race in different ways. As a narrative, it articulates with other narratives relating to gender, class and ethnicity. Both race and ethnicity are produced, negotiated and resisted as part of social interaction (Dein, 2006, p.72).

Aranda (2004), using a feminist epistemology and discourse analysis, highlights the ways in which community nurses were actively positioning themselves, and being positioned, by competing and contradictory discursive practice. She highlights how the community nurses interviewed revealed an ambivalence towards current narratives of equality, and uncovered the ways in which this can contribute to nurses giving oppressive and discriminatory care. Ruddock and Turner (2007) cite research by Danish researchers, Zarrehparvar (2000) and Jahn (2000), who both found racist attitudes by health care providers within hospital settings in Denmark, where ethnic minorities were often classified as problem patients. Discourses of power and oppression, while being central to scholars of sociology, post colonial studies, cultural studies and feminist sensibilities are a welcome attention to health care inquiry in recent years.

Recently, scholars in health are opening up a space to foster hybrid cultural meanings within health and to interrogate power relations, but they are as yet a minority voice. Health care literature continues to predominantly represent the objectified cultural 'other' without reference to issues of power, oppression or socio-historical positioning, despite a plethora of scholarly activity in neighbouring disciplines, which have been wrestling with such discourses for the last three decades. The continued dominance of bio-medical scientific discourses within health care, despite 40 years of critique (Illich,1976), have failed to significantly challenge the essentialisation of culture and 'race' in relation to health. 'Cultures' are defined in the same system of reference as disease categories. Theoretically essentialist, culture is bipolarised as 'them'

and ‘us’. As an occupational group, nursing, like medicine, is constructed through and by professional discourses (Halford and Leonard, 2001), and it has become very easy within health discourse to classify people into ethnic groups in the same way people are classified into groups of diseases.

Nonetheless, in contrast to the literature, which dominates the field of health and ethnicity, a new and exciting field of research is emerging which interrogates issues of culture, ‘race’ and ethnicity across disciplinary boundaries. Scholars within health are interrogating issues of professional power within theoretical post structural, post modern and critical fields of enquiry and are beginning to reshape thinking about health care. My research with health visitors situates itself within this body of scholarship, to look anew at health care and culture, while drawing on the vast body of scholarly literature across boundaries to challenge, inform and shape the future of health care delivery and education. It looks to a future where cross-pollination of disciplines and theoretical frameworks converges within health. A positive cross-fertilisation of theoretical insights across disciplinary boundaries is a welcome addition to the health and culture debates.

The lens of scholarly inquiry into the working practices of health professionals and clients who are from ‘other’ cultures has not only focused on knowledge/skills frameworks and issues of power and oppression, but the issue of ‘race’ and racism within health care has also begun to be examined in greater depth. As noted earlier, this is not a dominant discourse but is increasingly becoming an important area of

scholarly inquiry. Gerrish et al. (1996) highlight that students, teachers and practitioners identified the existence of racism in practice settings as a significant concern. Aranda (2005) uncovered the ways in which community nurses constructed discrimination as an inevitable but manageable aspect of their practice. In addition, she highlighted the ways in which health visitors could also be discriminated against by racist clients:

> This dangerous self, capable of discrimination, revealed the acute struggle and tensions with a professional practitioner and impartial self and, interestingly, often led to participants invoking their own experiences of discrimination or overt racism from clients and the organizations in which they worked (Aranda, 2005, p.136).

Narayanasamy (1999) identified racial discrimination as one of the significant obstacles to treatment and care for ethnic minority groups in the UK:

> Discrimination, racial harassment and oppression are compelling forces that may contribute to negative perceptions of health service treatment and care by black and ethnic minority groups (Narayanasamy, 2003, p.186)

Although non-essentialised concepts of ‘race’ and an acknowledgment of the experience of racism have been slow to be interrogated within health care, a review of the literature highlights that it is an active and

contentious area of study across neighbouring disciplines. Racism is not measurable but ‘racist incidents’ are. Crozier (2008) contextualises ‘symbolic violence’ and ‘otherization’, which is difficult to measure but can be demonstrated through qualitative research. People from black minority groups report underlying antagonism and racist abuse as a lived experience for many on a daily basis (Nayak, 2009). Racial harassment has increased following the invasions of Iraq and Afghanistan. Whiteness scholars alert us to the ways in which whiteness places black and white identities in opposition to each other against the ‘white norm’, and there is a disturbing resignation of the too common place of racism framed in discourses of ‘not that big a deal anyway’.

Issues of ‘race’ in health are commonly framed in relation to disease processes, and ‘race’ is easily reified as fixed and synonymous with culture. Nonetheless, there has been an increasing body of literature within medicine and nursing in recent years, which tackles issues of ‘race’, racism and health from a more critical stance. It is within this contentious context that scholars have sought to introduce educational approaches for health care practitioners in cultural ‘competency’.

2.3 Cultural ‘competency’

It is well documented that inequalities in health care related to ethnicity exist (Davey-Smith, 2000; Bhopal, 2110, 2007; Marmot, 2005, 2011) and, yet, the impact of health care practitioners have in exacerbating these inequalities is unclear (van Ryn and Fu, 2003). Research highlights racism (Nairn, 2005) and nurses treating everyone the same (Vaydelingum, 2005), as contributing factors. Despite an intense level of scholarly activity directed towards cultural ‘competency’ over the last two decades, there has been limited success in measuring cultural competent practice in health care. Culturally ‘competency’ programmes have flourished in the more economically developed countries of the world for the last three decades, but there is no consensus as to their impact on engagement across cultures. Since cultural ‘competency’ was first introduced into the nursing lexicon by the nurse theorist Madeline Leininger (1978), transcultural nursing has become the dominant discourse (Maire-Lorentz, 2008). There is, however, a growing body of work that critiques the epistemological foundations of transcultural nursing and related culturalist educational programmes. These critical perspectives urge scholarship to use post structural, feminist and postcolonial theoretical insights to interrogate the ways in which power and privilege perpetuate structural inequalities across cultures. In this section of the literature review, the historical development of cultural ‘competency’ will be traced, with particular attention to perspectives that call for a non-essentialised approach to culture (Culley, 2000, 2001, 2006; Gray and Thomas, 2006).

In recent years a large amount of scholarly attention has been drawn to the shared and disputed dimensions of cultural education (Gerrish, 2000; Duffy, 2001; Anderson et al., 2003; Culley, 2006; Gustafson, 2005; Dogra et al., 2005; Dogra, 2007). A plethora of educational programmes exist across many professional and educational disciplines around the popular concept of cultural 'competency'. Professional bodies such as the International Council for Nurses (2007) and the Nursing Midwifery Council (2009) expect nurses and midwives to deliver culturally appropriate care. The vocabulary used to describe culturally appropriate care has widened over the years to include, cultural 'competency', cultural safety, cultural sensitivity, cultural awareness and cultural desire, to name but a few. Within nursing, the dominant discourse is that of transcultural education. In nursing, cultural education is largely attributed in its formal form to the nurse theorist Madeline Leininger (1988) in the United States. She described transcultural nursing as:

> *A formal area of study and practice focussed on comparative holistic cultural care, health, and illness patterns of people with respect to differences and similarities in their cultural values, beliefs, and lifeways with the goal to provide culturally congruent, competent, and compassionate care* (Leininger, 1997, p.342)[italics in original]

Transcultural care as conceived and developed over the last three decades by Leininger has been adopted, and adapted not only in the USA, but in many countries throughout the world. Many models have

been spawned based on the founding principles of transcultural care (Purnell and Polanka, 2003; Jeffreys, 2006; Campinha-Bacote, 2003, 2010). Transcultural educational programmes have not only been developed within nurse education, but similar developments can be traced across the fields of medicine and social work also. The central focus of transcultural care is on the individual values and beliefs of the practitioner. Educational programmes working within this framework focus on the acquisition of knowledge and skills to enhance cross cultural engagement. It is largely about knowing the cultural 'other'. Papapopoulos et al., (1998) in her earlier writings, asserted the need for health care practitioners to develop both culturally specific and also culturally generic programmes, which she described as:

> Culture specific competence refers to knowledge and skills that relate to a particular ethnic group and that would enable the nurse to understand the values and cultural prescriptions operating within the client's culture….generic cultural competence, on the other hand, is defined as the acquisition of knowledge and skills that are applicable across ethnic groups (Papapopoulos et al., 1998, p. 1455).

Campignha-Bacote's (2003) Cultural Competency Care Model has been well developed over several years and defines the culturally 'competent' nurse as someone who is culturally aware, has cultural knowledge, cultural skill, cultural desire and cultural encounters. The focus is on the acquisition of knowledge and skills by the individual

nurse of the cultural ‘other’ (McFarland and Zehnder, 2000). In her early publications on transcultural care, Leininger defined culture as:

> the learned and transmitted knowledge about a particular culture with its values, beliefs, rules and behaviour, and lifestyle practices that guides a designated group in their thinking and actions in patterned ways (Leininger, 1978, p.491).

The danger of this approach is to reduce the complexity of culture to fixed and identifiable categories, and to reinforce cultural stereotypes to the detriment of cultural care. Culture can easily become static (Price and Cortis, 2000). Blackford (2003) warns of the dangers of focusing on cultural difference and traces the ways in which in Australia, the cultural ‘other’ is perceived as ‘deviant’.

In recent years, there has been a growing body of work, which challenges these individualistic approaches to culture, asserting the need for nursing scholarship to move away from a liberal humanistic framework to acknowledge the wider social determinants of health. Scholars warn of the danger of cultural education which focuses on the individual and cognitive aspects of culture, but fails to incorporate socio-historical and political aspects of culture into the programmes. Campesino (2006) asserts that cultural care cannot be removed from the historical formations, political context or from other constituent factors (such as socio-economic factors), which intersect with issues of culture and ‘race’. The publication of the Acheson report in the UK

(1998) into inequalities in health reported that, compared to the white population, people from ethnic minorities had poorer access to health services, experienced longer waiting times in GP surgeries, were less likely to be referred to secondary care and were less satisfied with the outcome of their consultation with the GP. Over the last decade minority ethnic identity has been increasingly recognised as an important factor in inequalities in health. The Acheson report (1998), along with structural recommendations, also recommended the training of health workers in cultural 'competence'.

The diversity and plethora of cultural 'competency' programmes remain largely unevaluated and there is no consensus on what should constitute cultural 'competency' (Park et al., 2005; Nokes et al., 2005; Ladson et al., 2006). Cultural 'competency' programmes include not only curriculum based education but also intercultural experiences abroad (Woods and Atkins, 2006; Walsh and DeJoseph, 2003). The limited amount of research into the evaluation of the effectiveness of teaching interventions in cultural competence, both in the United States (Jeffreys, 2002, 2006) and the UK (Dogra, 2005, 2007) has become a cause for concern.

Built upon a positivist epistemology, many cultural 'competency' programmes teach culture as a clinical skill, and 'competencies' are formulated, which are assessed within adapted educational frameworks (Seargent, Sedlak and Martsolf, 2005; Seeleman, Suurmond and Stronks, 2009). Medical and nursing schools in particular favour cultural

‘competencies’ as mapped on to educational and clinical competencies, even in some instances assessed during a clinical exam. Competencies are described in terms of attitudes, knowledge and skills. Cultural competency skills have also been developed where health care professionals measure their own competency in Cultural Self-Efficacy Scales (Coffman, Shellman and Bernal, 2004). Omeri (2004), speaking from the field of nursing, argues strongly for not only embedding transcultural nursing standards in to practice, but to also bench mark culturally competent nursing care within health care systems. Bench marking of standards and clinical ‘competencies’ are hall marks of professional bodies in the UK, and it is easy to transcribe culture as a ‘competency’ onto this framework. Educationalists argue over what constitutes ‘competency’ to practice (Govaerts, 2008) but the epistemological stance remains the same. Culture is essentialised and bounded, knowledge of the cultural ‘other’ is learned and cultural difference becomes reified and supported. Routledge et al. (2004) used standardised patient simulations to evaluate cultural ‘competency’ in many students in the USA. These approaches fail to look beyond the integration of knowledge, skills and attitudes to interrogate wider structural issues (Govaerts, 2008).

Scholars within the fields of nursing, medicine and social work working within these paradigms have published a plethora of literature in cultural ‘competency’ and yet Omeri (2008) concludes that:

> despite 50 years of transcultural nursing knowledge development through theory, research, and practice, there

> remains a lack of formal, integrated cultural education into nursing (p.x).

Educationalists working from a culturalist epistemology search for ways to pin down culture, to define and shape 'it' into something, which is measurable, assessable and universal (Kardong-Edgren et al., 2005; Lipson and DiSantis, 2007; Campinha-Bacote, 2010; Kardong-Edgren et al., 2010). Evaluations of outcome measures of cultural 'competence' remain contested and weak (Park et al., 2005; Ladson et al., 2006; Krainovich-Miller et al., 2008), as rigid frameworks are developed to try and contain the dimensions of culture.

Recognising that in order to provide effective health care in a multiethnic society, practitioners must move beyond individualistic conceptualisations of culture (Smye and Brown, 2002). Scholars in the 1990s began to call for cultural education, which recognised the socio-historic dimensions of health (Gerrish and Papadopoulos, 1999). The next decade saw an attempt by some scholars and educationalists to move away from cultural competency programmes, which focused on the 'cultural other' and tried to address some structural and racial issues.

> It is essential that students develop from the outset an understanding of both individual and institutional racism and develop the necessary skills and confidence to challenge racist behaviours (Papadopoulos, 1998, p.1455).

Racism has been recognised over the last two decades within health care discourse, as a significant factor in inequalities in health care by people in minority ethnic groups (Ahmad, 1993; Smaje, 1995; Nazroo, 1997). The Macpherson enquiry (2003) into institutional racism in the Metropolitan police force began to turn the spotlight to other institutions and the NHS. Research into racism within the health services recognised and sought to address racially oppressive and discriminatory practices (Gerrish, 1997; Papadopoulos et al., 1998; Narayanasamy, 1999b). Gerrish (1996) found in the mid-1990s that students graduating from nursing and midwifery programmes felt they were ill equipped to meet the health care needs of minority ethnic communities, and along with research by Papadopoulos et al. (1998) around the same time, found that newly qualified nurses were unable to challenge racist sentiments in practice settings.

In New Zealand at the same time, cultural safety is a concept, which was being developed by Maori nurses and brings to the fore the negative effect on health of inequities experienced by minority populations in a majority white post colonial country. To be culturally safe is to feel respected in terms of cultural identity, rights and needs. The concept focuses on not only the health status of the client, but also the inequality and unequal power relations, which operate within health care systems. Polaschek (1998) describes culturally unsafe environments as being characterised by diminished cultural identity and group disempowerment. Research by McKenzie (2003) and Lynam (2005) both add to this concept of cultural safety and they have

convincingly argued that cultural risk is increased when the racial identity or cultural group is disempowered. Maori researchers (Ramsden, 1995) in developing the concept of cultural safety have contested the discourse in much of the transcultural literature on culture, as a system of values and beliefs, which results in poorer health outcomes for the Maori people compared to the white New Zealanders (Ramsden and Spoonley, 1993). They have moved the lens of inquiry to investigate Maori health in terms of their social experience, as a colonized people in a postcolonial society. Canadian researchers have used the concept of cultural safety to examine issues of health inequalities in relation to wider ethnic minority groups (Anderson et al., 2003). The concept of cultural safety was initially a concept, which looked at the power dynamic that is in operation between the colonised and the coloniser, taking post colonial discourse as a theoretical framework. Smythe and Browne (2002) argue that cultural safety highlights for nurses the:

> long histories of economic, social and political subordination at the root of current health and social conditions among Canada's indigenous people(p.8).

Anderson et al. (2003) nonetheless argues that this dichotomy of the powerful coloniser and the powerless colonised is too simplistic, and that multiple forces are at work. Cultural safety is a way for nurses to examine where they are positioned within the health care system in relation to both the system and to their patients. Barker (2006) also develops the concept of cultural safety by exploring in her research the experience of Canadian Muslims following the 9/11 bombings in New

York. Her research participants described how they had experienced a sudden transition from cultural safety to cultural risk following 9/11, and she concludes that cultural risk is not necessarily only a result of colonial histories, but can be generated by external forces, which operate on individuals and communities in contemporary times.

Cultural safety has been widely adopted in Canada and Australia, as well as New Zealand, but concerns remain as to whether the original emancipatory thrust of cultural safety has become lost under the rhetoric of 'culturally safe' practice. Narayanasamy (2003) states that in cultural safety:

> the environment needs to engage clients as partners in care where efforts are made to establish respect and rapport, cultural negotiation, and where compromise is conducive for promoting a sense of safety (p.186).

A sense of cultural safety is most likely to promote trust and therapeutic relationships, which are central to meet cultural needs (Narayanasamy, 2002).

The danger of this conceptualisation of cultural safety is that cultural practice is reduced to individual knowledge, skills and values, and as a consequence, has no more emancipatory power than transcultural education. Kildea (2006) also raises concerns with the motion of empowerment and indigenous women, and challenges a health care system in Australia, which controls women through mechanisms of surveillance and control.

Scholars working within feminist, post colonial and critical epistemological paradigms have challenged cultural 'competency' programmes, which pay lip service to structural inequalities, racism and power issues, while maintaining an essentialist stance (Anderson, 2000, 2002; Duffy, 2001; Culley, 2006; Gustafson, 2005; Pon, 2009). Leininger (2007) has responded to criticisms towards the individualistic humanist nature of transcultural nursing care by expanding her definition of 'cultural care' as:

> The theory is a holistic, culturally based care theory that incorporates broad humanistic dimensions about people in their cultural life context. It is also unique in its incorporation of social factors, such as religion, politics, economics, cultural history, life span, values, kinship, and philosophy of living: and geo-environmental factors, as potential influencers of culture care phenomenon (p. 9)

Nonetheless, these definitions fail to challenge the essentialist stance of these theories and conceptualisation remains largely focused on difference, rather than the ways in which power constructs relationships through culture. Duffy (2001) asserts the need for cultural education, which challenges the deconstruction of self, and scholars writing from the perspective of white studies challenge the invisibility of whiteness and the structural processes that maintain white privilege. Fundamental challenges like this are not enacted by broadening out perspectives of culture to include a list of social influences of health. These scholars call for a fundamental change in epistemological stance, and to engage a

non-essentialised cultural perspective. Gustafson (2005) in a strong and convincing challenge to transcultural nursing education, urges leaders in cultural education to embrace a critical cultural perspective, which:

> constitutes a challenge to the liberal, individualistic discourse that is central to the construction and reproduction of nursing knowledge and institutional practices. Nursing as a profession must take seriously the invitation to dialogue about alternative ways of thinking and interpreting social reality (p.14).

A growing body of scholarly nursing literature, which challenges this epistemological view, calls for a non-essentialised teaching of culture, where culture is conceptualised as fluid and in flux (Bruni, 1988; Browne and Syme, 2002; Culley, 2006; Dein, 2006; Thomas and Gray, 2006). The field of social work is pushing forward in the development of cultural educational programmes which interrogate issues of power, structure and self (Baskin, 2006; Sakamoto, 2007; Pon, 2009). Pon (2009) pushes critique even further in arguing that cultural 'competency' has become the new racism in Canada. Sakamoto (2007) and Sue (2006) raise whiteness as a form of hegemony in social work practice. Pon (2009) argues:

> Cultural competency resembles new racism by otherizing non-whites by deploying modernist and absolutist views of culture, while not using racialist language. I assert that

> cultural competency is also an ontology of forgetting Canada's history of colonialism and racism (p.60).

Lee and Farrell (2006) writing from the field of anthropology also ask 'Is cultural competency the backdoor to racism?' (p. 9). Almost two decades ago, Prozatec (1994) asserted the need for social workers to gain an awareness of how white subjectivities influence cultural knowledge and the ways in which this is constructed and contested. Few educational programmes, which interrogate 'white subjectivities' are documented in the nursing or social work literature, but scholarly voices that call for these to be developed are gaining volume from the fields of feminist, post colonial and critical studies.

In practice, most of the cultural education programmes, which are unable to reconcile the concepts of culture and 'competence', and take a non-essentialised view of culture, direct their students towards emancipatory and/or anti-oppressive practice (Jessop and Rogerson, 2004). This is an easy 'fit' within social work practice, which has had a long and mature history of emancipatory practice. This is much more problematic within nursing and health visiting practice, where discourses of political and social change are rare. The closest current conceptualisation of this comes from the arena of cultural safety. Although some authors argue that cultural safety as a concept is problematic with multicultural groups, rather than in countries with indigenous groups (Kirkham et al., 2002, Smye and Browne, 2002), cultural safety remains the most widespread cultural programme that considers issues of power and privilege. Cultural safety was endorsed

by the Nursing Council for New Zealand in 2005, and has been widely adopted across Canada (Walker et al., 2009). Cultural safety is defined as:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual beliefs and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual (Nursing Council of New Zealand, 2005, p.7)

Nonetheless, cultural safety is still poorly understood by nurses in the clinical setting (Johnstone and Kanitska, 2007). Although widely adopted in New Zealand, Australia and Canada, Richardson (2004) points out that there is a limited evaluation of its effectiveness. Whether the concept of cultural safety can be used within a multicultural setting such as the UK remains to be seen, but health visiting in the UK remains caught within discourses of care, rather than emancipation. Although scholars call for non-essentialised cultural education, the reality for most is of some form of cultural education, which reifies

cultural stereotypes and reduces the complexity of culture to essentialised categories of knowledge, skills and attitudes. The scope for future development is wide, but discourses of clinical ‘competency’ are strong, where culture is mapped onto clinical skills. The result is a striving for cultural ‘competency’ assessment tools, which remain unsurprisingly as elusive as the concept of culture itself.

Chapter 3: Methodology - data collection, analysis and development of conceptual theory

3.1 Introduction

In this chapter, the methodology used for collecting data is explained, including the rationale for the use of grounded theory and the strengths and weaknesses of this approach. Theoretical perspectives are explored and a detailed description of the analysis of the data is given, including the process of open, axial and selective coding using the comparison of textual data from the interviews, and the theoretical memos which accompany that analysis. The emerging theory is also described.

Cathy Charmaz (2006) has developed a stepped 'process' for undertaking grounded theory and this has been used to frame the data analysis and presentation of this chapter. The process is described in 11 stages, all of which were undertaken during this research study but as with any process within social research, the stages were at times overlapping and ebbed and flowed. Nonetheless, the presentation of the research process follows these stages, in order to clarify the process of grounded theory and subsequent generation of a conceptual theory. The stages were described by Charmaz (2006) as:

1. Identifying the research problem and opening research questions

2. Identifying sensitising concepts and general disciplinary perspectives
3. Initial coding and data collection
4. Initial memos, raising codes to tentative categories
5. Data collection, focused coding
6. Advanced memos, refining conceptual categories
7. Theoretical sampling and seeking specific new data
8. Adopting certain categories as theoretical concepts
9. Sorting memos (described along with initial memos)
10. Integrating memos and diagramming concepts
11. Reconstructing theory (p.11)

Interviews 1-4 introduce the method of open coding, where each incident throughout the interview data analysis is coded and compared to each other incident. Tentative themes emerged, but the codes remained open and were explored further during interviews 5-7. Following the first 7 interviews, tentative categories were developed, which required further exploration. During interviews 8-12, these open codes began to move towards axial coding (or focused coding), when the theoretical categories began to emerge at a conceptual level of analysis. This process required re-working many times to ensure the interpretation of the data was consistent with the views of the health visitors, as expressed in the interview data. The purpose of this stage was to find out what was going on in the data. After intense focused (axial) coding in each category, interviews 8-13 were carried out and these axial codes were further developed toward selective coding. Interviews14-16 were undertaken alongside the focused coding of

certain categories. This enabled the researcher to continue to open up the categories, which had not reached saturation, and to take the new data and compare it with previous codes and categories. The final stage of data analysis, selective coding, was completed during interviews 17-21, where the two core conceptual categories of **'relational journeys through culture'** and **'emotional encounters through cultural terrain'** emerged. These two conceptual categories were used to generate the substantive theory, **'emotional encounters through cross cultural terrain: shaping relational journeys through culture'**.

Corbin and Strauss (2008) assert that:

> The cohesiveness of the theory occurs through the use of an overarching explanatory concept, one that stands above the rest. And that, taken together with the other concepts, explains the what, how, when, where, and why of something (p.55).

'Emotional encounters through cross cultural terrain: shaping relational journeys through culture' became that overarching explanatory concept. Through this process of constant coding, categorisation and comparison, using the process of grounded theory as outlined by Charmaz (2006), the researcher was able not only to answer the research question, but also to develop a conceptual theory, which was acceptable to the health visitors working in practice. The expectation is that this can then be used to challenge future training in cultural education, and to expand the theoretical conceptualisations of

emotional capital and emotional *habitus* as found in the work of Pierre Bourdieu (Section 5.2.2).

3.2 Research problem and opening research questions

Grounded theory is a widely recognised and accepted method of research enquiry throughout the social sciences, education and nursing (Melia, 1982; Lincoln and Guba, 1985; Cutcliffe, 2005; Clarke, 2005; Charmaz, 2006). Nonetheless, recent constructivist interpretations of grounded theory move away from the original positivist epistemology, and challenge the position of the researcher in the process (Mills et al., 2006).

> Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations (Denzin and Lincoln, 2003, p. 4).

The study sought to situate the researcher within the research and through the process of grounded theory methodology, to make the lived world of the health visitors who participated in this study, visible. Interpretivist grounded theory does not set out to portray the studied world as an exact representation, but as a co-constructed narrative involving the words of the research participants and the analysis and thoughts of the researcher. Corbin and Strauss (2008) are explicit when they describe the constructivist viewpoint as being when:

> concepts and theories are *constructed* by researchers out of stories that are constructed by research participants who are trying to explain and make sense out of their experiences and/or lives, both to the researcher and to themselves. Out of these multiple constructions, analysts construct something they call knowledge (p.10, italics original).

Researchers are not impartial observers located outside the research, but rather constructivist grounded theory places the researcher within the research process itself. Researchers and research participants come to the research encounter with assumptions, beliefs, values and judgements which embody their respective views. They take these into the research process and draw upon them to influence their views and actions (Charmaz, 2005). I acknowledge that my personal beliefs, values and the world view were brought into the research process, but throughout, I tried to remain as open as possible to the world of the research participants themselves. In writing a reflective diary, I was able to make explicit my personal assumptions throughout my research journey, and to examine these in relation to subsequent data and coding.

Interpretive research requires that the researcher moves into and engages with the participant's world, and establishes rapport as an important aspect of this process. Glaser and Strauss (1967) have been criticised for taking a detached view of the interview process, remaining separate from the research and distant (Dey, 1999). This research does not claim to reproduce the exact views of the participants and yet, while

acknowledging the specific and at times hidden nature of individual meanings (Murphy and Dingwall, 2003), a theory has been produced from the data, which has meaning for the health visitors involved. Raw data was taken, interpreted and investigated to look for new ways to interpret that data. This included finding taken-for-granted, and hidden assumptions and interrogating them within the data.

3.3 Data collection and analysis

Glaser and Strauss (1976) emphasised the uniqueness of grounded theory data collection. The central premise of grounded theory data collection is not to amass huge amounts of data for later analysis, but to analyse it against the current data and then adapt it to the new data generated. Duhscher and Morgan (2004) assert that grounded theory is not a linear approach but concurrent, iterative and integrative. The constant comparative method (Becker, 1993) helped me in this research to strive towards conceptual depth**.** Concepts and theories are then generated through the constant comparison and analysis of the data.

Data collection in grounded theory is focused around gathering rich data which contains 'thick' description (Geertz, 1973). Charmaz (2006) describes rich data as both focused and full, revealing:

> participants' views, feelings, intentions, and actions as well as the contexts and structures of their lives (Charmaz, 2006, p.14).

Rich data enables grounded theorists to generate strong conceptual theories and can be generated from many different kinds of data, including observational field notes, printed documents and interviews. Data was generated in this study using interview data and research diaries. There is no specific method of data collection required in grounded theory, but Glaser (1992) in classical grounded theory, asserted that it was essential to have observation, as well as interviews to uncover the meaning of the participants, otherwise the broader contextual factors which impinge on the phenomenon may be ignored. Nonetheless, in this study I felt that to observe health visitors within family homes would be too intrusive, and therefore guided interviews were used to collect the data. Over the last two decades, grounded theory has developed tools to contextualise interview data and in this study situational analysis (Clarke, 2005) was employed (see Section 3.3.3). Although Murphy and Dingwall (2003) and (2009) both caution that interview narratives do not necessarily reflect the reality of experience or practice, Charmaz (2005) asserts that:

> Intensive qualitative interviewing fits grounded theory methods particularly well. Both grounded theory methods and intensive interviewing are open-ended yet directed, shaped yet emergent, and placed yet unrestricted (p.28).

3.3.1 Interviews

Twenty one in-depth interviews were conducted with participating health visitors between May 2008 and September 2009. I conducted all of the interviews and they were all conducted in English. Interviews were recorded using a semi-structured interview schedule to encourage participants to reflect on their experiences of working with people they identified as belonging to another culture. All names were changed to preserve the anonymity of the research participants. The initial interview schedule was used only as a guide and questions developed depending on the direction of each individual interview (Appendix B).

Interviews were recorded, transcribed in full and then analysed. Memo writing and an audit trail of all coding and data analysis decisions were made throughout the analysis and used to ensure confirmability. Methodological tools are important for analysis and the computer software NVIVO was used initially as a tool for organisation and retrieval of interview data, but it is the analytical skills of the researcher which are the most important. 'A keen eye, open mind, discerning ear, and a steady hand can bring you close to what you study' (Charmaz, 2006, p.15). Interviews do not reproduce the realities of experience (Silverman, 2000) but it is a co-construction of a reality. Charmaz (2006) asserts that:

> An interview is contextual and negotiated. Whether participants recount their concerns without interruption or

> researchers request specific information, the result is a construction - or reconstruction - of a reality (p.27).

The construction of this reality was verified by the health visitors themselves following the conclusion of the research process and the development of the final conceptual theory. A summary of the overall findings of the study were sent to all participating health visitors at the end of the study and their views were welcomed.

3.3.2 Forcing data

Glaser (1978) cautions against the danger of forcing interview data into preconceived categories.

> Interviewing challenges us to create a balance between asking significant questions and forcing responses, more so than other forms of data collection (p.32).

Glaser (1998) warns against the use of 'interview guides, units for data collection, samples, received codes, following diagrams, rules for proper memoing and so forth'(p. 94), but Juliet Corbin has written in detail of the methodological 'steps' of grounded theory, which have been very useful in this study (Corbin and Strauss, 2008). Charmaz (2006) asserts that:

> Rather we follow leads that we define in the data, or design another way of collecting data to pursue our initial interests (p.17).

The ways in which the researcher situates themself in the research, and how relaxed or not they are, will all shape the data. Interviewing, at its simplest is a directed conversation (Lofland and Lofland, 1995). Nonetheless, the conversation is directed by the status, personality, situation, attitude and skill of the interviewer.

3.3.3 Situational analysis

Grounded theorists over the last three decades have developed, stretched and re-worked various analytical tools to help them to situate their research within the contextual space of the research enquiry. Glaser and Strauss (1967) used the conditional/consequential matrix, which was subsequently developed by Strauss and Corbin (1990) into social world/arena frameworks. Recently, Adele Clarke, a student under Anselm Strauss, has expanded and stretched grounded theory round the 'post modern turn' by developing an analytical tool she calls situational analysis (Clarke, 2005). Clarke (2005) firmly situates her work as building on the work of Anselm Strauss, not as an alternative to it:

> Situational analysis is itself grounded in Anselm Strauss's social worlds/arenas/discourse frameworks as an alternative

> conceptual infrastructure to that of basic social processes of action (Clarke, 2005, p.291).

In order for constructivist grounded theorists to locate research within the wider social world, which lies beyond just the participant and the researcher, Mills et al., (2007) having tested some work done by Adele Clarke, have expressed their opinion that:

> Situational analysis has proved a breakthrough for constructivist grounded theorists by providing tools for the researcher to use in visually opening up the field of inquiry – illustrating participants' social worlds and their arenas of negotiation (p. 78).

At its most basic situational analysis consists of a set of analytical tools, which place the researcher and the research participant within a social and structural context, and move the research beyond the individual participant. Analytical frameworks are not new within qualitative research, Goffman (1974) developed a framework of analysis almost 4 decades ago and qualitative researchers have been using analytical frameworks to expand data analysis ever since. Nonetheless, what is important with situational analysis is that Clarke (2005) makes explicit her epistemological foundation as constructivist, pushing towards the post modern. In doing so, she opens up new and exciting possibilities for analysis. Situational analysis pushes data analysis beyond simply analysis of the collected data itself, and forces the researcher to continually analyse the data in the wider context of the social, cultural,

historical and political worlds the research is situated in. In itself this is not particularly novel, but what is really exciting about situational analysis is that Adele Clarke has developed a set of analytical tools which work within a post modern framework. She does this specifically by using positional mapping, an analytical tool which interrogates discourse.

> Positional maps lay out most of the major positions *taken in the data* on major discursive issues therein – topics of focus, concerns, and often but not always contestation (Clarke, 2005, p.126.Italics original).

Post modern epistemologies challenge scholars not only to contextualise research within the known social arenas, but to look beyond what is seen and known, to look beyond taken-for-granted knowledge and to listen to the silences, and to the extant discourses and to the language of discourse itself. Clarke (2005) draws heavily on the work of Michael Foucault (1980, 1991) to shape her analytical tools and in doing so, has developed situational analysis as an analytical tool to help researchers not only to listen to the silences, but also to uncover the ways in which power operates within the social world the research participant occupies. Clarke (2005) has developed three different frames of analysis, which she calls situational, social and positional maps. These maps are diagrammatical representations of the social world arenas, which the researcher and the research participants find themselves in, and Clarke (2005) is very helpful in giving very detailed

explanations and examples of how to do and use situational mapping within grounded theory methodology.

Situational maps consist of a set of diagrammatical strategies to articulate all of the elements in a given situation, and are a way of examining the relations between each of the elements. These elements Clarke (2005) describes as human, spatial and non-human in character.

In this study, I was drawn to situational mapping for both its epistemological visibility, and as a useful analytical tool to help explore initial findings and develop them to a conceptual level. Positional maps were particularly useful in this respect. Initially, I used situational maps to identify all of the elements of the situation the health visitors found themselves in. Although initially a struggle, the ‘messy situational map’ (Appendix E1) was developed and refined into the ‘ordered situational map’ below (Table 3.1):

Table 3.1 Ordered situational map

Ordered Situational Map: health visitors working with people from other cultures

Individual human elements/actors

Health visitors — Nursery nurses
Clients and their families
GPs
Hospital staff
Specialist community liason nurses
Social workers

Collective human elements/actors

Nursing midwifery council
Health visitors trade union
Community associations
Pharmaceutical companies

Discursive constructions of individual and /or collective human actors

Health visitors as nurses
Nurses as 'caring'
Health visitors as 'good mothers'
Health visitors as 'social police'
Patient uniqueness
Individual nursing care
Racial and ethnic stereotyping
Administrators as interfering and manipulative
Managers as constraining

Political/economic elements

Rising costs of community care
Expansion of community services
Value for money

Temporal elements

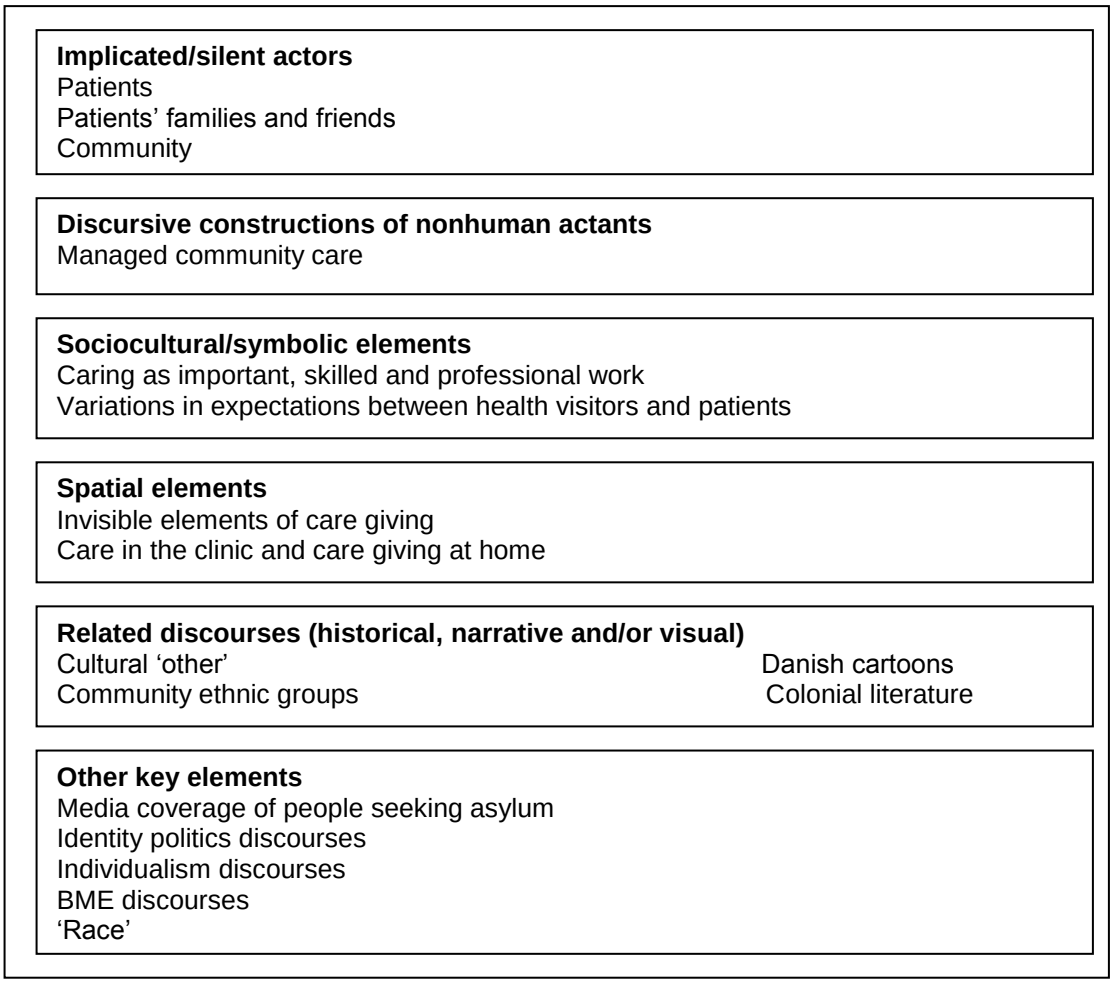
Caring as invisible nursing work that takes time
Nursing time per patient and overwork issues
Invisible aspects of health visiting
Historical constructions of 'race' within health care

Major issues/debates

Nurse/patient ratios and time allocations
Culture as static/fluid
Barriers to cultural care
'Race'. ethnicity and health

Nonhuman elements

Information technologies
Medical technologies
Pharmaceutical treatments
Restructuring of organisation
Patient expectations



Situational maps were developed in an attempt to explain the relationship between the different elements of the situation the health visitors find themselves in (some examples of these are detailed in Appendices E2, E3 and E4).

> Pursuing situational analysis involves the making and analysing of three kinds of maps – situational, social worlds/arenas, and positional maps – as a means of opening up and analysing data cartographically, emphasizing relationally and positionality (Clarke, 2005, p.292).

Initially, the situational maps were kept in the background of the research as a contextual tool, but as the research progressed they were

drawn upon many times, to help to open up the data categories and to push deeper into the data. The specific ways this was done are explained throughout the thesis. Although theoretical memos were the primary tool of analysis (Corbin and Strauss, 2008; Charmaz, 2006), situational maps were used to supplement these as the research progressed.

Social world maps were the second type of maps, which were drawn upon (Appendix F), and Clarke (2005) describes them as 'cartographies of collective commitments, relations, and sites of action' (p.86). Social worlds/arenas maps enabled the researcher to visualise the health visitors as members of different social worlds. These are multiple social worlds, overlapping and intersecting with each other. Clarke (2005) urges researchers to use social world maps to ask:

> What are the meaningful commitments of the social world and how are these collectively acted upon in the situation? What is happening between particular worlds? Here structure/process is enmeshed in the flows of people and nonhuman objects doing things together. Structure is action and action is structure and everything is perspectival (p.108)

Positional maps (Appendix G) are the most contentious arenas of situational mapping, as they move the research towards the 'post modern turn' by exploring discourse, language and the inherent meanings contained within discourse. Positional maps are defined as

‘simplification strategies for plotting positions articulated and not articulated in discourses’ (Clarke, 2005, p.86).

In the nursing literature, there has been a robust discussion over the last few years as to the use of positional maps. Mills et al. (2007) strongly argued that they were unable to use positional mapping within a social constructivist research epistemology, as it brought in to question the agency of the research participant. They argue that to use positional mapping denies social agency and therefore cannot be used. While understanding the reasoning for this standpoint, re-examining the work of Adele Clarke (2005), and after grappling with the epistemological issues, I did not read Clarke’s intention with positional maps as following in the earlier work of Foucault, where agency is denied under dominant discourses of power. Adele Clarke (2005) herself urges researchers to ‘go beyond the knowing subject’, but she does not reject the knowing subject. She does not argue that situational analysis can only be used within a strong post modernist epistemology where discourse negates agency, but rather appears to recognise some agency within discourse. Positional maps were, therefore, tried in this research for their usefulness.

Initially, I used situational and social world maps to help contextualise the data, but as the research progressed, positional maps were increasingly drawn upon and became an invaluable analytical tool towards the end of the research process to explore discourse. Positional maps were particularly useful to develop discourses of cultural fluidity and cultural (dis)engagement (Appendix G1), discourses

of culture and policy framework (Appendix G2), discourses of cultural competency and professional (un)certainty (Appendix G3) and discourses of the Westernised ‘other’ and knowing the cultural ‘other’ (Appendix G4).

3.3.4 Sensitising concepts and general disciplinary perspectives

3.3.4.1 Theoretical sensitivity

Theoretical sensitivity is an important concept in grounded theory and relates to the sensitivity of the researcher to the subtleties in the data. Theoretical sensitivity can be achieved, according to Strauss and Corbin (1990), through the literature and through personal and/or professional experience. This study adheres to a high theoretical sensitivity, as I carried out a general initial literature review and the secondary literature was searched in line with data collection at the stage of selective coding. At this stage, descriptive codes were beginning to become more conceptual (Chapter 4). Familiarity with theory, publications and documents pertaining to the area under study meant I had a rich background of information that ‘sensitised’ me to what is going on with the phenomenon I was studying (Strauss and Corbin, 1990).

I have both personal experience of being a service user of health visiting services, and also several years working as a community practitioner with people from other cultures, although not as a health visitor. I am close to the research from both a professional and a

personal perspective and consequently have a high degree of theoretical sensitivity. Greenfield (2002) raises the importance of being 'close' to the participants in social research by stating that:

> the closer the interviewer is to the respondent in class, sex, age and interests, the greater the chance the interviewer has of being successful (p.213).

I am of the same gender, sex and broad ethnic group (as defined by standard ethnic monitoring forms) as the participants, and also adhered to a 'closeness' in relation to my professional experience.

3.3.4.2 Research Diaries

Research diaries were used throughout the research process in order to help record not only the words which were said by the research participants, but the tone, nuances and the flow of the interviews. The research diaries were then used as data in themselves, to compare and contrast with the interview transcript data. In this way, the interview conversation became a dynamic, integrative and interpretive piece of analysis.

Research diaries were kept following each interview, and were used in conjunction with the interview data analysis to make meanings from the interview data. The research diary below gives an example of the research diaries used throughout the whole research process.

Figure 3.1 Research diary: Jane 18 June 2008

18 June 2008_Research diary
Interview 2 Jane

This interview was very different to the previous interview. The research participant had 10 years experience working with people from other cultures (in a community with a large BME community). I asked a few questions but she largely just spoke in a continuous flow. Her language was very hesitant at times, as if she was looking carefully for the right words to choose. She also went onto the next sentence without finishing the last sentence, but I do not know if that was a 'norm' for her or as a result of this interview.

I asked largely the same questions as in the previous interview but the whole feel of the interview was very different. The participant was very angry, expressing how she felt as if she was struggling to cope with such a culturally diverse case load and how she has no support from management. She also felt overwhelmed by the enormity of the issues of 'culture' and expressed how isolated she felt professionally. She felt that she could only learn by her mistakes and this was a very negative way to learn. She also felt that there were many things hidden from her by clients from other cultures, although she did not articulate how this made her feel.

My overall impression of this interview was that the participant was very stressed, overworked and very unsupported in an area of high need. This expressed itself in anger towards her manager and also in frustration at her own inability to meet the demands placed on her by clients.

Research diaries were written throughout the research process but as the research progressed, they became a tool to articulate my thoughts and ideas, as well as a record of research events. The extract from the diary entry below exemplifies this, which was written near to the end of the analysis period.

Figure 3.2 Research diary: competency 2 October 2009

2 October 2009_Research diary: competency

I have just been to a conference on health care research by National Institute of Health Research (NIHR) which was really inspiring in many ways but it also struck me again how much health care is dominated by medical discourses of evidence based medicine. Although funding grants do go to some qualitative research and participatory research, the large (and prestigious) funding grants are given to high quality (Randomised Controlled Trials) from prestigious medically led universities. This really got me thinking about the power of evidence based medicine and started me to think about 'evidence' and discourses of evidence based practice within nursing. How does this affect discourses about 'competency' and conversely 'uncertainty'. There must be some uncertainty within medical practice – how does the medical profession deal with that? And social workers – how do they, as a profession deal with uncertainty? I think social workers work within a risk agenda but I need to go and read the literature around it further.

If uncertainty and anxiety are the dominant emotions expressed by health visitors when they are working across cultures, how do health visitors deal with this within dominant discourses of evidence based medicine? Is this a hidden work? I think I need to go and review the literature in this area further. This is an exciting development and I have so much to think about now. Where do I start…?

4 October 2009_ Research diary

Just checked back on my theoretical Figures and in my interview 17 with Susan, I have asked about **'denying uncertainty'**. I must explore this further.

The diary entry above was the beginning of an important body of work within this research project and led to the extensive discussion contained in section 5.3.2 around 'uncertainty and ambiguity in health and social care discourse'. Using the diary entry above and theoretical Figures (Appendix H11), the work of health visitors as **'emotional encounters through cross cultural terrain'** was explained as **'hidden**

work', and from this the implications for cultural education were explored in the subsequent discussion (Section 5.5).

3.3.5 Initial coding and data collection

3.3.5.1 Study sample and ethical approval

An initial purposeful sample was used in order to gather stories of working lives in health care contexts. Health visitors were interviewed because, by working in primary care, they occupy a unique role in advising families on health care and work largely independently, visiting families often at home. They have a very influential role in promoting access to services and often work with the most marginalised communities. Their work is often invisible, working alone in people's homes. In order to explore issues of culture and health care, practising health visitors were interviewed. All of the participating health visitors had at least one year or more current experience working in that role. The sample consisted of twenty one health visitors.

Ethical approval was granted from the University of Sunderland Ethics Committee (Appendix C1) and the NHS Ethics Committee (Appendix C2). Consent to carry out the research was obtained from the relevant Primary Care Trusts (Appendix C3). Sampling was largely controlled by the rigour of NHS Ethics Committee requirements. Ethical protocols ensured that a request was sent to the Director of Nursing Services at the relevant Primary Care Trusts, and they then cascaded the approved letter of invitation down to their staff to participate in the research

(Appendix C4). An information sheet was given to all participants (Appendix C5) and written consent obtained (Appendix C6). In some cases I was then able to contact the health visitor directly, but overall I was largely passive in the process. This was to comply with ethics committee requirements and to ensure that no coercion was employed, and the research participant had freely volunteered to be involved in the research. Although theoretical sampling was employed as part of the grounded theory methodology, this could only be done within the sample of volunteer participants. The implications of this are considered further in chapter 6.5, along with other weaknesses of the study.

Twenty one health visitors volunteered to be involved in this study and they were all interviewed for between 30-90 minutes in a one-to-one recorded interview. The health visitors were all female and between the ages of 35-60 years old. Nineteen of the research participants described themselves as white and British, one participant described herself as white and half-German, and one described herself as white and half-Swedish. All health visitors were interviewed within a health centre, GP practice or a community venue, and all interviews were confidential and anonymous. All health professionals interviewed were fully qualified health visitors, and employed by a Primary Care Trust in the North East of England at the time of the interviews.

Table 3.2: Participant profile table

	Name	**Age group**	**Self defined ethnic group**	**Length of time qualified as HV**	**Area of practice***
1	Rebecca	35-40	White British	10+ years	Mixed middle/ working class area of city.
2	Jane	45-50	White British	15+years	Inner city with majority of clients from BME groups
3	Helen	50-55	White British	8 years	Majority BME clients in area of high economic deprivation
4	Joy	40-45	White British	4 years	Majority BME clients in area of high economic deprivation
5	Alice	55-60	White British	10+ years	Minority of BME clients in area of high economic deprivation
6	Leah	45-50	White British	20+ years	Minority of clients in BME groups. City area of urban

					regeneration
7	Emma	55-60	White half-German	20+ years	Mixed socio-economic area of city with majority white clients.
8	Mary	40-45	White British	8 years	City suburb with majority white clients.
9	Sophie	50-55	White British	15+ years	Inner city area with majority of clients from BME groups.
10	Ruth	40-45	White British	10 years	Inner city with a few BME groups.
11	Steph	25-30	White British	1 year	Inner city area with a few BME groups
12	Denise	30-35	White British	5+ years	Inner city area with a few BME groups
13	Cathy	40-45	White British	15 years	Inner city area with some BME clients
14	Beth	45-50	White British	16+ years	Inner city area with a high BME population.
15	Lisa	40-45	White British	5 years	Multicultural area in an inner city area.

16	Kate	50-55	White half-Danish	6 years	Small town with only a few BME clients.
17	Susan	55-60	White British	35+ years	Multicultural area in a medium sized town.
18	Annette	45-50	White British	20+ years	Small town with some BME groups.
19	Olivia	40-45	White British	10+ years	Worked in a town with the travelling population.
20	Jessica	35-40	White British	3 years	Town which has a community of Polish migrants.
21	Alex	30-35	White British	6 years	Town which only has a few BME groups.

*Area of practice was as described by the health visitors themselves

Following the initial purposeful sample (the first two interviews), theoretical sampling was used in line with grounded theory methodology (Section 3.3.6.2). Theoretical sampling is central to grounded theory methodology. Theoretical sampling is a process where sampling is on the 'basis of concepts that have proven theoretical relevance to the evolving theory' (Strauss and Corbin, 1990, p.176). Theoretical relevance refers to emerging concepts, which appear to be more analytically significant. As the data from the grounded theory study is analysed and the codes are compared and contrasted, certain

categories emerge which are repeated (or omitted) and these become significant. Strauss and Corbin (1990) assert that:

> The aim of theoretical sampling is to sample events, incidents, and so forth that are indicative of categories, their properties, and dimensions, so that you can develop and conceptually relate to them (p.177).

3.3.5.2 Analytic coding and categorising of the data – micro analysis

Data analysis in grounded theory consists of a set of prescribed methodology whereby raw data chunks are ‘coded’. Glaser and Strauss (1967) originally described the coding of these data chunks as open, axial and selective coding but subsequently scholars have extended and expanded the terminology. Kathy Charmaz (2006) uses the terms ‘initial’ and ‘focused’ coding to describe broadly these similar processes. Open coding is when the codes are descriptive and involve the labelling of chunks of data in terms of their content. The participants own words are often used to open code in the initial stages. Axial coding usually occurs after several interviews and open coding has progressed.

> As the codes take shape, the researcher will look for relationships between the codes – links and association that allow certain codes to be subsumed under broader headings and certain codes to be seen as more crucial than others (Densicombe, 2007, p. 98).

As axial coding progresses, through constant comparison and contrasting of these data codes, the codes become more abstract, and eventually I was able to focus my attention on the core codes which were emerging. Selective coding occurred when core codes had emerged and less relevant codes were discarded. Theoretical generation could then begin, using these abstract selective codes. Abstract selective codes lead to the development of concepts, which then formed the basis of the final conceptual theory.

The first seven interviews were coded and categorised in line with grounded theory methodology, but following a detailed discussion with research supervisors at that time, it became apparent that I had collapsed initial codes into conceptual categories too quickly and data was being lost. The emerging categories were too broad, too shallow and lacked conceptual depth. I returned to the data and the work of both Corbin and Strauss (2008) and Kathy Charmaz (2005) to find analytical tools to help to re-open up the data. Several analytical tools were uncovered and employed in the subsequent data analysis, including the use of comparisons, flip-flop technique, waving the red flag, looking at language, looking at emotions that are expressed, looking for words that indicate time and thinking in terms of metaphors and similes (Corbin and Strauss, 2008). Micro-analysis was also employed as an initial tool of analysis.

Situational and social world maps were also turned to, as a means of opening up the data again. It became necessary for me to then re-visit

these initial interviews and re-code them from the micro-analysis stage to open up the data again. The categories had closed too soon and rich data was being lost. Corbin and Strauss (2008) warn of the dangers of quick closure of categories when they assert that:

> Flexibility and openness are linked with having learned to sustain a fair amount of ambiguity. The urge to avoid uncertainty and to get quick closure on one's research is tempered with the realization that phenomena are complex and their meanings are not easily fathomed or just taken for granted (p.14).

The following research diaries describe the process and my thoughts at the time.

Figure 3.3 Research diary: supervision meeting 20 October 2008

20th October 2008_Research diary
Supervision meeting

I had a good meeting with my supervisors today and I am feeling much happier than I have been for the last few weeks. I have been feeling swamped with data and really did not know where to start. I have been rushing the analysis and have not linked codes to categories, nor have I analysed the data in nearly as much detail as I should. I seem to have rushed and now I have collapsed my data into categories too early. I need to go back to the data from the last few interviews and really grapple with the data, analyse deeply and keep my codes very open in order to let the categories emerge. In my rush to categorise, I have missed much of the rich data contained in my interviews. I will go back and micro-analyse the data and let the themes emerge. I have written very few theoretical Figures the last few weeks, which is an indication of my lack of reflection and analysis. It has taken all my time just to transcribe the interviews I have had and I have hardly done any analysis. I will go back now to interview 5 and re-analyse the last four interviews in much greater detail. I need to keep my codes very open at this stage. I am learning not to rush data analysis, as much can be lost or missed without deep and detailed analysis.

16th November 2008_NVIVO
Research diary

I have given up with NVIVO data analysis – I feel as if I am splitting up the data into different categories and somehow loosing the context and richness of the data. I sat down today and read all 7 interviews in their entirety and it feels much better. I can feel my data much more intuitively now. It gives me context and nuance and allows me to use intuitive skills to analyse the codes. The open codes are much more 'alive' somehow now and I can see categories which I had completely missed before. I feel so much happier now and positive that I can move forward with data analysis in a much more intuitive way.

Re-reading the interviews, using a more intuitive method of data analysis and returning to the tools of analysis, as recommended by scholars in grounded theory (Clarke, 2005; Charmaz, 2006; Strauss and Corbin, 2008) enabled me to analyse the open codes to ensure they were opened up fully, to allow the richness of the analysed categories to emerge.

The first analytical tool employed was ‘micro analysis’ as a form of open coding. Microanalysis is used selectively and usually at the beginning of a project (Strauss and Corbin, 2008). The purpose of micro-analysis is:

> To generate ideas, to get the researcher deep into the data, and to focus in on pieces of data that seem relevant but whose meaning remains elusive (Corbin and Strauss, 2008, p. 59).

The first interview was transcribed and micro analysis was employed to code the data.

Interview 1 - Rebecca

Rebecca is a female health visitor who has been qualified as a health visitor for over 10 years. She was aged 35-45 years old and had been working in this particular area for 8 years. She describes herself as white British. The area she works in has a broad social mix, but she described it as a mixed middle class and working class area within part of a city in the North East of England.

Example section of text - interview 1

166. **Fiona:** What is your biggest fear when working with people from other cultures?

167. **Rebecca:** I worry, I would hate to offend and not to know that I had done it

168. and walk out, them thinking I don't want her back in, that would really offend

169. me. In some houses I worry about I am careful what I say, only because I am

170. Aware that when I leave the mum might have questions to answer about why have

171. You told her that. I give baby rice or told her this, that and the other, so that does.

172. I am always a bit worried that I can do that, but you can't get them on their own

173. and there is always the extended family there so you are never going to be able

174. to get a one-to-one, you are always going to get the whole family there so

175. your questions are going to be quite generalised and then you have to try and

176. interpret what they are saying and take from that what you need and read it as

177. best as you can really. [sic]

Micro-anlaysis of text

167. I worry – *why? What could you cause offensive about?*

167. not know that I had done it – *unconsciously causing offence?*

168. I don't want her back in – *why is refusal of access a bad thing? Professional? Personal offence?*

168. would really offend me – *how would she be offended?*

169. careful what I say – *barriers to communication? Why? What are they?*

169. in some houses – *which houses? Any in particular?*

170. mum might have questions to answer – *to who? Other family members? Protecting mum from others?*

172. am always a bit worried I can do that – *why? Legally? Professionally? Culturally?*

172. but you can't get them on their own- *why do mothers need to be on their own? In between mothers and other family members?*

173.always extended family there – *problematic extended family? Why?*

174. you are never going to be able to get a one-to-one – *why is one-to-one so important? Necessary or cultural norm for health visitors?*

175. questions are going to be quite generalised – *why can't you ask specific questions if the whole family are there? Threat? Intimidation? Embarrassed?*

176. interpret what they are saying – *interpretation when speaking English? Cultural interpretation?*

176. Take from that what you need – *how do you know what you need? Whose needs are being met?*

177. Read it as best as you can – *uncertain you can't 'read it'? what does 'read it' mean?*

Initial coding

167. anxiety in cross cultural encounters

168. anxiety over causing offence

168. anxiety around refusal of future access

169. protecting self from offence

169. taking care in verbal communication

169. anxiety within the house

170. mum in the middle

170. anxiety over what can and can't do

172. getting mum on her own

173. extended family as barrier

174. importance of one-to-one care

175. extended family impede effective communication

176. cultural interpretation more than language

176. pick and mix what you need from cultural exchange

177. uncertainty of meanings

The whole interview was micro-analysed as the sample above demonstrates, and following initial coding 104 initial codes were identified. These initial codes were then questioned, compared and contrasted until 12 categories began to emerge from the data. These initial categories were framed as below.

Initial categories emerging from open coding and micro analysis

1. When to probe…when to accept

- Not seeing things my way
- Rely on the law
- Rely on procedures and processes
- Usual do's and don'ts
- Hierarchy of views and opinions
- Lifestyle choices
- Personal lifestyle choices and balances
- Need to know what is going on
- Young receptive, older people are not
- The more westernised, the more likely to listen to advice
- Know when to pry otherwise can't move forward

2. Culture as 'other'

- People verses populations
- Perception of populations
- Importance of whether clients speak English or not
- Difference between being 'established' in the UK or not
- Importance of length of time here
- To be Westernised equals having children who are born here
- To be established equates to choosing Westernised names
- To be Westernised equals being happy to talk about weaning
- Very, very Westernised equals professional, high flying job, high income earner
- How 'they' express themselves
- Believe in Black magic, I know a lot of them do
- Split between business people and those in poor areas
- Definitions of legal status in UK

3. Finding common ground

- Priority is to meet the child's needs
- Personal lifestyle choices which conflict with professional advice
- Finding middle ground
- Not being able to probe
- Finding common ground
- Common ground to work on
- Bringing together
- Mum in the middle
- Different expectations
- Proviso of professional assertions (safe environment health needs met, no child neglect)
- Speaking from the child's perspective

4.Behind the shield of the extended family

- Only able to ask generalised questions
- Problematic grandparents
- Power of grandparents
- Hold of parents over the adult son
- Grandmother causes problems
- Extended family as barrier
- Power of grandmother within household
- Complying with mother-in-law
- Lack of freedom
- Mums as slaves to grandparents
- 'Poor girls' who live with parents
- Assumption of having no friends if live with parents
- Mums should have control over their babies, not grandparents
- 'Take over' by in laws
- Mum needs to forge her way forward – *against the mother in law?*
- Hard life for young girls at home with parents in the house
- Controlling mother in law
- Mum in the middle
- Extended family impede effective communication

5. Picking up the little things

- Interpretation is more than just to do with language
- Uncertainty re interpretation of information
- Little things only interpreters can pick up on
- Not being as open
- Language barriers
- Uncertainty of meanings
- Pick and mix what you need from cultural exchange
- Talking to interpreter rather than client
- Interpreters can pick up little things because of their culture
- Interpretation as a three way conversation
- Health visitors are 'blind' to certain things
- Things are hidden
- Difficulty in having as open conversation

6. Anxiety in cross cultural encounters

- Having to be really careful what you say
- Fear of offending
- Anxiety over refusal of future access
- Professionals as guests in the home
- Anxiety over causing offence
- Anxiety cause unconscious offence
- Anxiety in cross cultural encounters
- Protecting self from offence
- Taking care with verbal communication
- Anxiety within the house
- Anxiety over what can and can't do
- Uncertainty of meanings
- Afraid to insult
- 'Walking on egg shells'
- Intrepidation things aren't right
- Concerned not to interpret something as 'right'
- Concerned to 'miss something out' during assessment

7. Integration vs specialist provision

- Same service provision
- Acting differently
- No set pattern of questions
- Concerned something will be missed during assessment
- Equality of provision
- Integration should be encouraged through Surestart groups
- Resentment re specialist groups
- Ensure equality with all clients
- Primary visit has to be done at home (no difference with other clients)
- 'I always try to be more…' overcompensation

8. Under the gaze of the 'other'

- How do they perceive us?
- Feeling that 'they' don't know what health visitors do
- Distrust – they think what we do is wrong
- Unknown and untrustworthy

9. Getting mum alone

- Dad is only English speaker in mum's world – *problematic?*
- Celebration of individuality – *mum on her own = good*
- Getting mum on her own
- Importance of one-to-one care
- Always extended family there, never get one to one

10. Home of confinement…public spaces of freedom

- Assumption mums want to come to the clinic to 'escape the house' – how know that?
- Assumption want to escape the pressure from in laws inside the house – is this know or assumed?
- Assumption no friends within domestic sphere
- Suspicion within the house
- Outside the home perceived as 'open'…inside the home as 'closed'

11. Interpretive signs of expression

- No language for depression
- They are not able to express that
- Cultural interpretation more than language
- Not being able to 'get through'
- 'They' don't understand
- Cultural secrets

12. Surprised by the 'other'

- Europeans can also have 'radical' cultural differences
- Odd Europeans have different norms
- Opening up
- Surprising you can make yourself actually understood
- Surprise clients cope
- Excited by cultural difference

Overview of theoretical Figures for interview 1

Micro-analysis of the first interview enabled me to open up some very interesting categories. In order to keep open to all of the data, the most important categories were not identified at this stage, but theoretical memos were written for all of the categories and the text was explored, questioned and examined for additional meanings and insights. One area which was particularly noticeable in interview 1 was the category **'anxiety in cross cultural encounters'**. This subsequently became a core category in this research. The initial theoretical memo below explores the concept of **'anxiety in cross cultural encounters'**.

Figure 3.4 Theoretical memo: anxiety 19 June 2008

19th June 2008_Theoretical memo
Interview 1 Rebecca_anxiety in cross cultural encounters

It is really interesting but the biggest emotion expressed by Rebecca in her interview was anxiety and uncertainty. This seemed to shape much of her interactions with her clients across cultures. She was very uncertain, not only about meanings and interpretation, but also about causing offence, saying the wrong things or missing something out. Her whole interview was shrouded in a narrative of uncertainty and anxiety.

Is this the same for all health visitors working across cultures or only for Rebecca? Her anxiety was palpable – what does that mean for practice? I will ask about uncertainty and anxiety in the next interview as this could be important in cross cultural working.

Using the constant comparative method

The first ten interviews were carried out between May 2008 and January 2009. Each interview was digitally recorded, transcribed and the first seven were micro-analysed as above. Open coding was applied to each chunk of data and categories identified as above. After each interview, a research diary was written and the codes were compared and contrasted with previous codes. Analytical memos were written and in this way, each category was developed.

Using constant comparison, each interview was concurrently analysed. The codes from interview 1 were compared and contrasted with interview 2, and theoretical memos were then written and used to compare and contrast with the next interview. This was repeated as codes were interrogated, opened up and closed down until theoretical saturation was reached (Appendix A).

Interview 2 - Jane

Jane is a female health visitor, who described herself as white British and was between 45-50 years old. She worked as a generic health visitor, but she worked in an inner city area where over 80% of her clients were of a British Minority Ethnicity. She had worked in this area of the city for over ten years and was seen by colleagues as a 'bit of an expert', but she did not feel she was an expert herself.

The main open codes which were identified as similar existing codes to those identified in interview 1 were:

1. When to probe…when to accept
2. Culture as 'other'
3. Behind the shield of the extended family
4. Getting mum alone
5. Anxiety in cross cultural encounters
6. Under the gaze of the other
7. Homes of confinement...public spaces of freedom
8. Integration vs specialist provision
9. Surprised by the other

Several new codes also emerged from the micro-analysis of interview 2, which included:

10. Learning on the job

11. Meeting them half way
12. Closing down; protecting self
13. Trial and error
14. ‘They’ find it hard to express how they feel
15. Working in the dark at the coal face
16. Professional boundaries and assertions
17. All equal but different services..or the same?
18. Losing confidence
19. Cultural boundaries or cultural mist?
20. Interpretation as a three way conversation
21. Beyond interpretation – hidden cultural meanings
22. Not understanding what we are about
23. Overwhelmed by relativity
24. Unsupported by management
25. Standing on uncertain ground
26. Feeling devalued

Figure 3.5 Summary memo: Jane 23 June 2008

23 June 2008_Summary memo

Interview 2_Jane

Jane's interview uncovered some very different categories to those of Rebecca. Several themes arose which were around how she used to feel as if she was on solid ground, when she first started working in areas with people from other cultures, she felt confident and almost arrogant. Now, however, the longer she works with people from other cultures, she feels as if she is working in a muddle and cannot untangle all of the complex threads which make up people's lives. As a consequence, she feels angry that she is unable to deliver satisfactory care and she is losing her confidence. She feels particularly out of her depth in the area of culture and mental health and feels as if she is working **'at the coal face'** and **'in the dark'**. She feels very isolated, but it is not yet clear who or what she feels she is isolated from (colleagues, management, the cultural 'other'). She is unsupported by management and learning is by **'trial and error'** and '**on the job'**.

What does it mean to be **'working in the dark'**? What **'light'** do other health visitors use? What does **'working at the coal face'** mean? How does cross cultural working compare to other types of health visitor work?

Again this whole area of uncertainty and anxiety in cross cultural work is evident. Jane's whole interview was a narrative of uncertainty, anxiety and subsequently, losing confidence in cross cultural work. The emotion of anxiety appears to influence practice – is this an important area of investigation, because both Rebecca and Jane have now highlighted anxiety and uncertainty as important in cross cultural work? I will ask some specific questions on this in the next interview.

Initial codes, emerging categories and memos were written, and in line with theoretical sampling I began to ask questions in relation to anxiety in cross cultural work, and in this way used theoretical comparisons to explore these categories further.

3.3.6 Initial memos and raising codes to tentative categories

3.3.6.1 Theoretical memos

Theoretical memos are used throughout grounded theory to record my thoughts, to analyse the emerging codes, to enhance analytical transparency and to create an audit trail for the final analysis. Theoretical memos begin as an organising tool for descriptive data and changed as the research progress became more conceptual. Memos incorporate data from the interview text, and the research diaries were employed as a means of interpreting the data and raising it to an emerging category. Theoretical memos were continually written throughout the research process to help to compare code with code, and category with category, and the writing of the memo itself was often part of the process of defining my thoughts and analysis. As data analysis progressed, the theoretical memos were used to compare and contrast data, as the following memo extract demonstrates:

Figure 3.6 Theoretical memo: common ground 6 July 2008

6 July 2008_ Theoretical memo

Compare and contrast interview 1 and 2: 'meeting them half way', 'middle ground' and 'common ground'

Anxiety in cross cultural encounters is the same code as in interview 1, but the content is framed quite differently. The participant in interview 2 has felt anxious, but also acknowledged that the clients are anxious not to cause offence to her, so it is about **'meeting them half way'**.

> Jane: Because I was scared to offend and I have essentially been told by another worker that it was offensive but I never experienced that , however what I have to say is that I think the families that I see are very tolerant and will almost (pause) they make allowances, kind of like what taking your shoes off. The blurb tells you if you see a load of shoes by the door then take your shoes off but you know what you will find is that clients that you are going to see is that they are absolutely adamant that you keep your shoes on almost as if they are afraid of causing offence. It is as if you are not prepared to meet them half way or acknowledge their custom. So, my sense is that almost they are making exceptions for us (Jane:193-201) [sic]

'**Meeting them half way'** relates possibly to **'finding common ground'** and **'finding middle ground'** (Rebecca), but there is an emotional element to this, which is uncertainty of the ground you are standing on and the considerable amount of anxiety this appears to cause. Is this something which has been explored in the literature, both from the perspective of the professional and also from the client from another culture? This will be examined later in the data analysis.

What is particularly interesting about Jane, is that not only does she appear to be **'standing on uncertain ground'** but she also feels she is **'working in the dark'**. The metaphor of coal mining is stark, **'working at the coal face'** and **'working in the dark'.**

> Jane: I am at a point where I feel very angry about the lack of provision for professionals on the coal face that are having to deal with essentially child protection and em, (pause) human rights issues when you are working in the dark. Although you know, people say I've got expertise around sort of Bengali and Pakistani families I really don't like that at all, I say well OK I've got experience but I still, because there is still this bit around training missing. I don't feel I can be called an expert and I am very much involved (Jane:19-24) [sic]

There are many questions which stem from this extract. What does it meant to work in the dark? Is this a darkness of knowledge? Is it a cultural darkness? What does it mean to not be able to see the way ahead? Is something hidden? Is this why there are so many references to being uncertain or anxious in cross cultural encounters – do professionals feel as if they are stumbling forward, working in the darkness?

The above memo exemplifies the comparing and contrasting of different codes and categories during the data analysis. This constant collection of data and the comparison of codes, enabled me to adhere to grounded theory methodology and develop textual codes from open to axial, then axial to selective coding, until a theoretical framework emerged.

Interviews 3 and 4 – Helen and Joy

Interviews with Helen and Joy were very interesting and, although data analysis yielded many common codes between these two interviews, they were very different to the codes yielded in the first two interviews.

Helen worked as a specialist health visitor for British Minority Ethnic clients within a small town in the North East of England. She also described herself as white British and said that she had also lived abroad. She was aged between 50-55 years old and had been in her current role for 8 years.

Figure 3.7 Research diary: Helen 24 June 2008

24 June 2008_Research diary

Interview 3_Helen

This was a completely different interview. The health visitor has actively chosen to work in a specialist role with people from other cultures and she appears to be very comfortable in that role. She repeatedly said that she felt comfortable working with people who are from other cultures because she has lived in another culture herself and because she does it all day, every day then it becomes the norm for her. There appeared to be no anxiety, as expressed by the previous two interviewees. She also saw herself in a position of empowerment and to establish trust was a priority for her to be able to work effectively. This was a really interesting interview and Helen gave completely different (and possibly contradictory) views to the first two interviews. The interview was also very long so I think there will be a large amount of rich data to analyse. I feel very excited after this interview.

Again the interview was transcribed and micro-analysis applied to each chunk of data. Open codes were attached to the data and categories began to emerge. Eighteen categories emerged following open coding, most of them new categories.

Emerging categories – Interview 3

1. Establishing trust
2. Mutual respect
3. Empowering clients
4. Take the ball and see what we can do with it
5. Feeling comfortable and relaxed
6. Working in partnership with extended families
7. Culture as fluid
8. Comfort with complexity

9. Marrying it up
10. Having a framework
11. Confident to challenge
12. Negotiated identities
13. Taking on board
14. Exploring and asking
15. Empathy having lived abroad
16. Relationship journey
17. Fight against injustice
18. Moving the whole family forward
19. Experienced living abroad

Initial memos, as above, were raised for all of the open codes. I explored and reflected upon these codes in great detail. These memos were then compared to other codes within the same interview and also with emerging codes from previous interviews (Appendices A1-A5).

In contrast to interviews 1 and 2, the codes of **'marrying it up'** and **'exploring and asking'** are explored in the memo below:

Figure 3.8 Theoretical memo: marrying it up 21 July 2000

21 July 2008_Theoretical memo

Interviews 1-3 _ Compare and contrast 'marrying it up' and 'exploring and asking'

'Exploring and asking' and **'marrying it up'** appears to be interesting categories, which can be contrasted to **'finding middle ground'** (Rebecca), **' finding common ground'** (Rebecca) and **'meeting them half way'** (Jane). The emphasis in interview 3 with Helen is in **'exploring and asking'** and then the analogy is of marriage when Helen talks of **'marrying it up'**. This appears to be much more in terms of working together with her clients, rather than each coming from different perspectives and **'meeting in the middle'**. Does mutual respect play a part here? This is something which could be explored further. The following extract clarifies.

> Helen: But there are things that are not research based, some practices, that as you, you have to try and find out, some cultural practices which you have to explore and talk about with them because you have got to find out, could they possibly have. The thing is, with female genital mutilation…you need to explore it further, but there are more simple things, like not feeding the first breast milk to the baby, where they perceive that the first breast, milk is dirty, in some cultures but we know from research that that is where they get their immunity from the colostrum, so you have to explore what they think and marry it up. (Helen:137-148)[sic]

What does it mean to **'marry it up'**? This points to negotiation and mutual respect. Both parties are seen as adults entering a consensual relationship. How does this differ from **'finding common ground'** or **'meeting them half way'**? This is more of a battle field analogy. There is no indication that both parties will go forward in a relationship together. With marriage, whatever the definition, there is some understanding that a relationship will be formed into the future. This seems very different to just **'finding common ground'** and going away again, separate ways. The expectation of **'exploring and marrying it up'** is that a relationship will be formed. Relationship building is central to the health visitor/client relationship – is there no expectation of this with some health visitors and their clients from cross cultures? Possibly this is an area to explore in subsequent interviews.

8

There appears to be a strong emphasis on **'exploring and asking'** in interview 3. Any issue which is not clear is confidently **'explored'** and **'questions asked'**. Confidence to ask questions is not outweighed by **'fear of offending'** (interview 1). **'Confident to challenge'** appears to have some significance at this stage.

'Working in partnership with extended families' is used later in interview 3 by Helen, again in relation to the negotiation of cultural practices. This appears to be similar to **'marrying it up'** and confirms mutual negotiation between the health visitor and the client.

> Helen: so you find out what they (pause) you deliver your information, your guidance, whatever you want and then you find out what their thoughts are on it, you have got to put what is best for the child, that is what we called reciprocity, then we come out with a working tool together. It is not good this is black and they are saying that is white, it is not good, you have to show you are working together and you have to bring them in and show you can work with them and you hear what their beliefs are and within that you can move forward. (Helen:200-205) [sic]

Again the relationship here is of a partnership which is **'moving forward together'** not of just coming together on **'common ground'** or **'middle ground'** and then going away again to separate ground. The participant here is moving forward to develop a relationship which will then progress. **'Moving forward vs meeting in the middle'** may be a new category to further consider.

Interview 4 - Joy

Joy is a health visitor who had been working in an area she described as having a high proportion of people who were from other communities as living there. She had lived in a non-European country on a few occasions and had chosen to work in this area, as she enjoyed working with people who were from other cultures.

Emerging categories from open coding in interview 4

The first seven categories are the same as those in interview 3, the second five categories emerged as new categories:

1. Feeling comfortable and relaxed
2. Working in partnership with extended families
3. Culture as fluid
4. Negotiated identities
5. Mutual respect
6. Confident to challenge
7. Empathy in having lived abroad

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8. Learning to ask
9. Explore and learn
10. Skidding on ice and can’t get a grip
11. Swamped by emotional need
12. Need someone to explain the little things
13. Finding cultural norms
14. Emotional door

Summary memos helped me to bring together several open codes and to summarise my thoughts into several summary memos following the data analysis for each interview (Appendix A1). Joy described her experience of working across cultures as metaphorically **'skidding on ice'** and **'can't get a grip'.** These became interesting categories and are associated with **'losing confidence'** in cross cultural encounters.

> I think the hard thing when you work with people from other cultures, you sort of feel as if you are not on solid ground. I remember when I lived abroad, if something happened, I don't know, even something quite simple like someone shouted at you in a shop, you didn't know if that was OK or rude or just not acceptable at all. It is like being on shifting ground. You didn't know what the solid ground was, so you couldn't react and you just lost your confidence. Well, I think it is sort of like that now, when you work with people from another culture. You are not sure what is normal and acceptable and so you don't feel as if you are standing on solid ground so you're not, I don't know, really confident in what you are saying. If you know what is culturally acceptable, then you can sort of push it but if not then you feel as if you are sinking a bit. Well not really sinking, I think just sort of skidding on ice and you can't really get a grip on what is going on. (Joy:72-83)[sic]

The metaphorical space where cross cultural interactions occurred began to emerge as an important category.

Figure 3.9 Summary memo: skidding on ice 3 September 2008

3 Sept. 2008_Summary memo

Compare and contrast 'skidding on ice', 'finding common ground' and 'loosing confidence'

In interview 4, Joy described her encounters with people from other cultures at times as if she was **'skidding on ice and can't get a grip'** of what is going on. It is interesting to compare this with references to 'surfaces' in other interviews and explore what some of these mean. In interview 2, Jane wanted to find **'middle ground'** and in interview 1, Rebecca was trying to find **'common ground'.** Joy feels as if she is standing on 'ice'. Why is it so important to know the certainty of the ground you are standing on as a health visitor? Is this related to confidence and anxiety, again recurring themes in the first two interviews? Jane also appeared to be **'losing confidence'** as the certainties of fixed cultural groups became more relative for her, particularly in the area of mental health. This appeared to be a confusing area, without clear consensus or definition and policy was not in line with practice experience. Explore this further in the literature – mental illness, culture and certainty. Is it something about the 'ground' they are standing on?

Joy said 'you are not sure what is normal and acceptable' and this relates to 'cultural norms' as discussed by Helen. **'Finding cultural norms'** was a basis for Joy's working knowledge (and confidence?). How important is 'finding cultural norms' for confidence and practice?

Recurring themes of **'ground standing on'** and **'anxiety in cross cultural relations'** are strong themes at this stage to explore in future interviews. Joy also felt **'swamped by emotional need'** in cross cultural relationships**. 'Emotional door'** has been framed in previous interviews as **'opening up'** (Rebecca) and Helen as **'closing down: protecting self'**. In interview 3, Helen metaphorically talked about **'taking on board'**. In this interview, **'emotional work'** is described in relation to people seeking asylum as **'being swamped by emotional need'.** The following quote from Joy and accompanying Figure (Figure 3.10) explore these concepts further.

> Joy: I find it really difficult emotionally working with asylum seekers, but that isn't the same with all people.
> Fiona: Can you explain that further?
> Joy: Well, I think it is really difficult emotionally to listen to stories of rape and torture and it just turns my stomach at times but you sort of think, I am only listening to this, they have actually lived through it. It is so difficult not to be swamped by the emotional need, especially where people have lost all their family and begin to rely on you. It isn't like that with other families obviously, but at times it is really draining. (Joy:106-113)[sic]

Joy was keen to point out that this was specifically with people seeking asylum, but the intensity of emotional work is high and she feels 'swamped' by it at times. I started to consider the ways in which this might affect her working relationships. Questions remained as to how

Joy protects herself from feeling overwhelmed and the coping strategies that she employs.

Figure 3.10 Theoretical memo: opening up…closing down 12 September 2008

12 September 2008_Theoretical memo

Compare and contrast memo 'opening up', 'closing down', 'taking on board' and 'feeling swamped by emotional need'.

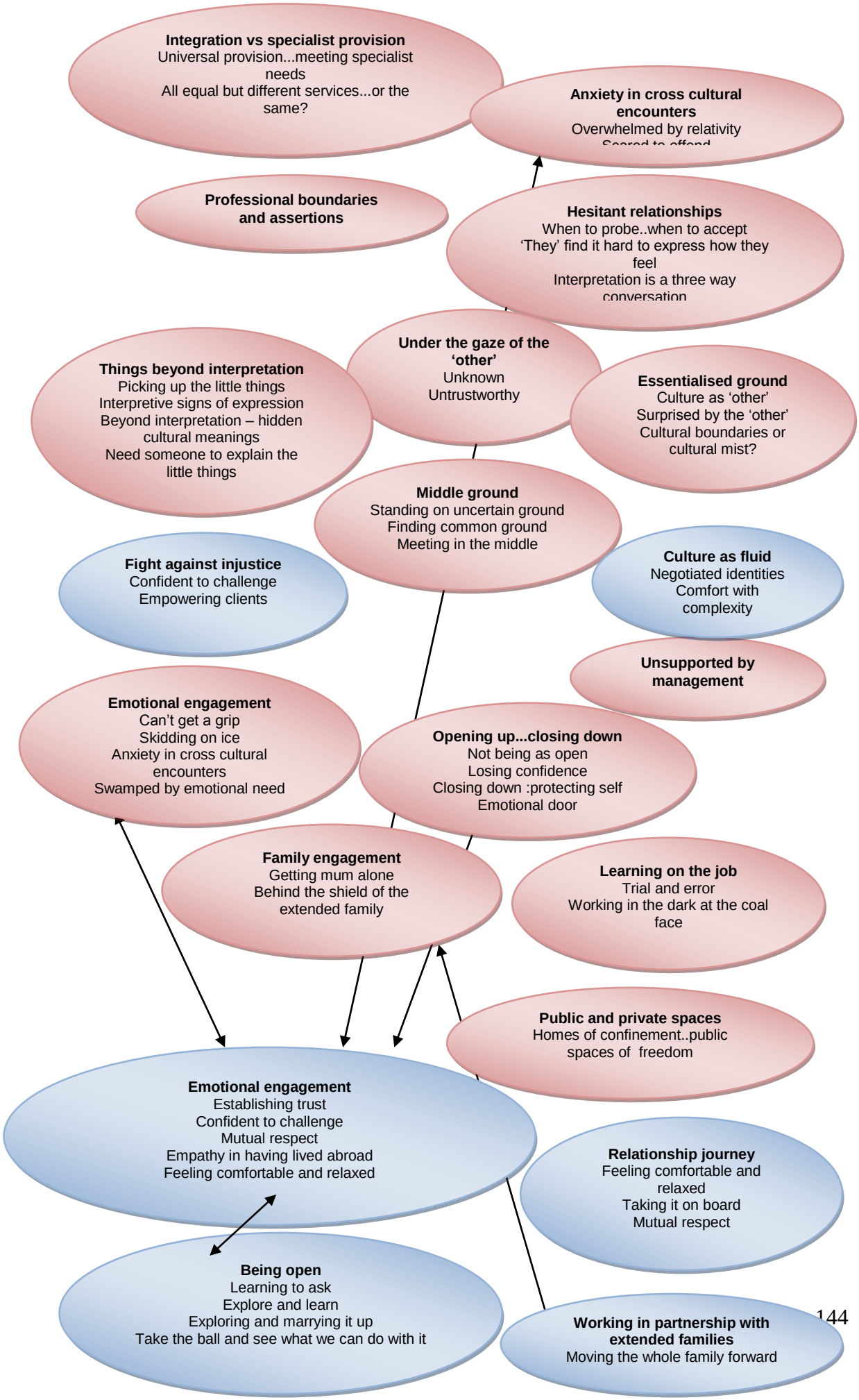
It is interesting to compare these four emotional responses to the **'emotional door'** in the first 4 interviews. **'Opening up'** (interview 1) was very much in terms of being initially closed**.** Is that true of all relationships or in particular to certain families? Jane talked of **'closing down'** when she felt overwhelmed by the relativity and complexity of culture. Was this her emotional coping strategy? What does it mean to '**close down'** and how does that affect the client/professional relationship? Helen appeared to be open and willing to **'taking on board'** the needs of her client. Why was she able to do this, when others aren't? Is it a product of personality? Understanding? Emotional ability?

Finally, Joy felt **'swamped'** – was this the nature of her workload or was the emotional nature of the job and the difficulty for her to cope with? What was her response to feeling **'emotionally swamped'**? What were the symptoms of this?

Working with people who are from other cultures is clearly **'emotional work'** but the responses to this are very different. This needs to be further in subsequent interviews.

Following the analysis of the data, creation of memos and comparison of the generated codes, tentative themes from the first 4 interviews were developed into the conceptual map below. The arrows indicate the relational associations between themes.

Figure 3.11 Conceptual map - Tentative themes: relational map interviews 1-4



3.3.6.2 Theoretical sampling

Theoretical sampling is central to grounded theory methodology and described by Corbin and Strauss (2008) as:

> A method of data collection based on concepts/themes derived from data. The purpose of theoretical sampling is to collect data from places, people, and events that will maximize opportunities to develop concepts in terms of their properties and dimensions, uncover variations, and identify relationships between concepts (p. 143).

Theoretical sampling occurred in line with grounded theory methodology. Theoretical sampling requires that data collection and data analysis happen concurrently, and that questions are asked of the next participant based on the emerging data from the previous interview. Charmaz (2006) explained it as:

> Seeking pertinent data to develop your emerging theory. The main purpose of theoretical sampling is to elaborate and refine the categories constituting your theory. You conduct theoretical sampling by sampling to develop the properties of your category(ies) until no new properties emerge (p.96).

Theoretical sampling occurred from Interview 2 onwards. This occurred throughout the research process and has been documented throughout

Chapter 3. Theoretical sampling was central to the research methodology and data analysis in this study and two examples of this are detailed below:

Firstly, following Interview 1 with Rebecca, the subject of racism had not come up with the health visitor, despite a plethora of literature, which indicates it is prevalent in many communities. In constructivisit grounded theory, Charmaz (2006) emphasises the importance of listening to the silences in narratives and Clarke (2005) asserts that listening to the silences is a part of seeking to be ethically accountable researchers:

> In seeking to be ethically accountable researchers, I believe we need to attempt to articulate what we see as the sites of silence in our data. What seems present but unarticulated? What thousand-pound gorillas do we think are sitting around in our situations of concern that nobody has bothered to mention yet (p. 85)

In working towards making theoretical comparisons, Corbin and Strauss (2008) recommend at times taking similar types of situations as the basis for comparison, and at other times to use what they call ‘far out’ comparisons. In interview 3, the participant was sampled (from the volunteers) because she worked in a specialist capacity with a particular group of cross cultural clients. In this way, the data could be coded, compared and contrasted to help to move the data towards some theoretical comparison.

Following the grouping of open codes in to tentative themes after interview 4, and the building of a relational map, two different categories of response were identified. These were initially described as ‘specialist’ and ‘generalist’ practitioners. Theoretical sampling was used to try and to explore both of these groups of health visitors further, but it became clear as the research progressed that the health visitors could not be placed into two neat categories of ‘specialist’ and ‘generalist’. Jane, Helen and Joy had all chosen to work in more specialised areas with clients from cultures other than their own and, yet, their responses were markedly different to each other. The categories that emerged from the interview with Joy overlapped with the categories of Helen, but also some of those of Jane and Rebecca. Rebecca worked as a generic health visitor and had no specialist interest, but many of the categories identified by the other three, were most similar to those of Rebecca. Corbin and Strauss (2008) advise that it is important to move from description to more abstract properties, to avoid trying to force participants into simplistic categories:

> The making of theoretical comparisons has a function of moving the researcher more quickly away from describing the specifics of a case, such as this particular garden is very pretty, to thinking more abstractly about what properties various gardens share in common and what is different about them (p.77).

The health visitors in interviews 5-8 were all chosen, as they identified themselves as ‘generic’ health visitors who worked in various city locations and had largely white clients on their case loads, with a few clients they identified as from minority ethnic groups. In interview 9, the health visitor was chosen for her work in a ‘specialist’ area of practice. This enabled theoretical comparison of the emerging data.

Interviews 5, 6 and 7

Interviews 5, 6 and 7 were all conducted over a two week period at the beginning of September 2008 and subsequently analysed together. Although I recognised that this is not optimum in grounded theory methodology, practical considerations meant that this was the only way to secure the interviews. Work related issues and time constraints on the part of the participating health visitors meant that it was only possible to arrange and conduct these three interviews during that particular two week period. The interviews were analysed separately using micro-analysis with interviews 5 and 6, but comparison of the data was made at the same time across all three interviews. The interview questions were subsequently guided for all three interviews by the themes which had emerged from the first 4 interviews, and were similar for interviews 5, 6 and 7.

Interview questions for interviews 5, 6 and 7

The questions for interviews 5, 6 and 7 remain semi-structured and ‘open’ in content, guided largely by the research participants, but certain

specific themes were explored by the researcher based on the emerging categories from interview 1-4. The aim was to open up some of the categories that had been identified as important, while not closing down other categories too quickly.

There was also opportunity given for the research participants to discuss any other barriers or opportunities they may have experienced when working with people from other cultures. There is a danger of missing the 'elephant in the room' if interview questions are clearly directed, and no opportunity is given to disclose any new issues, which may be of prime importance to the participant. This was discussed in my research diary entry for interview 5, as explained below.

Figure 3.12 Research diary: Alice 20 September 2008

20 September 2008_Research diary extract

Interview 5_Alice

This is the first time I have used 'guided questions' in my interview and I was really aware the whole way through the interview that I might be missing something really important. Grounded theory requires that I guide my interview questions based on the themes which have emerged but it is really difficult to do. I feel very anxious that I am not putting words into the mouths of the participants. My questions either feel too prescriptive or so general they are not guided at all. I think this probably improves with experience, but I found it a difficult interview in that respect. There seems to be a difficulty in guiding the interview and finding that balance between not forcing the data and yet at the same time not to miss the elephant in the room.

Interview questions for interviews 5, 6 and 7 were based on the codes and questions that had emerged during interviews 1-4. By theoretically

sampling for emerging codes and concepts, certain emerging categories can be opened up further and others collapsed.

Interpretive grounded theory explicitly looks for the ‘silences’ in the data, and the researcher was interested in the ‘silence’ in the narratives of the health visitors in relation to issues of racism. None of the health visitors in interviews 1-4 had discussed racism at all, nor had they mentioned ‘race’. This needed further exploration. Interviews 5-7 were structured to ask questions which interrogated these ‘silences’ and the emergent themes further (Appendix B2).

Interview 5 - Alice

Alice described herself as white British, and had been working as a health visitor for 10 years, and prior to that she worked as a district nurse. She has always worked within the same geographical area in her professional career. She described the area as having a high level of economic social deprivation, where most of the housing is private rented housing. The turnover of new clients is relatively high and the population appears to be fairly mobile.

Data analysis interview 5

Micro-analysis was applied to the interview data, so that data was not submerged under existing themes and any new categories could be uncovered. Following micro-analysis, the data was examined and emerging categories developed (Appendix D1). Data collected in

interview 5 added to the existing codes and tentative categories, but the most interesting category which opened up was the category of **'universal provision…specialist needs'**.

'Universal provision…specialist needs' began to emerge here as an interesting category following interview 1, but subsequently became central to the final conceptual theory and is therefore detailed here. For Alice, the difficulty in balancing the need to provide a universal health visiting service and also to give specialist time was very problematic, as the memo below demonstrates:

Figure 3.13 Theoretical memo: universal provision 19 September

19 September 2008_Theoretical memo

Compare and contrast_ 'universal provision…meeting individual needs' and 'all equal but different services...or the same?'

There appears to be something worth exploring which is evident in all five interviews so far, about the need to give an equal service but also recognising that people from other cultures might need some additional provision. This is a very confusing picture. If this is framed within the situational map exploring the context of health inequalities and BME groups (Appendix E3) it reflects discourses within health visiting today

> Fiona: What do you think about the specialist services?
> Alice: I think in the specialist service they probably had more time to look at the issues which were pertinent to those cultures and that was what they needed but really what they are getting now is a universal health visiting service unless there are issues of high dependency or child protection then it tends to just be a universal service and you don't have the capacity to maybe address some of the culture issues really. We know what they are, we can identify what they are but we don't have the capacity to do that because it is time consuming and because we are currently trying to get so much up and running with the general population with regards to the children's centres it is trying to encourage, I don't know, other cultures to participate in that but it's not tailored to their needs. (Alice:60-70) [sic]

Alice was very angry that a specialist service for BME clients, which had been in existence for several years was suddenly disbanded and they were left to take on the clients, without any additional training or support.

Alice: We were told that the case load responsibility would come back to us but it didn't work like that. The caseload responsibility came back down to us and the training never came or got off the ground (laughs). Now the trainers don't really exist really.
Fiona: How did you feel about that?
Alice: We were just thrown in at the deep end and left to get on with it really. Basically.
Fiona: Had you had any experience before of people from other cultures or was this a new experience?
Alice: Very limited because they had been kept away (*people seeking asylum and other BME groups*) and we hadn't used interpreters before, we hadn't had the need to so overnight we suddenly had to use a lot of different things we hadn't needed to before. (Alice: 31-43) [sic]

This relates very closely to the code **'all equal but different services..or the same?'**, which emerged during interview 2 with Jane. There was confusion with Jane but there is resentment with Alice that the equality agenda does not mean 'the same' in terms of provision of services. What does this mean for the health visitors involved? How does this resentment affect service provision and engagement by the health visitors?

This interview was returned to several times later on in the data analysis process, when the categories of '**knowing in professional practice'** and **'tools of knowledge'** (Appendix H5) were opened up further using positional mapping (Appendix G1). Alice's assertion of being **'thrown in at the deep end'** and of being **'left to get on with it'** were not initially opened up, but were returned to later in the analysis process and became part of the conceptual category '**developing a toolbox over time'** (Appendix H4).

The interview with Alice also introduced new codes, including '**professional status devalued'** and **'they don't know what our role is'.** Analysis of the theoretical memo written in consideration of this

shows the emergence of the conceptual category **'professional self',** which becomes a central conceptual category, **'positioning self'**, later in the data analysis (Figure 3.32).

Figure 3.14 Theoretical memo: professional devalued 24 Sept 2008

24 September 2008_Theoretical memo

Compare and contrast memos: 'professional status devalued', 'they' don't know what our role is' and **'under the gaze of the 'other'**

Alice re-iterated many of the same themes already brought up by Rebecca in interview 1, about not feeling trusted, valued, feeling that 'they' don't know what health visitors do and not being sure how health visiting is perceived. The extract from Alice below summarises her feelings:

> Alice: Sometimes you find that there are quite a few different families living in one home.
> Fiona: How do you find that?
> Alice: It is very different and you are tending to do mass health visiting when you go in because there tend to be a few mums and children and you are never very sure who's children is whose and so you just have to talk generically and it goes back down as well, it is sometimes I don't think that the health visiting service is really valued because the person who actually came to see may be somewhere else in the house because they have disappeared off and you are left speaking to other family members. You suddenly realise and think, where has mum gone and she has disappeared off and you think…, it is about valuing the service and sometimes it's just not valued.
> Fiona: Why do you think that is?
> Alice: I don't know. I think it is a lack of understanding, not knowing what we are there for. It is a little bit of suspicion and the issues we are telling them and are really conflicting to what they would be doing normally regarding their culture. (Alice: 135-151)[sic]

Health visitors come to a visit with their clients that they will be afforded some sort of special professional status and Alice appeared to be angry that this was not established with her clients across cultures. In what ways does professional identity influence cross cultural encounters? How do health professionals present themselves? **'The professional self'**– what does that mean?

Finally, the interview with Alice raised some very interesting narrative about her experience of asking about racism with her clients. This was initially coded as **'racism exists but it's not the norm'.** This is a code which is expanded in further interviews, developed in future memos (Figures 3.32 and 3.15) and explored using situational maps (Appendix E5).

Interview 6 - Leah

Leah described herself as white and British. She had been a health visitor for about 20 years in the same area. The area she described as mixed, with some new housing estates, some private housing and some 'high price end' housing. The area she worked in was within a city, and she also said that it had one of the big council housing estates, which was currently being pulled down and rebuilt as part of the Government regeneration scheme.

Interview 6, while building upon many of the open codes already in use (Conceptual map 3.1), introduced a new area of enquiry. These were specifically labelled as **'playing the 'race' card'** and **'challenging non-disclosure of child protection/domestic violence'**.

Figure 3.15 Theoretical memo: playing the 'race' card 21 September 2008

21 September 2008_Theoretical memo

Playing the 'race' card

What is initially interesting and new about this interview is that Leah expressed a fear of being accused of 'racism'.Non-disclosure of domestic violence and child protection issues were alluded to – why was this? Fear of being accused of 'racism' against a family? Fear of mis-interpretation?

It is interesting to see if this has been referred to in any of the other interviews. I will go back and look and explore further. Also I need to explore the literature which supports anxiety over discussion of 'race'.

The following section of interview text is interesting in this regard:

> Fiona: Are your clients able to talk about their experience with racism with you?
> Leah: Em, I felt as if, there was one man who was very angry and he said he wanted this and I felt, he was personally going to play the racist card with me and it was (pause) and 'I know why I am not getting the service' (imitation of client) and it was (pause), the service didn't exist (laughs) no-one was getting that service and the service didn't exist but it was (pause), you know how, I just got this uncomfortable feeling and his next words were going to be (pause, stopped talking).
> Fiona: How did that make you feel?
> Leah: Well, that makes you feel really uncomfortable and when you put the phone down it makes you feel, you realise it isn't because that service isn't available and it makes you reflect on yourself and you know so, I think sometimes it is easier telling people that there isn't a service but you feel that people can believe that it is because of their race rather than because the service doesn't exist (Leah: 102-.118) [sic]

Figure 3.16 Theoretical memo not pushing forward 27 September 2008

27 September 2008_ Theoretical memo

'Not pushing forward' and 'not asking and not looking'

In interview 1, Rebecca first introduced the code of **'when to probe..when to accept'** but now it is directly in relation to issues of 'race'.

> Fiona: How do you thing people from other cultures understand your role as a health visitor?
> Leah: I am not quite sure. I think some, I think some people think it is a good thing and it is surprising how welcoming people are and some of the people take up the clinic and for free and I think they are amazed that this service exists, so I think some of them are quite surprised at this but I could think of some people would think of it as an intrusion and I think you just have to look at the child protection numbers to see how many Asian families there are on the child protection register and I don't think there are any.
> Fiona: Why is that?
> Leah: I don't (pause), I think it is the family is so guarded and professionals worried about putting a referral in (pause), I just don't know, but I'm sure there is physical violence goes on because I think some of them do use physical violence, you know, it's (pause) maybe just the way it is, I don't know, I think they are very (pause) , they stick together in that type of way and they are very protective of this thing and they don't welcome intrusions of that nature. I would find that really uncomfortable. If I had a child protection referral to make, I think, some families I could have no problem but I would find that particularly stressful (pause), I think I would.
> Fiona: Why in particular?
> Leah: Because I think if (pause) , that, because I think some of them want to keep it very private and they don't want you interfering and I think some people (pause) , it is like anybody they just tell you what you want to hear but I think that is the same with some families.

> Fiona: Would you find it harder to push forward with a disclosure for child protection or domestic violence with a family from another culture?
> Leah: Yes, I think I would. I think if I am honest, I think I would. I would be frightened I caused offence where I wouldn't if they were an English family, I wouldn't, I would be more worried about the safety of the child, which I know sounds awful, but I would be concerned about em (pause) difficulties I might encounter as well as, em, (pause) but I am sure if it was so definitely obvious I would but if you just had a suspicion I think it would be, em, hard to, em, yes (pause), you know. And I think it is the not understanding of the language and you know (pause), I don't have an understanding of their language so am I picking it up the wrong way? Am I interpreting things, you know, especially if it is not an obvious thing, you know? (Leah: 41-71) [sic]

What is especially worrying here is that Leah is afraid to push forward with child protection issues. In listening to the 'silences', 'racism' is an area which is not discussed by the health visitors and become a hidden issue. Context is so important here – the socio-historic context of 'race' appears to shape practice. The situational map (Appendix E5) is really useful here. How does this also related to **'racism exists but it is not** the norm' (interview 5)? The health visitors are **'not asking and not looking'**…is this a way to manage the anxiety (and fear at times) in working across cultures. Fear of someone **'playing the 'race' card'** means that they just **'don't ask'** and **'don't see'**. How does this affect practice?

The narrative account of Leah is around **‘not pushing forward’** with child protection and/or domestic violence. Again issues, or anxiety and uncertainty surround and drive her action (or non-action), and she is **‘scared to offend’**. Health visitors avoid engagement, by being **‘silent on racism’, ‘not pushing forward’** and **‘not asking and not looking’**. This is detailed in the memo below:

Figure 3.17 Theoretical memo: take it or leave it menu 10 October 2008

10 October 2008_Theoretical memo

Compare and contrast memo: 'when to probe…when to accept', 'take it or leave it menu'

In comparing and contrasting this interview with the previous interviews, Leah does not appear to 'probe' at all but just enters the encounter with her clients who are from another culture and gives them a **'take it or leave it menu'**.

> You have given them that knowledge and it is up to them what they want to do (Leah:166-167).

Alice in interview 5 also presented a **'take it or leave it menu'**. She offered advice but then just left it open and did not really push for engagement with her clients;

> Fiona; How far do you feel you can push you advice?
> Alice: Well, you can literally, you can just keep on emphasising the information really. If it is not being detrimental to the children's health then you can just leave it there really and just leave the lines of communication open really. You just say, give us a ring and encourage them to come to the clinic really. We don't tend to have a very good attendance at the clinic really. (Alice:154-160) [sic]

The question to ask is why? Is her expectation just to enter a **'middle ground'** and to give her information and leave again? Is she anxious that she will be entering **'dangerous ground'** if she does try to 'push'?

There appear to be several categories which are now coming together and overlapping. The **'cultural terrain'** appears to be emerging as an important category. This can either be **'middle ground'**, or **'dangerous ground'.** Looking at the Figures relating to both **'middle ground'** and **'dangerous ground'**, they combine several common codes across these first six interviews. **'Middle ground'** relates to also finding **'common ground'** and it appears to be defined by neutrality, security, confidence and an area for negotiation. **'Dangerous ground'** is very different defined by anxiety, feels threatening in some way and unstable. It is associated with **'loosing confidence'** for Jane and somewhere clients might 'play the 'race' card'. This needs to be explored further in subsequent interviews.

There is also something else here, when comparing these categories. It is not only the **'cultural terrain'** which is important, but also whether the health visitors try and move forward within that encounter or just stay still. To stay still is to offer a **'take it or leave it menu'**. There are many different reasons for this. It can be a lack of willingness to move into a relationship with clients who are from another culture (Leah), or a **'scared to offend'** (Rebecca, Jane and Alice) or a feeling of uncertainty **'when to probe…when to accept'**. Health visitors appear to use a legal framework for child protection and domestic violence as to know **'when to probe…when to accept'**, but out with that, it is ambiguous.

Interview 7- Emma

Emma described herself as white and half German. She has worked as a health visitor for 20 years, but prior to that trained as a midwife in London. Her mother is German and she chose to mention this in the interview. She currently works in a mixed socio-economic area in a city, and has been in her current post for 8 years.

Research diary

Figure 3.18 Research diary: Emma 29 September 2008

29 September 2008_ Research diary

Diary entry immediately following interview 7

This interview felt slightly awkward. I felt as if the health visitor was very angry about specialist provision and had a strong 'integration' agenda. She was also very defensive and it took a large part of the interview to help her to relax.

I can identify themes we have already looked at but there were a couple of new things.

1. For the first time in my interviews so far, the participant used the word 'political correctness' in our conversation.

2. The second thing to note is that this participant voiced the opinion that the equality and diversity training she had received as doing 'the opposite to what it is trying to do'. She felt it was counterproductive.

Interview 7 was again micro-analysed and the emerging codes (Appendix D2) were compared and contrasted with each other. Several existing codes emerged along with 14 new codes. The new codes were conceptualised as below:

1. Lacking knowledge and back up

2. Changing over time – becoming more comfortable and relaxed

3. Things lost in translation

4. Things lost in culture

5. Frustrated with framework assessments

6. Damage caused by specialised BME teams

7. Specialist provision unfairly advantages BME groups

8. Treading on glass

9. Anger people won't integrate

10. Problematic political correctness
11. Protecting your back
12. The contradiction of equality and diversity training
13. Waiting to be tripped up

Emma's narrative was very angry, and in particular her anger was directed towards **'problematic political correctness'** and having to **'protect your back'**. She was very positive about working with people from cultures other than her own, but she was angry that some groups did not try to integrate, and particularly frustrated that specialist health care teams exacerbated this. She also felt, along with Leah, that health visitors in cross cultural work were **'not pushing forward on child protection'**.

> Fiona: If you were going to design training to help you in your day to day work, what would you do?
> Emma: Oh, pause. We do the annual equality and diversity training and I think sometimes it can actually, em, do the opposite to what it is supposed to be doing, em, (sigh) it , I think sometimes within the children's centre and something that recently came up within the children's centre was that they couldn't have a Christmas thing, they could have a winter wonderland because it would be offensive to everyone else and I don't actually think that when it is said that, that when it is said to the community it can generate really negative feelings and I don't perceive that most people from other cultures or from other cultures have problems with us

having Santa Claus and a Christmas tree because if we allow them to celebrate their culture, which is quite right, then I think it should be exactly the same in our way and I don't think it has anything to do with other cultures but people are just becoming so politically correct in many ways that we have got to get away from because that can generate such massive problems (Emma: 36-51)[sic].

Emma not only raised issues of **'problematic political correctness',** but in one particular example she talked about **'protecting your back'** against an accusation of racism.

Fiona: Do you feel anxious at all when you are in the homes of people from other cultures?

Emma: In this particular household I am very, very careful and this sounds very cynical but I feel as if I have protected my back by everybody ensuring the CAF form [3]went in to make sure there wasn't anything available because I didn't want to be called racist for not giving care. But in other households I have never felt like that, I haven't felt I was treading on eggshells, I've felt very welcome and sort of, and you do try and respect if their partners are working late in the restaurant and you'll go on the afternoon, so you'll try and do things like that different, but I've never ever had any problems, in this household it is (pause), it is one of those households you don't feel comfortable going in (pause).In

[3] CAF form refers to the Child Assessment Form, which is a universal initial assessment form used by health visitors .

> fact you take someone else to witness what you have said and that is not the way it should be and I feel that it should be almost as if it is, as if you are kind of waiting to be tripped up and that feels very uncomfortable but that is a particular case (Emma: 72-85)[sic].

In summary, all 7 initial interviews were micro analysed as recommended by Corbin and Strauss (2008) in order to:

> Generate ideas, to get the researcher deep into the data, and to focus in on pieces of data that seem relevant but whose meaning remains elusive (p. 59).

Following micro analysis, the chunks of raw data were ‘labelled’ with an open code, and these codes were then further analysed and categorised. Categories were then concurrently compared to new interview data and re-analysed. Analytical tools, such as the use of questioning, looking at language, looking at emotions, thinking of metaphors and similes, looking at the structure of the narrative and consider words, which use the concept of time. All of these analytic tools were used throughout the process to enhance data analysis (Corbin and Strauss, 2008).

Each interview yielded many initial codes, which were grouped in to 17-23 categories following initial data analysis, and these codes were

interrogated through the use of theoretical memos relating to each code. These theoretical memos were then used to subsequently compare and contrast emerging categories and codes against previous data. Following the initial 7 interviews, several categories appeared to contain strong recurring themes, and many categories remained ‘active’ but awaiting further interviews and analysis. All of the categories remained open at this stage, and were subsequently revisited and reanalysed in relation to subsequent interview data.

Open codes were then compared to each other and the categories began to expand rather than collapse. This led to much richer analysis and the beginning of axial coding. Table 3.1 represents the outcome of this process.

Table 3.3

Tentative categories and related open codes_ Interviews 1-7

Tentative category	**Open coding**
Solid ground	Culture as 'other' Essentialised ground Surprised by the 'other'
Porous boundaries	Culture as fluid Negotiated identities Comfort with complexity Negotiated identities
Uncertain ground	Things beyond interpretation • Interpretive signs of expression • Picking up the little things • Hidden cultural meanings Finding common ground Middle ground Meet in the middle Working in the dark at the coal face Losing confidence Cultural boundaries or cultural mist? Overwhelmed by relativity Standing on uncertain ground Skidding on ice and can't get a grip Unsupported by management
Dangerous ground	Playing the 'race' card Treading on glass Problematic political correctness Protecting your back Not pushing forward Waiting to be tripped up Not asking and not looking
Emotional work	Scared to offend Anxiety in cross cultural encounters Anger in cross cultural encounters Anger people don't integrate

	Establishing trust Empathy in having lived abroad Mutual respect Feeling comfortable and relaxed Confident to challenge Changing over time – becoming more comfortable and relaxed
Relationship building Communication Lacking trust	Hesitant relationships When to probe…when to accept Under the gaze of the cultural 'other' Unknown Untrustworthy Need someone to explain the little things 'They' find it hard to express how they feel 'They' don't understand us Gaps in interpretation Lacking trust with interpreters Interpretation as a three way conversation 'Other' cultures beyond reach Things lost in interpretation Things lost in culture Feeling comfortable and relaxed Taking it on board Mutual respect Exploring and marrying it up Establishing trust
Cultural learning	Learning on the job Lacking knowledge and back up The contradiction of equality and diversity training Trial and error Take the ball and see what we can do with it Exploring and marrying it up Taking on board Learning to ask Explore and learn
Professional boundaries and assertions	Having a framework Professional status devalued 'They' don't know what our role is

	Frustrated with framework assessments
Integrations vs specialist provision	Universal provision…meeting specialist needs All equal but different services…or the same? Damage caused by specialist BME teams Specialist provision unfairly advantages BME groups
Avoiding injustice Fighting injustice	Racism exists but it's not the norm Take it or leave it menu --- Confident to challenge Empowering clients Fight against injustice
Family engagement	Behind the shield of the extended family Getting mum alone Intimidated by the extended family --- Working in partnership with extended families Moving the whole family forward
Opening up…closing down	Closing down; protecting self --- Being open Asking Feeling comfortable

3.3.7 Data collection and axial (focused) coding

3.3.7.1 Axial coding

Axial coding is the stage of data analysis when theoretical categories begin to emerge at the conceptual level. This is the result of rigorous thought, detailed initial open coding, and a constant comparison and interpretation of the narrative data. During axial coding, three important categories were identified, which were fundamental to the generation of the final theory **'emotional encounters through cross cultural terrain: shaping relational journeys through culture'**. These categories were **'relationship building', 'cross cultural terrain'** and **'managing emotions'**. This section describes the search for these important categories, as I tried to explicate what was going on in the data.

Initial axial coding emerged as above and began at around interview 8 until interview 14. The conceptual maps (Table 3.1 and 3.4) were developed and used with the situational maps (Appendix H), as an analytical tool to interrogate these important categories. Intense thought and re-working of the data was required at this stage until categories began to emerge. Four main conceptual (axial) codes began to emerge, and were subsequently developed. These were named as **'taking a toolkit'** (Figure 3.19), **'treading lightly on cultural ground'** (Figure 3.20)**, 'positioning self'** (Figure 3.32) and **'universal provision…specialist needs'** (Figure 3.23).

Interviews 8,9,10 and 11

Interview 8 - Mary

Mary had been a health visitor for 8 years and worked within a city suburb. She has worked in two different areas of the city but described them both as 'Surestart' areas, indicating some social and economic deprivation. She described the area as 'very British, with few families she would call BME families.

Analysis of the data from interview 8 expanded and built upon many of the categories, which had already emerged during previous data analysis. Participant 8 particularly challenged the areas of **'relationship building',** and the concepts of **'family as barrier'** and **'interpreter as barrier'**. **'Relationship building'** began to be conceptualised as **'relational journeys'** (Appendix H12) in later interviews, but it remained an open code at this stage of analysis.

Mary also introduced the code of **'finding the right tool'** and **'tools of knowledge'**. Initially, this was a minor code but as data analysis progressed, this became an important code and was re-visited in the light of subsequent data analysis (Appendix H5).

Figure 3.19 Theoretical memo: taking a toolkit 4 November 2008

4th November 2008_Theoretical initial memo

'Taking a tool kit'

Mary talks about taking two different types of equipment with her into her clients across cultures. The first is conceptualised as **'finding the right tool'** and the second as **'tools of knowledge'**. In both cases, Mary feels that she lacks **'the right tool'** and also there appears to be something about the **'tools of knowledge'**:

> Mary: I am thinking of one of the forms that we use to screen for post natal depression, em, which we would only use for certain families anyway and we certainly don't use within the Bangladeshi community because their culture does not believe in that (depression) anyway, so we wouldn't use, em , that form. They don't believe in depression, so we wouldn't use that form, yes, we would do a clinical interview that we would probably get the answers that we needed but we wouldn't use the form. We would ask the questions in a different way, em (pause). It is all about working really. I think the questionnaire we use, it can only be passed for use with, em (pause) to be used with British families anyway (Mary:36-43) [sic]

For Mary, her **'toolkit rendered ineffective'** across cultures. She is also anxious that she lacks the **'tools of knowledge'**, as the vignette below indicates:

> Fiona: What aspects do you find most difficult when working with people who are from another culture?
> Mary: Em (pause) I think probably the lack of understanding, because I think we have so many different people working in the area that it is impossible to know what is right for one culture and not for another culture, em, so I think that em (pause) I find quite difficult (Mary:189-193) [sic]

What is the role of knowledge of the cultural 'other' in professional practice? Professional knowledge is a powerful discourse within nursing literature and professional practice – in what ways does this desire for knowledge make health visitors want to understand culture? Does making culture essentialised help this?
Mary uses very essentialised language to discuss depression:

> Mary: So it is about talking around things, so it would be the same as other cultures that we wouldn't use that form for and would talk around some of the issues and just talk about, em (pause) feelings and mood and not mention the depression word and things like that.
> Fiona: Why wouldn't you mention depression?
> Mary: Because as I say, within the Bangladeshi community they wouldn't accept depression anyway, they would deny it completely but they may say that they are feeling a bit down, so you would use those sorts of words, so it is about changing the words around, so you could use it for English families too (Mary:56-63) [sic]

Previous codes have also indicated **'tools of experience'** such as **'learning on the job', 'exploring and marrying up', 'taking the ball and see what you can do with it'** and **'trial and error'.** How do these relate to **'taking a toolkit'**? This needs further exploration. Alice's assertion of being **'thrown in at the deep end'** should also should be returned to here. A positional map of professional knowledge/cross cultural engagement also helps to open up the data (Appendix G1)

Interview 9 - Sophie

Sophie was a very experienced health visitor, who had worked in other cities in the UK and also lived abroad. She described herself as white and British. She had worked as a health visitor for over 15 years, and had worked in various inner city areas, which had high populations of BME clients. Her interview was illuminating and brought out many of the similar themes, which had been identified in interview 3 with Helen. Sophie had worked in several specialist BME roles.

The main categories which emerged, following data analysis and comparison with other interviews, were:

1. Establishing trust
2. Mutual respect
3. Empowering clients
4. Experienced living abroad
5. Feeling comfortable and relaxed
6. Working in partnership with extended families
7. Culture as fluid
8. Confident to challenge
9. Comfort with complexity
10. Negotiated identities
11. Taking it on board
12. Empathy in having lived abroad
13. Relationship journey
14. Fight against injustice
15. Moving the whole family forward

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16. Activist self
17. Emotional flexibility
18. Anger against injustice
19. Listening and learning
20. Journey against the system
21. Travelling together
22. Walking together with the family
23. Moving towards empowerment
24. Discovering together
25. Negotiated relationships

Figure 3.20 Theoretical memo: treading lightly on cultural terrain 4

January 2009

4 January 2009_Theoretical memo
Emerging axial code: 'Treading lightly on cultural terrain'

Something really interesting appears to be emerging following comparison and contrast of this interview with Sophie (interview 9) and the interview with Helen (interview 3) .The emerging codes from these two interviews are very different from the other 7 interviews so far. In interviews 1,2, 4-8, the codes are focused around **'cross cultural terrain'** as **'middle ground'**, **'common ground'** and **'meeting them half way'**. The categories emerging from interviews 3 and 9 lie in stark contrast**. 'Cross cultural terrain'** is not evident in these narratives, but the **'relational journey'** is at the centre. Both Helen and Sophie **'tread lightly on cultural terrain'**.

For both Sophie and Helen, the cross cultural terrain is less important than the **'fight for injustice'** and the importance of **'empowering clients'**:

> Sophie: I've always sort of fought for the underdog really and I will always root those people out and I have always sort of stood up for inequalities sort of things because I am very much about fairness, so if you can do this for one person, you can do it for everyone and I suppose that is sort of my philosophy really and I think that is what has pushed me into ethnic minorities (Sophie:58-61) [sic]

> Helen: As long as the child is in the middle and you are safeguarding the wellbeing of the child, then this is their child to bring up the best they can the best way they can and as long as the child grows to be healthy, to be safe, to be empowered then this is what you are doing for the child (Helen:132-134) [sic]

Sophie and Helen also are confident to negotiate, challenge and to work with their clients and families together:

> Helen: It is not good this is black and they are saying that is white, it is no good, you have to show you are working together and you have to bring them in and show you can work with them and you hear what their beliefs are and within that you can move forward. To me it is the only way you can work. (Helen:212-214) [sic]

> Helen: look at cultures where you , where the extended family all stay together as one unit and see and look and see how they function and work with them. I would never separate them, because I look at cultures from abroad where the family is not just mam, dad and the children, but it is aunties, uncles that will all live in the same house or the same area of land and that is how it works out there, so to exclude them is to go against the cultural norm. And you are setting up that young mam and husband into a probably more antagonistic house and family and failing and you will never achieve any health promotion if you separate them, you have to work with them and slowly by, in some ways by acknowledging that the grandmother is the powerful person in the house, then by working with her, you will actually move the whole family forward. That is how I would see it and that is how I would work (Helen: 254-262) [sic]

> Fiona: What are the best things about working with people who are from other cultures?
> Sophie: (Pause) I think, em (pause) it is being that a lot of them do have a lot of extended family support and you often get to know the whole family and it isn't just the mother, it is the whole family, the extended family which is nice (Stephanie: 25-28).

I guess the question remains, Nonetheless, what are the qualities which make Sophie and Helen confident to focus on the **'relationship journey'** with their clients, when many of the other health visitors appeared to stumble and focus on the **'cross cultural terrain'**?

Interview 10 - Ruth

Ruth was very reluctant to discuss issues of culture and gave very brief, concise answers. She only said that she had worked in the North East of England for the last 10 years, but did not expand on that. Her current post as a health visitor was in a city centre, as a generic health visitor. She said that they had a few clients who she described as BME clients. This was a difficult interview and I came away feeling frustrated that the further I probed in relation to issues of culture, 'race' and ethnicity, the more superficial Ruth's answers appeared to become. Nonetheless, analysis of the data following the interview with Ruth opened up further the category of **'professional boundaries and assertions',** by introducing a new code, **'reduced professional power and increased personal frustration'**. Ruth described it as **'banging your head against a brick wall'**:

> Well, I think you sort of feel people are just telling you what they think you want to hear and then going to do their own thing anyway. Sort of they will do what their mam says anyway and they just nod but are sort of suspicious of you anyway. If the grandmother is there, then you sort of feel you are not going to get anywhere anyway because they will just do what she says and so you feel you are just banging your head against a brick wall sometimes' (Ruth:46-50) [sic]

Following interview 10, it became apparent that Ruth was trying to assert her professional status as a qualified health visitor to overcome

issues of disagreement with her clients. This code was compared and contrasted with previous codes and a new category began to emerge around **'professional boundaries and assertions'** called '**positioning self'** (Appendix G4). In line with grounded theory, theoretical sampling enabled me to gather further data based on the concept of **'positioning self',** by asking subsequent research participants questions about how they viewed their role in cross cultural work. **'Positioning self'** is further developed in interviews 14-17 and became an important conceptual category in the development of the substantive theory (Appendix H3).

One concern I had during interview 10 was that the further I probed with Ruth into the issues of culture and race, the more superficial I felt the answers became. In probing deeper, the interviews appeared to elicit shallower answers. Axial coding was suspended while I grappled with this, as the research diaries demonstrate below:

Figure 3.21 Research diary: difficulty getting through 12 January 2009

12 January 2009_Research diary

Difficulty of 'getting through'…participants close down and I try to probe deeper

I have been reflecting on the last three interviews which I have done and it appears that the harder I try to probe, the less depth I seem to obtain in the interviews. It is almost as if the harder I probe, the shallower the responses seem. I am aware that issues of 'race' are politically contentious and no-one wants to be seen in any way as racist but I can't seem to get beyond this. I need to employ some new strategies to deal with this more effectively but I am not sure what to do.

Figure 3.22 Research diary: supervision support meeting 19 May 2009

19 May 2009_Research diary

Supervision support meeting

What a breakthrough! I spoke with my supervisor last week about the issue of probing further and participants withdrawing more. This is when I really feel my inexperience as a researcher. I was given some really useful techniques to help to probe deeper without appearing to ask threatening questions which cause the client to close down. In particular she suggested that I use the following questions:

- Research shows that…what do you think?
- You obviously have many years of experience as a health visitor, what advice would you give to a new health visitor who was going to work with people who are from other cultures for the first time?
- How have you changed over time in your work with people who are from other cultures?
- I was reading about a piece of research which highlighted ……., what do you think of this?
- One of the things some of the health visitors I have interviewed have said is …… Can you relate to that in any way?

Using the interview techniques as described in the research diary above proved to be a real breakthrough in the research process. The subsequent interviews elicited much richer data and contradictions in the narrative story of the health visitors were uncovered.

Interview 11 - Stephanie

Stephanie has been a health visitor for over 1 year and prior to that, worked as a paediatric nurse. She has worked in various communities as a health visitor, including some rural locations but had been in her post for 4 years in a central city location.

Data analysis from interview 11 raised many codes, which had previously been opened up but the most important area of interest that emerged from this interview was in relation to the concept of '**changing face of health visiting'**. Health visiting appears to be sandwiched between competing agendas, of **'equality of service'**, **'pressures of time'** and **'universal provision…specialist intervention'**. The initial literature review (Chapter 2) and the situational mapping (Appendix D4) were important analytical tools in expanding this category. In the initial literature review, I had investigated the scholarly material around health visiting in the contemporary context, and this was used to inform the data analysis following Stephanie's interview, as the memo below demonstrates:

Figure 3.23 Theoretical memo: universal provision…specialist intervention 17 Feb. 2009

17 February 2009_ Theoretical memo

Compare and contrast memo: 'equality of service' and 'universal provision…specialist intervention'

Stephanie was very concerned about whether health visitors should give specialist provision (and additional time) or universal provision and treat everyone exactly the same. Stephanie was concerned with **'equality of service':**

> Stephanie: They (cross cultural clients) really do appreciate a home visit and so we do it more but then we are sort of , em constrained, em we are only supposed to offer a couple of visits but our team leader is very good and she just says , so as often as you need to, which is what you do but sometimes people say to you, you know you should just do your two visits but you know, you can try them to come to clinic but you know they don't want to come out or can't come out so what can you do, especially if they are depressed (Stephanie: 105-110) [sic]

This was compared to similar concerns raised by Rebecca in interview 2, where the code **'universal provision…meeting specialist needs'** was raised:

> Rebecca: I quite often take a crib sheet, it is awful really but I don't want to miss anything and not give the level of service that I give to everyone else and I feel that they are entitled to that and I feel that it would be wrong of me to miss something out, so I just do that then I know I have given this mum 100%. (Rebecca:195-198) [sic]

Emma approached her clients across cultures as **'all equal…all the same'**:

> Emma: It just kind of goes in phases but I do think everyone would have, em the same, otherwise it becomes quite a cliché doesn't it. I think it just emphasises different people. Even saying the Bangladeshi health visitor, the families had all the access to the safety gates and equipment that, you know other families who were in the same area couldn't have access to that, so that to me just generates ill feeling which is the exact opposite to what you are trying to do and I think just how illogical is that?(Emma:165-170)

Two concurrent things appear to be operating here, firstly health visitors struggle to know whether they are a universal service and give a universal service, or a specialist service and should give more time and resources to those in the greatest need. The literature review in Chapter 2.2 supports this. The second, and very interesting code is the one **'all equal…all the same'**. Emma uses this approach to ensure equality of provision but there is a danger that it is also used to avoid meaningful engagement across cultures. By treating everyone as the same, it does not allow for good culturally sensitive practice. Is this an avoidance technique? This needs to be explored further and possibly opened up further in subsequent interviews.

Interviews 8-11 had opened up many new categories, and concurrent data and analysis and comparison of data had moved some open categories towards more focused (axial) coding.

Several axial codes emerged at this stage, although many of the tentative categories from previous data analysis remained open and underdeveloped, as the table below illustrates:

Table 3.4 Axial codes and related open codes Interviews 1 -11

Axial codes	Open codes
Focus on cultural terrain	**Solid ground** Culture as 'other' Essentialised ground Surprised by the 'other' **Uncertain ground** • Things beyond interpretation • Finding common ground • Middle ground • Meeting them half way • Working in the dark at the coal face • Losing confidence • Cultural boundaries or cultural mist? • Overwhelmed by relativity • Standing on uncertain ground • Skidding on ice and can't get a grip • Unsupported by management **Dangerous ground** • Playing the racism card • Treading on glass • Political correctness • Watching your back • Not pushing forward on child protection • Waiting to be tripped up
Treading lightly on cultural terrain	**Porous boundaries** Culture as fluid Negotiated identities Comfort with complexity Negotiated identities **Relational journeys**

	• Establishing trust • Empathy in having lived abroad • Mutual respect • Feeling comfortable and relaxed • Confident to challenge • Changing over time – becoming more comfortable and relaxed • Taking it on board • Exploring and marrying it up • Confident to challenge • Empowering clients • Fight against injustice
Emotional engagement **Emotional avoidance** **Emotional flux**	Being open Asking feeling comfortable Emotional flexibility Anger against injustice Banging your head against a brick wall _____ Closing down; protecting self _____ Anxiety in cross cultural encounters Anger in cross cultural encounters Anger people don't integrate Opening up…closing down
Family as barrier **Family engagement**	Behind the shield of the extended family Getting mum alone Intimidated by the extended family _____ Working in partnership with extended families Moving the whole family forward
Active client resistance	
Relational journeys **Hesitant**	 When to probe…when to accept Under the gaze of the cultural 'other'

relationships	Unknown Untrustworthy Need someone to explain the little things 'They' find it hard to express how they feel 'They' don't understand us Gaps in interpretation Lacking trust with interpreters Interpretation as a three way conversation 'Other' cultures beyond reach Things lost in interpretation Things hidden in culture Active client resistance Interpreter as barrier Not having the language to use
Taking a tool kit	Toolkit of knowledge • Lacking knowledge and back up Toolkit of experience • Learning on the job • Trial and error • Take the ball and see what we can do with it • Exploring and marrying it up • Taking on board • Learning to ask • Explore and learn Toolkit of frameworks and assessment • Having a framework • Frustrated with framework assessments Toolkit rendered ineffective
Positioning self	Professional status devalued 'They' don't know what our role is Reduced professional power and increased personal frustration

Integration vs specialist provision	Universal provision…meeting specialist needs All equal but different services…or the same? Damage caused by specialist BME teams Specialist provision unfairly advantages BME groups The contradiction of equality and diversity training All equal...all the same Equality of service
Avoiding racism	Racism exists but it's not the norm Take it or leave it menu Not asking and not looking

Interviews 12-14

Interview 12 – Denise

Denise worked in a city centre and had been health visiting for over 5 years. She had previously worked as a hospital based nurse in an acute setting and was returning to do that in the near future. She worked within a supportive health visiting team, and the area she worked in had a relatively large number of BME clients for the city.

Denise presented a strong discourse around the **'role of women'** and **'women as oppressed'**. The cross cultural ground she walked on was **'solid essentialised ground'**. Insights from this interview helped to open up the categories:

- **'Solid essentialised ground'**
- **'woman as oppressed'**

- **‘the role of women’**
- **‘behind the shield of the family’**
- **‘home of confinement…public spaces of freedom’**

These codes were categorised as **‘leaving norms and values’**. I grappled with the additional data in this interview, and began to understand that all health visitors are on a **‘relational journey’** with their clients, but for some there are barriers, which prevented some of the health visitors from truly engaging across cultures. **‘Relational journeys through culture’** was identified at this stage in the research, although was not recognised as one of the core variables until much later in the research process. **‘Barriers to moving forward on cultural terrain’** also emerged as a category, which required further interrogation. This appeared to be getting to the central themes in the research, and the research was clearly moving forward towards answering some of the core questions initially posed by this study.

Figure 3.24Theoretical memo: barriers to moving forward 9 March 2009

9th March 2009_ Theoretical memo
'Barriers to moving forward on to cultural terrain' – categories identified so far:

Cultural terrain – *the nature of the terrain itself*

- Uncertain terrain
- Dangerous terrain

Relational barriers through culture – *barriers to forming a therapeutic relationship with clients*

- Hesitant relationships
- When to probe…when to accept
- Under the gaze of the cultural 'other'
- Unknown
- Untrustworthy
- Need someone to explain the little things
- 'They' find it hard to express how they feel
- 'They' don't understand us
- Gaps in interpretation
- Lacking trust with interpreters
- Interpretation as a three way conversation
- 'Other' cultures beyond reach

Toolbox rendered ineffective – *the toolkit which the health visitors usually rely on, they discover doesn't work. This toolkit contains tools of knowledge, experience and framework assessment tools.*

Obstacles in cultural terrain – *things are hidden in culture and there are also barriers in cultural terrain*

- Family as barrier
- Interpreter as barrier
- Working in the dark
- Toolbox doesn't work at the coal face
- Things beyond interpretation
- Things hidden in culture
- Active client resistance
- Not having a language to use

Emotional barriers – *emotions expressed are fear, anxiety, anger and empathy so far. How do these influence engagement across cultures?*

- Emotional avoidance
- Emotional flux

Strategies employed – *the health visitors seem to employ a range of different strategies to help them in cross cultural work*

- Positioning self
- Taking a toolkit
- Avoiding 'race'

Categories still open

- Integration vs specialist provision - *where does this fit in? Explore further.*

This memo feels like a real breakthrough in the research. There are many barriers experienced by health visitors to working with people from 'other' cultures, but they can all be categorised into three different areas as above. What is the relationship and overlap between these three areas? How do they work together or apart?

In the next interview with Cathy (Interview 13) the **'politicised climate of 'race'** becomes very evident in the hesitancy of speech, and one of the resulting memos compares this with previous interviews. The situational map: historical discourses with 'race', was used again as an analytical tool to explore this conceptual category further (Appendix E5).

Interview 13 - Cathy

Cathy described herself as white and British and had been working as a health visitor for the last 15 years. She had moved around a lot, as her husband was in the armed forces and she had been in the town for the

last 7 years. She had had some experience of working with people who were from BME groups, but mostly second or third generation immigrants and some asylum seekers.

'Am I allowed to say that?' emerged as a new category along with the **'politicised climate of 'race'**. These new categories were held open at this point, but I re-visited this category later in the data analysis in relation to subsequent analysis in relation to **'mapping the ground'.** The diary entry made after the interview with Leah was also returned to during this analysis stage:

Figure 3.25 Research diary: Leah 2 October 2008

2nd October 2008_Research diary

Interview 7_Leah

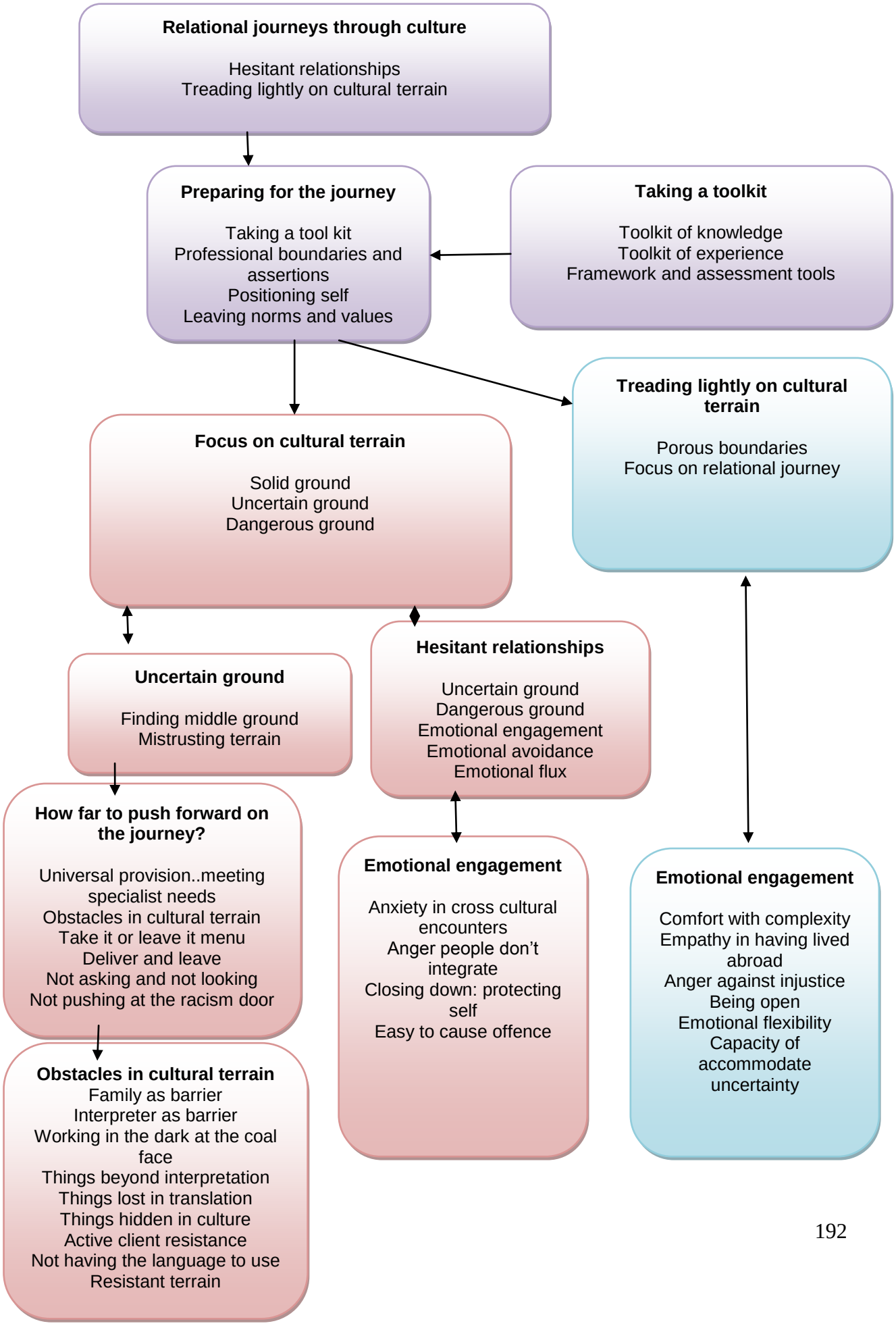
The thing which really struck me about this interview was the difficulty this participant had in articulating her thoughts. I possibly noticed it because it was something I had been aware of with the previous participant in Interview 6. She really struggled at times to finish her sentences and there were many pauses and sentences just seemed to be left hanging in the air. The health visitor didn't appear to be nervous at all and was confident to speak to me but it was as if she was struggling to find the right words to use.

This makes me also think about another interview, I think Interview 2, where I really noticed while transcribing how hesitant the participant was and how many of the sentences were not finished. She spoke very quickly throughout the interview, so I didn't notice it at the time, but while transcribing, there were many unfinished sentences. I must go back and look over Interview 2 again for silences and pauses and compare with my previous interviews. Maybe there is something important here about finding it difficult to talk about issues of 'race' and ethnicity for health visitors.

Using the situational map: historical discourses of ‘race’ (Appendix E5), I was able to expand initial thoughts on the historico-political context of ‘race’ in the UK and the fear and anxiety around that. This was an important step in the building of the core conceptual category **‘emotional hesitation: stabilising uncertain cultural terrain’,** and along with the secondary literature review forms the basis of the discussion around ‘professional-client relationships across cultures’ (Chapter 4.2).

At the end of the first thirteen interviews**,** several conceptual categories had begun to be developed and the relationships between these categories had been explored. These can be summarised in the conceptual relational map below:

Figure 3.26 – Conceptual map: main conceptual/relational categories following interviews 1-13



Many codes and categories still remained open beyond this conceptual map, and were held open to further analysis and investigation. It was difficult to fit the data into categories or tables from this stage of the data analysis onwards, but Corbin and Strauss (2008) reassure qualitative researchers that this is to be expected:

> Qualitative analysis is many things, but it is not a process that can be rigidly codified. What it requires, above all, is an intuitive sense of what is going on in the date; trust in the self and the research process; and the ability to remain creative, flexible, and true to the data all at the same time (p.16).

Interviews 14-21 continued to further refine some of these categories, open up others again, and re-configure others, as the analysis became more detailed and conceptual.

3.3.7.2 Emergent categories leading to secondary literature reviews

A secondary literature review began around interview 11 and continued until the completion of data analysis. The scholarly literature on professional relationships across culture was explored, along with the literature on communication, trust and the nature of 'cultural terrain'(Chapter 4). The result of the literature review indicated that the results from this study concurred with scholarly writing in the area of cross cultural relationships. So far, this research has revealed issues of relationship, communication, trust and interpretation as the most

important concerns health visitors express, when considering their work with clients who are from cultures different to their own. These results are nothing new and there is a plethora of scholarly literature supporting these findings. In order to illuminate new scholarly insights, the dimensions of these **'relational journeys through culture'** needed to be interrogated further, in particular in relation to the ebb and flow of those relationships (Figure 2.27). Also of particular interest at this stage in the research process were the two emerging conceptual categories of **'cultural terrain'** and **'emotional engagement'**, which were explored and expanded in subsequent interviews and emerged as the second core variable **'emotional encounters through cross cultural terrain'** in interviews 17-21. The secondary literature review focused on scholarly material across many disciplines but largely pertaining to the conceptual categories of:

- Relational journeys through culture – professional relationships across culture, communication, trust and interpretation (Chapter 4.2)
- Cross cultural terrain – culture boundaries and health care discourse (Chapter 4.3)
- Emotional engagement through culture – emotion work in nursing (integrated into the discussion in Chapter 5)

Figure 3.27 Advanced memo: moving forward...retreating back 2 April 2009

2 April 2009_Advanced theoretical memo

Moving forward…retreating back: emotional engagement, cross cultural terrain and relational journeys

I really am not sure what is going on here. There seem to be several categories which are related but not explored fully. It is something about **'moving forward'** on to **'cross cultural terrain'** and **'retreating back'** but I am not yet sure what yet. **'Emotional engagement'** with clients across cultures is an important conceptual category but I am still not clear how it intersects with **'cross cultural terrain'** or **'relational journeys'.** The emotions of anger, fear, empathy and anxiety have all been expressed and they appear to shape engagement with clients across cultures.

'Treading lightly on cultural terrain' is where the health visitors do not really focus on **'cross cultural terrain'** but focus on the **'relational journey'** across cultures. They are not anxious about **'cross cultural terrain'** and are rather propelled forward by anger (injustice against the system) or empathy (lived in another culture). This was clear in the narratives of both Helen and Sophie. Emotions drive them forward, but they seem to have much more **'emotional flexibility'** than many of the other health visitors interviewed. Why is this? Is this something they have developed over time? I need to start to ask 'time' questions now. How has practice changed over time?

'Hesitant relationships' should possibly be renamed **'hesitant steps'.** This is where the health visitor appears to want to move forward in a relationship with the clients but meets resistance and did not want to probe or feel able to probe and push further. This was very evident in the narratives of many of the health visitors. Resistance is felt in several ways;

- Active client resistance ('**behind the shield of the family'** and **'culture as control'**)
- Things hidden in culture **('things hidden in language', 'lost in interpretation'**)
- Unstable terrain ('**politicised terrain', 'uncertain terrain', 'easy to cause offence'** and **'mistrusting terrain'**)

The health visitors want to and recognise the value of forming a relationship with clients across cultures but are hesitant because **'cross cultural terrain'** is **'unstable terrain'** and **'resistant terrain'**. What strategies to the health visitors use to help reduce their anxiety and fear? How do they make **'cross cultural terrain'** more stable? I need to go back into the data to explore this further. What 'stabilisation strategies' are used?

'Avoiding cross cultural terrain' occurred when the health visitors just seemed to take information and **'deliver and leave'** or **'take it or leave it menu'**. They also did this when they were **'not asking and not looking'**, particularly in relation to issues of racism and **'not pushing at the racism door'** on child protection issues.

'Emotional door' – is there something here about being emotionally open **('emotional engagement')**to the clients and emotionally closed **('emotional avoidance')** to the client? **'Opening up…closing down'** has already been identified as a conceptual code. How does that fit with the categories above? I seem to have more questions than answers at this stage and all of the interviews I have done so far just raise more and more questions!

3.3.8 Advanced Figures – refining conceptual categories (Selective coding)

'Relational journeys through culture' had become a core conceptual category (selective code), but many categories still remained open and required further investigation until these categories were saturated.

Two different types of journeys had been identified. One group of health visitors focused on the relationship with their clients from other cultures and not specifically the **'cultural terrain',** this was categorised as '**treading lightly on cultural terrain'.** The focus of the second group was on the conceptual **'cross cultural terrain'** and was, therefore, categorised as **'focus on cultural terrain'.** Interviews 14-17 sought to explore the dimensions of both the **'cross cultural terrain',** and the

ways in which the health visitors were managing their emotions throughout the **'relational journey',** and/or through **'cross cultural terrain'.** This was done by opening up some categories, which were not yet saturated. In particular, the researcher investigated the data in three dimensions. Firstly, the **'cultural terrain'** was interrogated. Secondly, the **'relational journey'** was explored, in particular with a focus on the dimension of time. Finally, the '**emotional engagement**' between the health visitors and their clients was explored to a greater depth. In this way, theoretical sampling of the emerging concepts enabled a deeper exploration of the data still not opened up fully and brought new categories to the analysis. All of the new data was coded and compared with previous categories until data saturation was reached and no new categories emerged.

Corbin and Strauss (2008) recommend various analytical tools to open up categories to further investigation and in particular asking questions about time. They suggest using temporal questions such as frequency of events, duration, rate, and timing.

> The use of 'time' related works often denote a change or shift in perceptions, in thoughts, events, or interpretations of events. Time words are words such as when, after, since, before, in case, and if (p.83).

The conceptual category **'cross cultural ground'** had become an almost saturated category at this stage (Appendix H1), but questions remained around pre-entry to that ground. What were the

consequences of emotional engagement to entering or retreating from this **'cross cultural terrain'**? There appeared to be a journey into cultural terrain, but it was at times very hesitant. Questions remained as to the properties of this **'relational journey'** on to **'cross cultural terrain'**. There also appeared to be a relationship to the emotional **'opening up…closing down'** described by the health visitors, as they entered **'cross cultural ground'**. These categories were still very open at this stage and by theoretically sampling based on the conceptual category of **'emotional engagement',** and using 'time' as an analytical tool, the selective codes relating to **'emotional flexibility', 'emotional hesitation'** and **'emotional avoidance'** began to open up (Appendix E2).

In interviews 14-21, several specific research questions were specifically explored. These included questions relating to the time dimensions of relational journeys on to cultural terrain. Questions were asked to interrogate the ways in which the health visitors changed their practice over time and with experience. The dimensions of **'taking and leaving'** were expanded and questions asked as to what things were taken on the **'relational journey through culture'** (Appendix E3).'**Changing over time'** is discussed in the memo below:

Figure 3.28 Theoretical memo: changing over time 4 June 2009

4th June 2009_Theoretical memo

Interview_17 Susan: 'changing over time' and **'the contradictory self'**

> Fiona: You obviously have a lot of experience as a health visitor but I was wondering what advice you would give to a new and inexperienced health visitor about working with people who were from other cultures?
> Susan: Em, (pause) I think just to be yourself, don't be frightened of other cultures, of maybe saying the wrong thing and just be open and don't be frightened of asking them things, because I think you can learn so much from other people and try not to make assumptions and we all do that, you have to or your life wouldn't be worth living and don't assume that because they are from this culture or from that culture they are going to be this way or that way and you often find that people will say, oh Pakistani women won't breast feed and won't give the colostrum but after the colostrum is gone, they start breast feeding you know, so I think that is a racial stereotype and it is not acceptable, so try to examine your own prejudices because we are all prejudiced and there is no need to be frightened of other cultures or frightened of going to see other people because you don't know if you are going to do something wrong, be brave and don't go in with lots of pre-set ideas and just take people as they are and work from there but at the same time learning from what I have learned , be aware of the pitfalls that you might fall into by believing when they say, oh no she doesn't' speak any English and assuming that they don't and often people don't or might not speak a huge amount of English but they do understand a lot and it is just the confidence to say it. It is maybe just to give people from other cultures extra time and to try to explain what you are about and they will understand why you are visiting and it is not about controlling them but about supporting them (Susan:191-209).

There are interesting contradictions here, as this health visitor had previously said that she didn't feel anxious when working with other cultures but she would advise new health visitors **'not to be frightened'**. Is there something about being **'denying to be afraid'**, as it undermines professionalism. This health visitor presented a **'professional self'** at the beginning of the interview and that was very important to her. This interview technique of asking about **'advice to new health visitors'** has elicited rich data, which has otherwise been possibly hidden. Again the 'cross cultural terrain' in conceptualised as **'essentialised ground'** when 'trying not to make assumptions and we all do that'.

Research participant 14 - Beth

The interview with Beth yielded some really interesting and important data. Beth is an experienced health visitor and team leader. She has 16 years of health visiting experience and worked in an inner city area, which had the most diverse population group for that city.

Research participant 15 - Lisa

Lisa described the area she worked within as multicultural, working with different people from different backgrounds. She very much described herself as inexperienced in multicultural working. She has been a health visitor for five years but has worked as a district nurse prior to that.

Research participant 16 - Kate

Kate worked in a small town and described herself as 'half Danish', brought up British but with a Danish mother. She has been qualified as a health visitor for six years and prior to that worked in community care. Her nursing experience spans 30+ years.

Analysis of the data in interviews 14-16 developed many of the existing categories of **'take it or leave it menu'**, **'not asking and not looking', 'not pushing at the at the racism door'** and **'deliver and leave'** into the conceptual category of **'travelling to the perimeter fence of culture'.**

Figure 3.29 Advanced theoretical memo: approaching the perimeter fence 10 April 2009

10 April 2009_Advanced theoretical memo

Approaching the perimeter fence of culture

In earlier Figures, the categories of **'take it or leave it menu', 'not asking and not looking', 'not pushing at the racism door'** and **'deliver it and leave'** were all identified but they have not been brought together into a conceptual category until now. The interview with Denise (interview 12) raised many of these codes again and this prompted further theoretical exploration.

> Fiona: have any of your clients talked to you about racist attacks they may have suffered?
> Denise: Within their own culture?
> Fiona: Any really. Do people disclose that.
> Denise: I don't think it would be frequent and I certainly don't remember any (pause) em (pause) because that would be quite shocking really, it is the sort of thing that always comes up in the assessment framework around community resources and accessing community resources and about your neighbours and antisocial behaviour and personally I can't think of any families.
> Fiona: Would you ask that question specifically or more generally?
> Denise: More generally really. Do you like living here, do you get on with your neighbours that sort of thing really, do you know people nearby that sort of thing really because obviously where you live and your home conditions affect your health as much as anything else really. So I don't think I would come out and directly and ask that question really.(Denise: 129-140) [sic]

In the **'relational journey'** with clients across cultures, the health visitors thus far have been categorised as either **'treading lightly on cross cultural terrain'** or as **'travelling hesitantly across cultural** terrain' but there are also a small group of health visitors who do not enter cross cultural terrain at all but are merely **'travelling to the perimeter fence of culture'.** They avoid meaningful engagement with their clients across cultures by either delivering the information and leaving, not asking questions in relation to culture or 'race' or by giving information for the client to either accept or reject, but they do not seem to mind either outcome.

> Fiona: How far do you feel you can push your advice?
> Alice: Well, you can literally, you can just keep on emphasising the information really. If it is not being detrimental to the children's health then you can just leave it there really and just leave the lines of communication open really. You just say, give us a ring and encourage them to come to the clinic really. We don't really have a good attendance at the clinic really (Alice: 157-161) [sic]

Why do some health visitors do this? Is it anxiety? Ignorance? What is the connection between this and the **'all equal…all the same'** agenda? What is the emotional dimension of this? These need to be explored further to understand the connections between emotion and avoidance on the one hand and emotion and engagement on the other.

'Relational journeys through culture' became conceptualised as happening in different stages, namely **'envisioning the journey', 'stepping forward', 'treading lightly on cultural terrain'** and **'retreating back'**.

Figure 3.30 Advanced theoretical memo: preparing for the journey 8 June 2009

8 June 2009_Advanced theoretical Figure

'Preparing for the cross cultural journey'

There seems to be something really interesting going on with the results from this research. Participants either appear to focus on the **'cross cultural terrain'** they are standing on, such a **'solid ground', 'uncertain ground' or 'dangerous ground'** or they focus on the 'relationship' of the client/professional. There are two different categories emerging relating to **'cultural ground'** or **'cultural journeys'**. Both groups of health visitors, Nonetheless appear to **'prepare for the encounter'**. This is an important area I have not really explored in previous interviews. I intend to explore this further in subsequent interviews. How do the health visitors position themselves before the cross cultural encounter? **'Professional self'** has come out so far, but this needs to be explored further. Also, what do they take with them to the cross cultural encounter? **'Taking a toolkit'** has already been identified as a category, but what does it contain? What if it doesn't work? Issues of power in the relationship should also be explored in relation to **'envisioning the journey'.**

'Preparing for the cross cultural journey' has not been opened up enough and it is an area I have closed down prematurely, but there appear to be important themes which have emerged and need to be re-examined.

'Envisioning the journey' began to emerge as a strong conceptual category. It became apparent during this stage of analysis that some of the categories needed to be re-opened, as they were not fully saturated and were absent from the categories above. This was in particular in relation to the categories identified as:

1. Taking a toolbox
2. Leaving values behind

3. Positioning self

4. Mapping cultural ground

5. When toolkit is rendered ineffective

These categories were again opened up and re-examined. This moved the data analysis further towards selective coding.

Figure 3.31 Advanced summary memo: envisioning the journey 20 June 2009

20 June 2009_Advanced sum

'Envisioning the journey', 'mapping the terrain' and **'moving forward...retreating back'**

Mapping the terrain

- Mistrusting terrain
- Negotiated terrain
- Uncertain terrain
- Active client resistance
- Not having the language to use
- Politicised terrain
- Things hidden in cultural terrain
- Scared to offend
- Dangerous terrain
- Culture as control

Positioning self

- Professional self
- Activist self
- White self
- Friend self

Positioning 'other'

- Stereotyping
- Non-Westernised
- Non white

Taking and leaving

- Taking a toolbox
- Silencing your voice
- Challenging gender norms
- Leaving values behind

Treading lightly on cross cultural terrain

- Establishing trust
- Listening and learning
- Exploring and marrying it up
- Taking the ball and see what we can do with it
- Walking together against injustice
- Experience of living in other cultures
- Working together with the family
- Treading lightly on cultural terrain

'Changing relational journeys over time' has emerged as a conceptual category and needs to be interrogated in relation to the categories of **'stepping forward towards cross cultural terrain', 'approaching the perimeter fence'** and **'moving forward...retreating back'.** The health visitors change over time and this is related to '**emotional engagement'** as well as having the **'tools of knowledge'** and the **'tools of experience'**. Does developing knowledge over time, increase emotional engagement? What are the dimensions of this **'emotional engagement through culture'**?

Following coding, further data analysis and comparison of the open codes and categories indicated that these categories were too rigid. The reality of the health visitor's experiences was understood to be much more fluid than previously conceptualised. The health visitors did not fit in to these 'neat' categories, they were much more fluid, more of an ebb and flow into cultural terrain, opening up and then moving forward or retreating back. The health visitors could not be neatly categorised into groups, those who were **'treading lightly on cultural terrain'** and those who embarked on a **'relational journey into cultural terrain'.** In Glaser's (1978) words, what was needed was to 'weave the fractured story back together' (p.72).In breaking the interview data down into word-by-word and line-by-line coding many areas were illuminated, but at the same time the overall narrative of the

interviews were in danger of being lost in the analysis. In order to further tell an analytical story these codes needed to be re-considered. The researcher went back to the original interviews again and read them as a whole, to get an overall feel for the data. The result of this was the realisation that for every health visitor they were entering a **'relational journey through culture'**. This journey was not a choice, but part of their professional work, but the choice remained for them, as to how far they travelled on the journey. For some, the journey was only **'travelling to the perimeter fence of cultural terrain'**, for others it was **'travelling through cross cultural terrain'** and still others journeyed together with the clients and were **'treading lightly on cross cultural terrain'**.

'Relational journeys through culture' were an important conceptual category, but still something appeared to be missing in the data analysis. Following careful data analysis and an exploration of previous categories, the elusive question of **'emotional engagement',** which had been identified in the initial axial coding began to be interrogated in much greater depth, and previously under explored categories were opened up again. In interrogating the dynamics of the **'relational journeys through culture'** the question had changed from an exploration of the details of the journey, but to ask rather what caused some health visitors to move forward into cultural terrain, others to stop at the perimeter fence and still others to move forward in therapeutic relationships across cultures? It was during this final analysis that the second core category, **'emotional encounters through cultural**

terrain' was identified (Appendix H2) and the three core variables uncovered:

1. **Emotional flexibility: treading lightly on cross cultural terrain**
2. **Emotional hesitation: stabilising uncertain cultural terrain**
3. **Emotional avoidance: travelling to the perimeter fence of cultural terrain**

3.3.9 Theoretical sampling and seeking specific new data

In subsequent interviews not one of the interviewees brought up the subject of racism until asked specifically by the interviewer, and by theoretically sampling the questions in this way, the conceptual category of **'not pushing at the racism door'** was uncovered. The advanced memo below explains this further:

Figure 3.32 Advanced theoretical memo: emotional dimensions of the perimeter fence 27 June 2009

27 June 2009_Advanced theoretical memo
'Emotional dimensions of the perimeter fence'

Although **'avoiding the perimeter fence'** has been explored through health visitors using the 'take it and leave it menu', there is comparison with the conceptual categories in relation to **'not asking and not looking'** and **'avoiding 'race'**. A strategy emerges whereby health visitors manage uncertainty and anxiety both around early Figures on **'dangerous spaces'** and **'stumbling over the vocabulary of 'race'.** These can all be brought under the conceptual category of **'approaching the perimeter fence'** because not only do they not enter cultural ground but they do not engage with cultural issues, although many of the health visitors interviewed were aware of racism issues.

The interview with Annett earlier this month really brought it to my attention again and a re-examination of the conceptual category **'travelling to the perimeter fence'** is not only a **'take it or leave it menu'** but also a strategy employed by health visitors in **'avoiding 'race'**.

> Fiona: Have clients ever disclose racist abuse to you as a health visitor?
> Annette: No I don't think it was, the area I worked in was (name of area),.where there was a much bigger ethnic sort of group and they tended to all sort of live together in the same roads and everyone in their area would be from a similar background, em so I think they would be fairly well supported and they didn't' stand out at all in their community. I am not saying that it didn't happen, but I think that they were fairly cushioned and protected where they lived. So no, it was never really brought to my attention, no, no' (Annette:164-170) [sic]

> Fiona: Do your clients ever speak to you of their experience of racism?
> Rebecca: I have only ever had one family and they had something written on their door but it was in another language, I didn't understand it but they said it was a racist culture, but it was obviously from their culture. It was in a foreign language and they just scrubbed it away, but on the whole I haven't really heard any. I think it does happen (Rebecca:292-296) [sic]

Re-working of these conceptual categories points towards a new selective code of **'emotional avoidance: travelling to the perimeter fence of cultural terrain'.** In avoiding the uncertainty and fear which both talk of racism and **'stumbling over the vocabulary of 'race'** and also of engaging with the emotions of the racism question, the health visitors cope by **'avoiding 'race'** and **'not asking and not looking'**. Annette was particularly hesitant;

> Annette: 'of all of the areas I have worked, latterly at (this town) it was predominantly a, em (pause) em a white ethnic background, there were very few families who were from , em (pause) em, other countries , em, I would say in (this town)) some of the extended families who were really settled, really integrated into the community' (Annette:8-11)[sic]

This is especially interesting as most of the health visitors said they were aware of racism in UK communities but failed to ask about it. The question remains as to how this impacts professional practice? I will continue to theoretically sample and explore the **'avoiding race'** by asking directly about racism with the health visitors. It is an area of 'silence' – why? Why do the health visitors avoid engagement by **'not asking'**.

In exploring the **'health visitor self'** the following memo is also an example of the way theoretical sampling occurred throughout the research process.

Figure 3.33 Theoretical memo: health visitor self 25 June 2009

25th June 2009_Theoretical memo
'Positioning self'

Health visitor self

The health visitors describe themselves in terms of **'professional self'**, **'friend self'**, **'white self', 'maternal self'** or **'activist self'**.

Professional self

> Helen: well, in the end I am the professional and I have a professional responsibility to give the best care I can and that is what I do (Helen: 98-99)[sic]

Several of the health visitors described themselves in professional terms, asserting their professional identity especially when there was controversy.

Assertive self

> Annette: Right, I think it was very important to make it known that this was normal, we weren't picking on you, I think a lot of people thought why is this lady picking on me, why is she coming into my home but to make it clear it is a universal service and every family regardless of race, wealth, where they live will have a nurse as a health visitor come to see you and your child and to help support you. We are not saying we have singled you out, this is a universal service here to support you, we don't think that you have a problem, we do it as a preventative thing so trying to make it, that they didn't have anything to hide and I wasn't trying to check on them, it was more supportive service and trying to get that message through to people (Annette: 36-44) [sic]

Categories of **'friend self', 'white self', 'activist self'** and **'maternal self'** have also been identified in the previous interviews. How does the way the health visitors present themselves to the clients, influence the relationship? The health visitors appear to prepare themselves for the relationship journey – how do they do this? What side of themselves do they present? In future interviews I will theoretically sample the topics for discussion based on the **'health visitor self'** concept and explore that further.

3.3.10 Adopting certain categories as theoretical concepts

The two conceptual categories of **'envisioning the journey'** and **'changing relational journeys over time'** were developed during interviews 17-21 and this was central to the conceptualisation of the core theory **'emotional encounters through cross cultural terrain: shaping relational journeys through culture'.**

Interviews 17-21 confirmed and saturated many of the previous categories, but only one new code was identified, and the data was saturated. At this stage in the research, the final conceptual categories relating to **'emotional engagement'** were explored, interrogated and expanded in relation to the literature, and as a consequence the core categories that constituted **'emotional encounters through cross cultural terrain'** were identified**.** Data collection, coding and constant comparison of codes, and the building of conceptual categories led to the development of a theoretical concept which recognised that in cross cultural working health visitors moved beyond straightforward **'relational journeys through culture'** as had previously been identified. The **'emotional engagement'** which was repeatedly referred to by almost all of the health visitors in this study, led to a re-examination of previous interviews and a thorough literature review in relation to **'emotional engagement'** within professional practice. A full discussion of this is presented in Chapter 5.

Interviews 17-21

Research participant 17- Susan

Susan described herself as white, British and qualified as a health visitor 35 years ago. She has extensive experience of working in many cities across the UK, and has worked in areas she described as multicultural, but was careful to ascertain that she was not an expert in this area. **'Denying uncertainty'** was developed from earlier codes and emerged as a **'hidden work'**. This is discussed in full in the discussion chapter of the thesis (Chapter 5).

Research participant 18 - Annette

Annette described herself as white, female and British. She qualified as a health visitor 20+ years ago, and has worked in various locations in the North East of England during this time. She is currently in a small town, which she describes as having a diverse mix of people.

'Relational journeys' were very important to this health visitor, but the category her interview really opened up was in relation to '**changing face of health visiting'**. Theoretical memos were compared with interview 11, particularly in relation to the categories of **'equality of service'**, **'pressures of time'** and **'universal provision…specialist intervention'**. A new code was also identified **'not what I signed up for'**. Following interview 18 with Susan, interrogation of the strategies employed by health visitors to **'stabilise uncertain terrain'** became a

major focus of enquiry. The categories of **'re-working the equality agenda: all equal…all the same'** and **'asserting the professional self'** were developed into selective codes (Appendix H6).

Research participant 19 - Olivia

Olivia described herself as white, British and worked in a specialist health visitor role for travellers. She asserted the importance of 'respecting and moving forward'. Olivia was also very 'possessive' with her clients and categorised as **'protector self'**. Olivia guarded the cultural ground and took on the role of the **'protector self'**. This again adds another dimension to the category of **'health visitor self'**.

Research participant 20 - Jessica

Jessica described herself as white, British and female**.** She has been a health visitor for three years and works mainly in an area which has many Polish migrants. She said that she did not have any experience with BME clients, and the town she worked in did not have any BME clients either. Her experience was around Polish migrant workers.

No new codes emerged following this interview, and many of the codes confirmed previous codes rather than expanded any categories or new areas of enquiry. **'Cultural ground'** was again confirmed as '**essentialised ground'** and was characterised by **'uncertainty'** and **'anxiety'**.

Research participant 21- Alexandra

Alexandra had worked in a multicultural area for 6 years, although she worked in a generic health visiting role. She described herself as white, female and Scottish. She said that she would like to work in a more multicultural area, but she only had a few clients who were from BME communities. Again the role of **'universal provision…specialist need'** was a dominant theme throughout this interview.

During interviews 17-21 and through constant comparison of the emerging categories, the core variables of the theoretical construct were identified. These core variables (selective codes) were identified as **'emotional flexibility: treading lightly on cross cultural terrain', 'emotional hesitation: stabilising uncertain cultural terrain'** and **'emotional avoidance: travelling to the perimeter fence of culture'**. These three variables together made up the conceptual category **'emotional encounters through cross cultural terrain',** and along with the conceptual category **'relational journeys through culture',** together these variables formed the substantive theory **'emotional encounters through cross cultural terrain: shaping relational journeys through culture'**.

3.3.11 Sorting memos

Throughout this chapter and by using many examples of theoretical memos, I sought to demonstrate how theoretical memos were used from the beginning of this piece of research until the end to identify

codes, compare categories and create theoretical concept, which resulted in the theoretical category of **'emotional encounters through cross cultural terrain: shaping relational journeys through culture'**. Memos were written, compared, contrasted and sorted until the theoretical concept became evident. In this way, I adhered to the methodology required by constructivist grounded theory to ensure that the finished grounded theory:

> Explains the studied process in new theoretical terms, explicates the properties of the theoretical categories, and demonstrates the causes and conditions under which the process emerges and varies, and delineates its consequences (Charmaz, 2006, p.8).

This study sought, in line with many other constructivist grounded theorists, to offer an interpretation of the studied world and does not duplicate an exact picture of it (Charmaz, 2006; Guba and Lincoln, 1994; Denzin and Lincoln, 2008). Theoretical memos were sorted and compared to construct a picture of that reality, which was acceptable to the health visitors involved in the study.

3.3.12 Integrating memos and diagramming concepts

Throughout the research process memos and diaries were written to interrogate the emerging codes and conceptual categories. Situational analysis (Clarke, 2005) was used as an additional means of analysing the data for both contextual and discursive material. As the research

progressed, the memos became more theoretical and conceptual, as earlier memos were integrated and selective codes emerged. The diagrammatical representation of conceptual categories was also used near the end of the data analysis, as a means of visual representation of the substantive theory, but it was found to be inadequate to represent the complexity of the theory. An attempt is given in the diagrams below:

Figure 3.34 Diagram - relational journeys through culture: treading lightly on cultural terrain

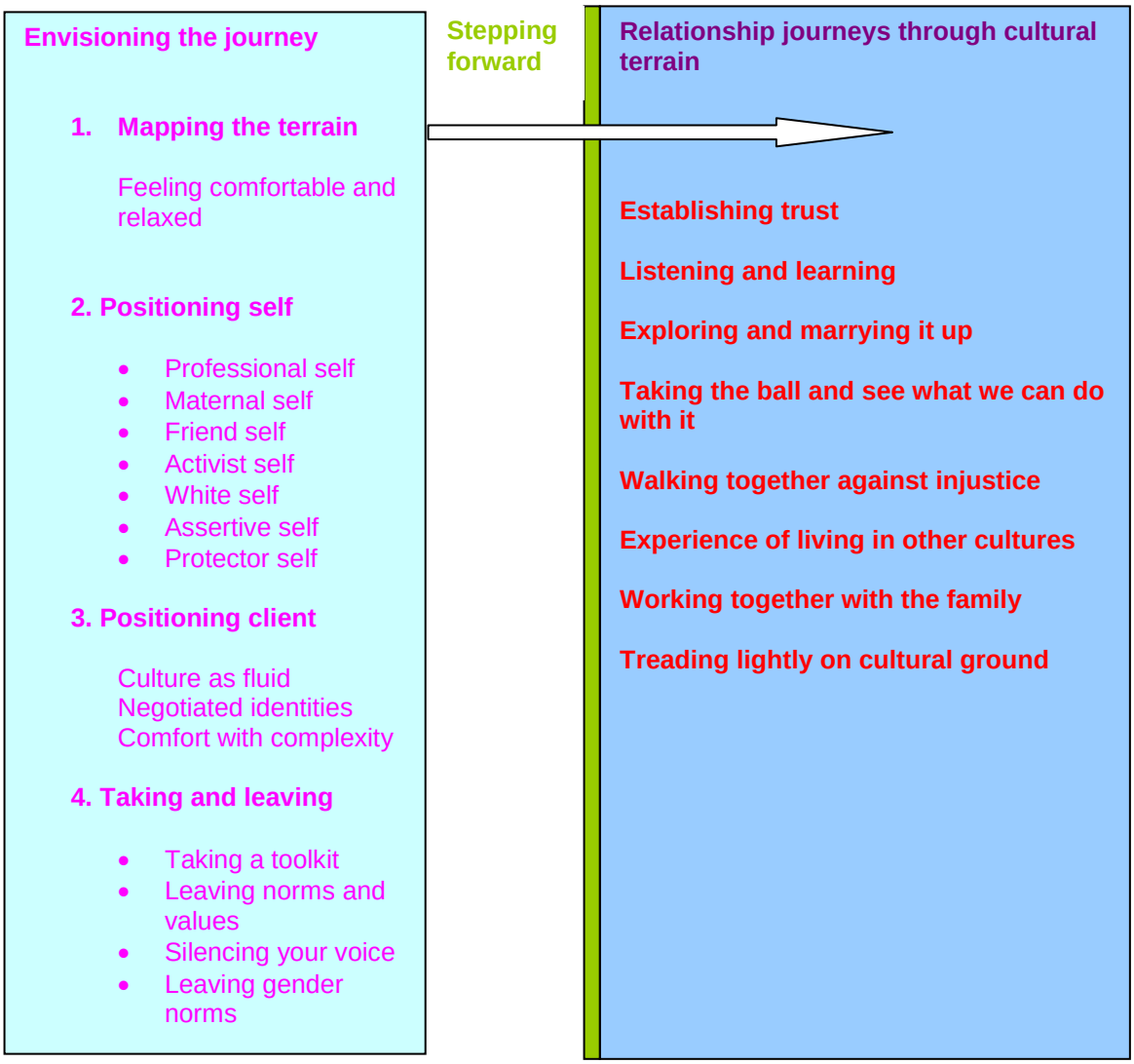


Figure 3.35 Diagram - Relational journeys through culture: travelling only to the perimeter fence of culture

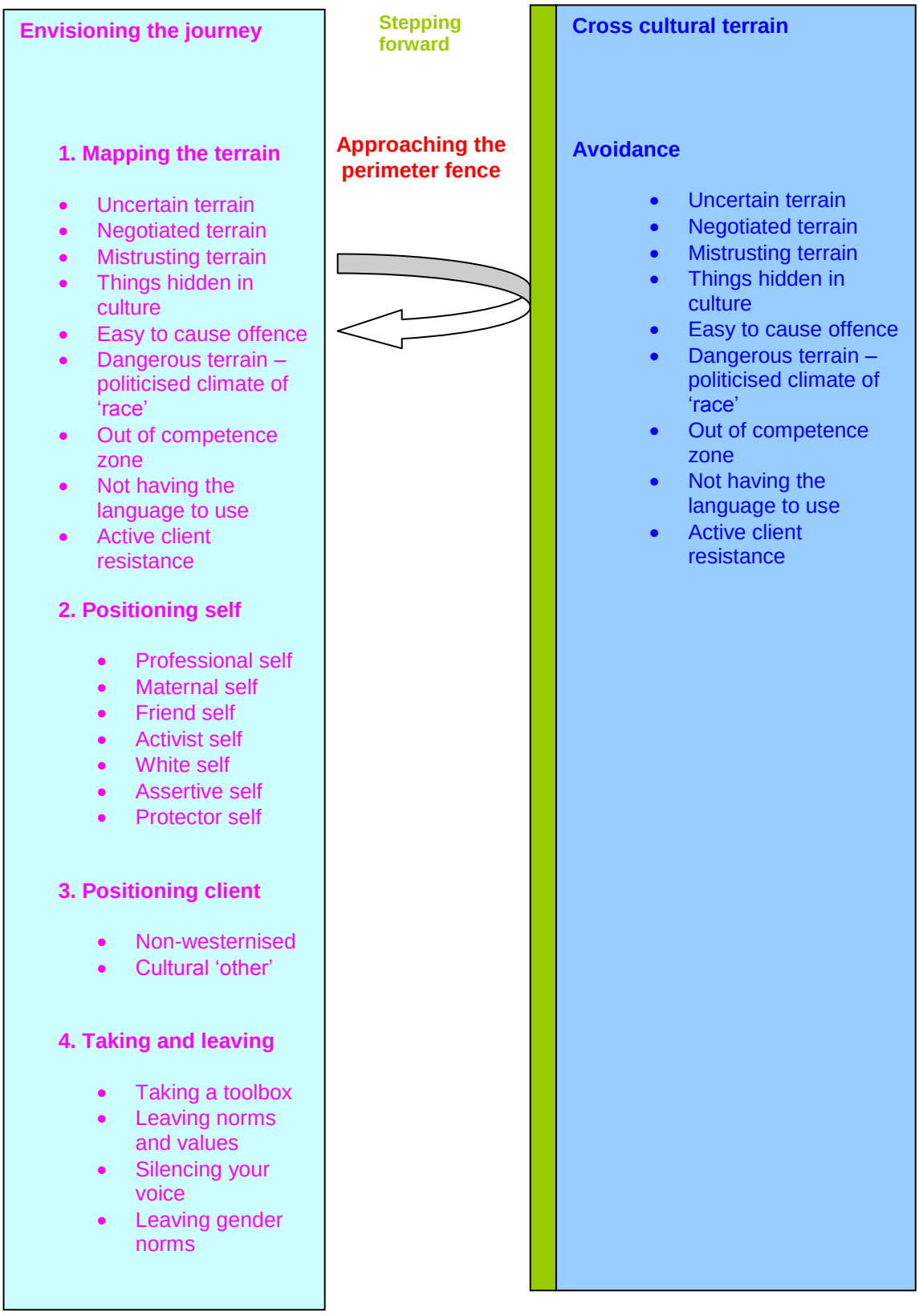
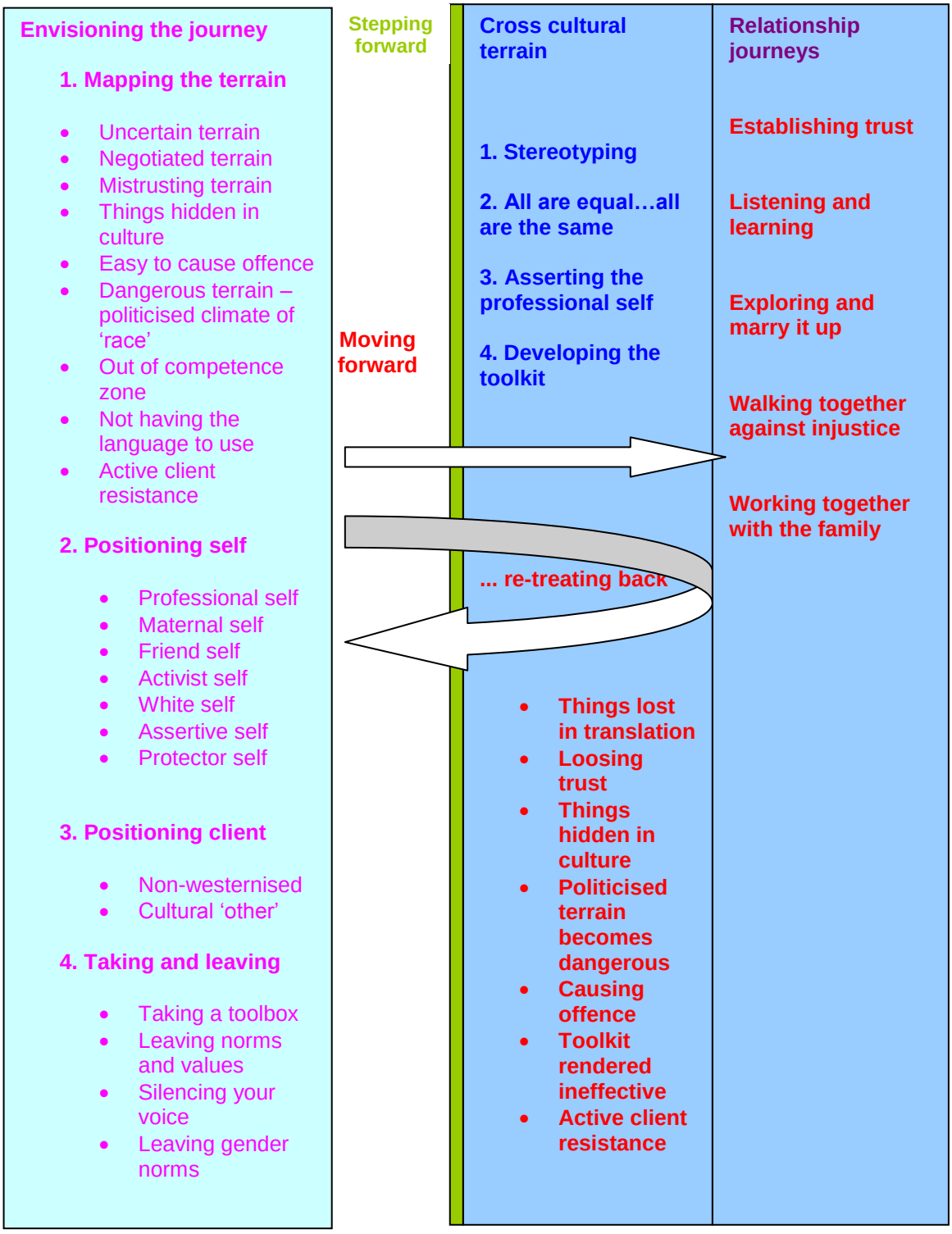


Figure 3.36 Diagram - relational journeys through culture: stabilising uncertain terrain



3.4 Summary of findings and construction of conceptual theory

In exploring with practising health visitors in the North East of England their experiences of working with clients who are from cultures different to their own, health visitors identify three areas of practice that are important to them. These are described as:

1. Relationship building
2. Metaphorical ‘Cross cultural terrain’
3. Managing emotions

The complex ways in which these three areas intersect with each other is what shapes professional engagement across cultures.

3.4.1 Relationship building

The formation and building of relationships between health visitors and their clients across cultures is the central theme health visitors choose to discuss when giving accounts of their work across cultures. There were many positive aspects to building relationships across cultures, including being excited about other cultures, but the main focus of the health visitors were on the barriers to forming relationships across cultures.

The main barriers the health visitors expressed to forming effective relationships with their clients across cultures were focused around poor communication, mistrust and problems with interpretation. The importance of building relationships across cultures is firmly established within nursing discourse and scholarly writing, and Dewey (1934; 1980) alerts us to seek a new vision of the phenomena under study:

> If the artist does not perfect a new vision in his process of doing, he acts mechanically and repeats some old model fixed like a blueprint in his mind (p.50)

In seeking a new vision of the ways in which health visitors work with clients across cultures, it is to the ways in which the health visitors in this study conceptualised working across cultures, as not only entering a **'relational journey'** with their clients that the reader is directed, but to the idea that these relational journeys, firstly, occurred by travelling through **'cross cultural terrain'** and, secondly, that the ability of the health visitors to engage (or not) with their clients was driven in part by their ability to manage their emotions. The relational journey was conceptualised as **'relational journeys through culture'** and the emotional engagement (or avoidance) was conceptualised as **'emotional encounters through cross cultural terrain'**. These two core variables made up the final conceptual theory **'emotional encounters through cross cultural terrain: shaping relational journeys through culture'.**

New theoretical insights uncovered during this research indicate that the **'relational journey'** the health visitors entered with their clients across cultures was shaped by three interconnected aspects, namely:

1. The ways in which the health visitors were **'envisioning the journey'**
2. The perceptions held by the health visitors of **'cross cultural terrain'**
3. The ability of health visitors to manage their emotions when working on **'cross cultural terrain'**

3.4.2 'Envisioning the journey'

In **'envisioning the journey'** the health visitors conceptually developed four areas of visualisation prior to embarking on a **'relational journey'** with their clients across cultures. These four areas were:

1. **Mapping the terrain**
2. **Positioning self**
3. **Positioning the 'other'**
4. **Taking and leaving**

The constitutive elements of these are diagrammatically represented in the situational maps (Appendix E), but the important concepts that were developed to inform this study were **'positioning self'** and **'taking and leaving'**. In **'positioning self'** the health visitors were also **'asserting the professional self'** and this was identified as a strategy used by some health visitors to **'stabilise uncertain cultural terrain'**. In **'taking and leaving'** the health visitors were **'taking a toolkit'** of knowledge,

experience and assessment frameworks, which were **'necessary tools for the job'**. **'Taking a toolkit'** helped the health visitors to feel more confident on **'cross cultural terrain'** but, importantly, often the health visitors found that their **'toolkit'** was **'rendered ineffective'** in cross cultural terrain.

3.4.3 'Cross cultural terrain'

'Cross cultural terrain' was conceptualised by the majority of health visitors (17 out of 21) in this study as a cultural space, which was categorised as **'unstable terrain'**. This **'cross cultural terrain'** was conceptualised in **'mapping the terrain'** as:

- Uncertain terrain
- Negotiated terrain
- Mistrusting terrain
- Things hidden in cultural terrain
- Easy to offend
- Dangerous terrain – politicised climate of 'race'
- Out of competence zone
- Not having the language to use
- Active client resistance

Rebecca, referring to her clients from 'other' cultures as 'they' summarised her perspective in the extract below:

> (Pause) I think it is always fascinating to see how they perceive us and they think what we do is wrong and what they do is right and it is about trying to find a common ground that we can both agree on, because some of their things are so extreme and some of ours are so extreme and it is about trying to find a common ground that we can work on really (Rebecca: 6-10)[sic].

The secondary literature review revealed a plethora of scholarly writing within nursing and health care discourse in relation to the issue of relationship building and culture, but often conceptualise communication as within a vacuum. This research demonstrates that relationships across cultures do not exist in a vacuum, but are shaped by the socio-historical and political context of 'race' and culture in the UK. This was identified in the situational maps written throughout the research and is developed further in the discussion in chapter 5.

3.4.4 Managing emotions

The most exciting and interesting finding in this research study lies in relation to **'managing emotions across cultures'** and specifically**,** the power of emotions to shape professional practice. Emotions were identified by the health visitors as very important in their work with clients across cultures, and the most common emotions identified were fear and anxiety but also anger and empathy.

‘**Emotional encounters through cross cultural terrain’** conceptualises the experiences of the health visitors in three different ways and describes the ways in which emotions shape professional practice across culture. The concept **‘emotional encounters through cross cultural terrain’** describes the three different ways the health visitors in this study engaged with their clients across cultures. The core conceptual categories which constituted this theory were:

a) Emotional flexibility: treading lightly on cultural terrain.

b) Emotional hesitation: stabilising uncertain cultural terrain.

c) Emotional avoidance: travelling only to the perimeter fence of cultural terrain.

Only two of the health visitors interviewed were placed into the first category of **‘emotional flexibility: treading lightly on cultural terrain’,** but some elements of this could be seen in the narratives to two other health visitors. The primary focus of this small group of health visitors was on forming relationships with their clients across cultures and not on **‘cross cultural terrain’**. Although aware of culture, their focus was on the relationship and they were not afraid of cultural terrain. Their practice was propelled forward by two emotions, firstly anger **(‘fight against injustice**’) and by empathy (they had all lived abroad for differing time periods in their lives). They were very much **‘walking together with the family’** through cultural terrain, and the health visitors in this category gave a narrative account of very successful cultural engagement and working practices. Emotionally, the health visitors in this category were very flexible and adaptable in their

emotions, able to move across and between cultural groups without anxiety and viewed culture as porous, flexible and complex.

The majority of health visitors interviewed were located within the second conceptual category: **'emotional hesitation: stabilising uncertain cultural terrain'.** In contrast to the first group of health visitors, who walked *with* their clients, this group of health visitors journeyed to a metaphorical **'cross cultural terrain'** to meet with their clients. This was expressed as a place to '**meet in the middle'** and was characterised by negotiation and compromise. The most interesting aspect of this **'cross cultural terrain'** is that it was a place of uncertainty, anxiety and at times fear. Conceptualised as **'uncertain terrain'** the work of the health visitors in cross cultural interactions was to **'stabilise uncertain terrain'.** Further discussion in chapter 4 also highlights the ways in which the work of health visitors in **'stabilising uncertain terrain'** becomes a **'hidden work'** within dominant discourses of evidence based practice, professional 'competency' and an increasingly litigious society.

I identified four ways in which the health visitors in this category sought to '**stabilise uncertain terrain'**. These are conceptualised as:

1. **Fixing a culture: unchanging throughout time** (see Appendix H7). This included stereotyping the cultural 'other' and fixing culture as static over time.

2. Re-writing an equality agenda: the same throughout time (see Appendix H9). The health visitors re-wrote the equality agenda to conceptualise everyone as **'all are equal…all are the same'** and negated cultural difference and the need for cultural adaptation.

3. Asserting a professional identity: undermined over time (see Appendix H10). The health visitors positioned themselves as the **'professional self'** but struggled when they felt their professional status was devalued by their clients as meaningful.

4. Developing a toolkit: strengthened over time (see Appendices H4 and H5). This included a 'toolkit' of knowledge, experience and assessment frameworks.

A full explanation of these **'stabilising strategies'** is given in appendix H6 and the implications of these strategies for practice and education are discussed in chapter 5.

The third, and final conceptual category, **'emotional avoidance: travelling only to the perimeter fence of culture'** applied to only three of the health visitors interviewed. These health visitors avoided entering **'cross cultural terrain'** and, although they were required by their job to engage with clients across cultures, they delivered the information and left, without engaging meaningfully with culture (or their clients) at all. The research identified two primary ways in which they did this, which were categorised as **'take it or leave it menu'** and **'not**

asking'. In the **'take it or leave it menu'**, the health visitors gave health and child care information but did not engage culturally with their clients, but rather left them with the information (and assumed their job was done) and retreated. In the second category, **'not asking and not looking'**, the health visitors did not ask their clients about issues of racism, culture, and it was also suggested child protection issues, and thereby, avoided dealing with the questions raised**. 'Not asking and not looking'** was a strategy to avoid **'unstable cross cultural terrain'.**

> It is just about listening really and make sure that everything they do is safe and that there has been a problem with sterilisation and they haven't understood about sterilisation and have just used tap water and so we had to say, no you mustn't do that, but really we are not really that strict. It is just about finding similar foods that are available to use. You give them information verbally and I have lots of translated stuff and pictures to show them and then you just have to let them get on with it really and if they come back with lots of tummy upsets, then you have to think again but if they are alright, then fingers crossed really (laughs) (Jessica: 127-135)[sic].

Jessica, along with two other health visitors all expected their clients to engage with their own cultural norms and values, to come to the health centre to see them and, although engaging physically with their clients across cultures, there was no evidence in their narratives of emotional engagement. Overall, they were paralysed by fear and anxiety and

consequently only went to the perimeter fence of culture, delivered health information and left.

This research uncovers some of the unacknowledged ways in which emotion clearly shapes professional practice across cultures, and the strategies health visitors employ to manage that emotional engagement. These strategies are discussed more fully in chapter 5.3.2 in relation to **'stabilising uncertain terrain'**. Nonetheless, two of the health visitors were not working to **'stabilise uncertain terrain',** but in contrast were **'emotionally flexible'** and were **'treading lightly on cross cultural terrain'**. The discussion in chapter 5.3.3 focuses around the issue of **'emotional flexibility'** and explores the possible dimensions of this concept. This leads on to a wider discussion of the work of Pierre Bourdieu and explores the current theoretical conceptions of emotional capital, as well as emotional *habitus* (Chapter 5.4).

Finally, the work of the health visitors in this study was to manage their emotions across cultures, but the work of managing uncertainty and anxiety remains a hidden work within current health care discourses of evidence based practice and cultural 'competency' agendas. Chapter 5.5 explores the controversial issue of cultural 'competency' and argues that culture should be an 'art' rather than a science within health care discourse. It is only then that the 'art' of cultural engagement can be practiced, tried and improved. The implications of this for theory, practice and education are discussed in chapter 6.

3.5 Research criteria and limitations

The measurement of quality in qualitative research has received substantial scholarly attention in recent years. Although traditional positivist measures of objectivity, validity and reliability are attempted by some researchers (see Kvale, 2007), many qualitative researchers reject these as inappropriate (Denzin and Lincoln, 2005; Charmaz, 2006; Flick, 2008). In the last few years, more and more checklists have been developed (Patten, 2002; Flick; 2006) with varying degrees of success. Flick (2008) highlights the importance of quality as integral to the whole process of research:

> Quality in qualitative research is more than just defining criteria or standards…it is the result of a series of decisions starting from the formulation of a research question, continuing with finding and using the appropriate methods for working on answering this question (p.137).

Grounded theory was an appropriate research methodology to use in order to ask the original research question in my study. In starting with the experiences of health visitors in their everyday lives, the question started at the 'ground' level and worked up towards theory. Epistemological consistency was used throughout the whole research process and a constructivist perspective was used throughout both the gathering of the data and the theoretical discussion. Charmaz (2006) uses four criteria in order to evaluate quality in grounded theory studies, which are credibility, originality, resonance and usefulness. Each of

these will now be considered in turn, to evaluate the quality of my grounded theory study.

In assessing the credibility of a study, Charmaz (2006) asks several questions in relation to the familiarity of the setting and the depth of data used. In my study, the research achieved familiarity with the setting and topic, as I had worked in community settings in the North East of England and consequently am very familiar with the topic under study. The data was sufficient to merit the claims of the study as health visitors were interviewed until data saturation was achieved. Systematic comparisons were made between the different categories of data and there are strong logical links between the gathered data and my argument (see Chapter 5 for the full discussion). I have also provided a clear and systematic audit trail of my memos and thoughts during the research process for the reader to be able to form an independent assessment of the credibility of my claims.

The originality of my research lies in the final conceptual theory and the new insights I bring to the theoretical conceptualisations of emotions in cross cultural work. My study has implications for practice, education and theory (detailed in Section 6.2-6.4), which are clearly defined and stated. Challenges are also made in my study to the ways in which current theoretical conceptualisation of emotion could be extended through the work of Pierre Bourdieu.

Resonance in grounded theory relates to the depth and breadth of the study. My study portrays the fullness of the experiences of health

visitors in cross cultural work, as told by the health visitors themselves. Taken-for-granted meanings were uncovered, particularly in relation to essential categories of culture and the ‘silence’ around racism. The larger contextual situation of the health visitors was continually referred to through the situational analysis. The results of my study were given back to the participating health visitors and their responses confirmed the study as being recognisable to them.

Finally, my study is useful in several ways. It offers new interpretations of the ways in which health visitors work with people across cultures. My analysis has sparked several suggestions for further research (see Section 6.6) and has contributed to the development of knowledge around emotional flexibility across cultures.

Using the quality criteria above, my study has demonstrated a high degree of credibility, originality, resonance and originality across all areas of the research process. The further strengths and weaknesses of my study are outlined at the end of my thesis (chapter 6).

3.6 Summary

The purpose of this study was to answer two research questions:

1. What are the most important issues health visitors express, when considering their work with clients who are form cultures different to their own?

2. What concerns do health visitors experience when they are working with clients who are form a culture different to their own?

The most important concerns health visitors express, when considering their work with clients who are from cultures different to their own are around the three areas of **'relationship building', 'cross cultural terrain'** and **'managing emotions'**. The ways in which these three conceptual categories intersect has been constructed into a conceptual theory named **'emotional encounters through cross cultural terrain: shaping relational journeys through culture',** and this can be used to explain the ways in which emotions have the power to shape professional practice across cultures.

Chapter 4: Secondary literature review

4.1Introduction

A secondary literature review was undertaken in this study in response to the emerging themes following the first eleven interviews. The initial findings revealed three areas of concern for health visitors when discussing their work across cultures, and the secondary literature review relates directly to these themes. Firstly, relationship building was explored, especially around the areas of communication, trust and interpretation (Section 4.2). Secondly, the scholarly dimensions of 'cultural terrain' were explored (Section 4.3). Finally, the literature in relation to 'emotional engagement' was explored. 'Emotional engagement' became the central theme of this research and consequently the initial review of the literature in relation to 'emotional engagement' continued, and was expanded throughout the whole research process. The presentation of the literature on 'emotional engagement' was woven into the wider discussion in chapter 5 (Sections 5.2-5.5) and is presented there, rather than being presented here in chapter 4.

4.2 Professional-client relationships across cultures

'Relational journeys' emerged as a key finding of the ways in which health visitors work with clients across cultures. This is not surprising, as the centrality of the nurse-client relationship, historically constructed and socially defined, lies at the heart of nursing policy, practice and education today (Peplau, 1988, 1991; Hagerty and Patusky, 2003;

Evans, 2008; Halldorsdittor, 2008; Koloroutis, 2008). Finfgeld-Connett (2008) re-iterates the normalised discourse when she asserts that 'nursing involves an intimate relationship-centred partnership between nurse and patient' (p.527).

Scholars of the history of nursing and health care contest that this has not always been a central discourse, Armstrong (2006), in his examination of the historical construction of medical ethics, asserts that over the last century there has been a shift from 'an ethics based on the relationship between practitioners to one based on the relationship with their patients' (p. 866). In foregrounding the historically constructed domains of knowledge, nursing scholars have over the last decade begun to move towards a conception of the relationship-centred partnership between health care practitioner and client, as negotiated across and between social spaces (Meleis and Im, 2001; Gunaratnam, 2001). The nurse-patient relationship becomes problematic as issues of power and partnership are explored (Randle, 2001; Henderson, 2003; Crowe and O'Malley, 2006; Fejes, 2008).

Nonetheless, until recently, the majority of nursing scholarship in the field of relationships and communication has failed to apply existing theories of structure and context from the fields of sociology, cultural studies, anthropology or social geography into their work (Hagerty and Parusky, 2003; Moser, Houtepen and Widdershoven, 2007; Koloroutis, 2008). Rather, nursing discourse has favoured the development of numerous exploratory theories developed from a predominantly humanist philosophy within the discipline of nursing, and without

reference to convergent theories in related scholarly fields. Hildegard Peplau's theory of interpersonal relations in the 1950's (Peplau, 1988, 1991), recognised within the nursing field as a landmark theory, emphasised reciprocity in interpersonal relationships between nurses and patients, but largely failed to recognise the importance of context in shaping those relationships.

Numerous theories on communication between nurses and patients/clients have developed within nursing scholarship over the last 50 years (Orlando, 1972; Crick and Dodge, 2003; Batey, 2009), but they have been critiqued for their failure to routinely examine the work of other disciplines to identify their similarities and to engage with cultural theory (Gunaratnam, 2001). Communication has been conceptualised as two dimensional, as between cardboard cut out people, rather than reflecting the multidimensional complexity of real life. Communication has been conceptualised as merely 'communication between strangers' (Gudykunst and Nishida, 2001), and has lacked the depth of analysis which reflects real life experience. My study seeks to move scholarship towards a conception of inter-personal relationships, as embodied within the socio-historic relations of the UK in the 21st century, and to make these visible, rather than to theorise outside of them. Nurse-client relationships are not only about the establishment of a 'connection' (Johnston, 1994) but it is about the inter-relation between social identities and subject positions.

Relational discourses within nursing and health visiting practice are bound up within such complex and contested concepts as empathy

(Morse et al., 1991; Reynolds, Scott and Jessiman, 1999; Kunyk and Olson, 2001; Alligood, 2005; Yu and Kirk, 2008), caring (Morse et al., 1992; Boykin and Schoenhofer, 2001; Brilowski and Wendler, 2005; Watson, 2005; Corbin, 2008) and presence (Engebretson, 2004; Finfgeld-Connett, 2006, 2008). Convergence amongst many of these similar concepts is articulated as the 'art of nursing' (Appleton, 1994; Corbin, 2008). Johnson's seminal work (Johnson, 1994) on the examination of 41 noted scholars' work on the 'art' of nursing highlighted the ability of the nurse to grasp meaning in patient encounters and the establishment of a meaningful connection as two central elements to the 'art of nursing'. This ability to meaningfully connect is articulated through a diverse and complex set of concepts within nursing discourse, which include inter-personal communication, empathy, holism, care, compassion and presence. Fuelled by this plethora of scholarly literature, interpersonal skills for nurses have emerged over the last 50 years as a new orthodoxy. Person-centred approaches have been found to improve patient satisfaction and patient health (Charlton et al., 2008). The World Health Organisation (WHO, 2010) and Department of Health (DH, 2010) stress the importance of client-centred relationships, and situated within the rhetoric of inter-personal relationships, student nurses must now meet the Essential Skills Clusters, as set by their professional body the Nursing and Midwifery Council , which include 'Care, Compassion and Communication'(NMC, 2007). Discourses of individualised nursing care have dominated health care theory and practice for several decades (Pollock, 1988; Reed, 1992; Henderson, 2003; Radwin and Alster, 2002; Suhonen, Schmidt and Radwin, 2007) with little reference to the

wider context of the delivery of that care. Individual nursing care has centred its focus on issues of communication and trust, arguably at the expense of context and socio-historic context.

4.2.1 Communication across cultures

In recounting their experiences of working across cultures, the health visitors in this research highlighted communication as the most important issue for them in their daily work. An exploration of the literature in communication and nursing reveals a plethora of scholarship on issues of interpretation and language for health professionals in cross cultural care (Gerrish, 2000, 2001; Gerrish, Chau and Sobowali, 2004). The role of interpreters has been shown to be complex and involves more than issues around mere translation (Diver et al., 2003), and staff express concerns that their inability to communicate effectively across cultures, which inhibits their ability to give therapeutic care (Richardson, Thomas and Richardson, 2006). It is not surprising that the health visitors choose to discuss communication as the most important issue when working with clients who are from other cultures, and much of the nursing literature conceptualises communication as merely a reciprocal process in which messages are sent and received between people (Balzer-Riley, 2004). What is interesting is that communication for the health visitors in this research was contextualised not only as inter-personal, but as operating within subject positions and involving social identity, ‘positioning other’ and ‘positioning self’. Exploration of the accounts of the health visitors interviewed for this research suggests that the concept of inter-personal

communication within nursing, as currently conceived needs to be expanded. The communication issues they discussed went far beyond the well documented interpretation issues, but situated communication as within a relational journey which challenged identity, culture and core norms and values. This study differentiates itself from much of the disembodied and unreflexive theorising, which surrounds a lot of the discourse in inter-personal communication in nursing and moves to consider not only agency and structure, but the dialectical relationship between the two.

Nurse theorists have tended to develop their own conceptualisations of interpersonal communication, largely based on humanistic psychology (Whitton, 2003), psychoanalytic psychotherapy (McCabe and Timmins, 2006) and counselling models (Browne et al., 2006) and failed to apply existing theories of communication, cultural studies or sociology. While not denying the benefits of cognitive behavioural psychotherapy (Grant et al., 2005), the political and scholarly interest in counselling in general has also influenced nursing perspectives. Hargie and Dickson (2004), writing from a communications background, assert that intercultural communication must be accounted for in terms of *person-situation context*. Social psychologists are also urging nursing to examine the organisational processes which shape practice (Augoustinous et al., 2006). Communication is context bound, situated in time, place and organisational structure. There are encouraging signs that this is changing (Finfgeld-Connett, 2008; Sheldon and Ellington, 2008), but many nursing discourses of inter-personal relationships are built on a

liberal humanist philosophy of morality (Wurzbach, 1999; Armstrong, 2006) without reference to more critical and post structural insights.

Relationships were a recurring issue for the health visitors interviewed in this study. This is neither surprising nor new to scholarly enquiry, given the pervading and burgeoning literature in policy, academia and practice on the issue. Nonetheless, what is new is that the conceptual theory, which emerged, 'cross cultural journeys: stabilising uncertain terrain' not only examines the agency of the health visitors, but also makes sense of the structural ways in which these relationships are constructed. Inter-personal relationships between the health visitors and their clients were not constructed disembodied from the social, historical or political context of their day. Rather these relationships were constituted as very much part of a socio-cultural history and were conceptualised as entering 'unstable terrain'. The health visitors were aware that they were not just 'communicating with strangers' but were required to build up inter-personal relationships with strangers across centuries of imperial history, of 'race' relations and of a myriad and complex interwoven cultural and political threads. Communication was not, as Ruesch (1961) (as cited in Bach and Grant, 2009) stated almost half a century ago, a universal function of humankind, independent of any place, time or context.

Although all of the health visitors cited communication as one of the most important issues in cross cultural work, and the scholarly literature around interpretation is well developed within nursing (Gerrish, 2001; Gerrish, Chau and Sobowale, 2004), probing further in the interviews,

issues of trust and lack of understanding were also shown to be of central importance in cross cultural communication.

4.2.2 Trust in professional – client relationships

In recent years, a large amount of scholarly attention has been drawn to the shared and contested dimensions of the concept of trust, as a foundation for the therapeutic relationship between nurses and their clients (Meiz-Grochowski, 1984). Trust is enshrined within nursing discourse as central to effective relationship building. Nonetheless, the concept remains elusive (Hupcey et al., 2001), vague (Johns, 1996) and contested (Bell and Duffy, 2209; Gilbert, 2005). The literature reveals a confused and contradictory field, where the discussion of trust in nursing is a loosely held together body of work investigating concepts of faith and hope (Gilbert, 1998, 2005; Hupcey et al., 2001; Herth and Cutcliffe, 2002), confidence (Sellman, 2007) and reliance (de Reave, 2002; Sellman, 2007). Reflections on the multiple and contingent ways in which trust is enacted within professional and client relationships reveals a discourse which places the responsibility for building trust with clients on the health professional. Little scholarly attention has been directed towards the ways in which relationships are shaped by socio-historical context and are reciprocal. Many of the health visitors expressed the opinion that they did not feel trusted in cross cultural encounters. ‘Lacking trust’ was identified early in my research as an important theme.

Contemporary nursing discourses draw attention to the ways in which 'trust is conceived as an outcome of skilled intervention on the part of the professionals' (Bell and Duffy, 2009, p.59), and yet the narratives of the health visitors in my study revealed a contextual space within which cross cultural work was performed and understood as a contested space, 'middle ground' or 'common ground'. Gilbert (2005) asserts that nursing practice is based on impersonal trust, which is a proposition that:

> Trust pre-exists the involvement of any individual and, crucially, does not require knowledge of any other individual within the system. Thus trust is established through the systems in which professionals are embedded (p.569).

Bell and Duffy (2007) extend this discourse in their concept analysis of nurse-patient trust by identifying the defining attributes of trust as an expectation of competence, the goodwill of others, fragility/vulnerability and an element of risk. Interestingly, Sellman (2007) found that among nurses, there is an expectation that patients should be willing to trust nurses. The accounts of the health visitors in my study suggest that impersonal trust does not necessarily exist in cross cultural working, where roles are not understood, valued or necessarily recognised.

In seeking to respond to such challenges, recent scholarly writings have begun to recognise that trust is contextually bound (Sellman, 2007). Sellman (2006) highlights the ways in which trust as a nurse is a multidimensional issue, challenged by diverse expectations of the

clients themselves, their families, managers, peers and organisations. Finfgeld-Connett (2008), doing a convergence analysis, found that partnerships need to be co-created actively by both the client and nurse. The co-creation of a relationship was central to the work of the health visitors. In an exploration of self-esteem and nursing, Randle (2001) explained it simply as:

> Individual nurses have their own identity but they do not operate in an emotional or social vacuum, and thus are not the sole determinants of their destiny (p.294).

While acknowledging that relationship building across cultures and establishing trust is a richly textured and reciprocal process, the complexity for the health visitors lay not only in building relationships and trust with the client, but also with the interpreters. The literature clearly reveals that this is a well documented issue with all health professionals when working across cultures (Gerrish, Chau and Sobowale, 2004; Flores, 2005).

Although the experience of many of the health visitors was of frustration, barriers and a lack of communication, some of the health visitors appeared to manage to negotiate the challenges and establish positive relationships with their clients. Expanding Luhmann's trust-mistrust dichotomy (1979), Gilbert (2005) proposes that:

> Mistrust assumes that trust is possible and it provides a means of managing diversity, as human unpredictability is a constant source of insecurity (p. 569).

Although the dominant discourse within nursing centres around communication, trust and relationships as within a decontextualised space, there are encouraging signs that nursing scholars, taking a feminist, post modern and more critical position, are exploring issues of power (Meleis and Im, 1999; Henderson, 2003; Fejes, 2008), along with identity and cultural context (Reimer-Kirkham and Anderson, 2002; Gustafson, 2005; Grant and Luxford, 2008) in their work. My research situates itself at the centre of these discourses as the concept of 'cross cultural terrain' is explored.

4.3 Cross cultural terrain

'Cross cultural terrain' has emerged as a conceptual category from the data analysis, which contained challenging and multiple meanings for the health visitors. In this section, through an examination of the extant literature, the nature of 'cross cultural terrain' is explored and examined. The central issues which require detailed interrogation relate to the dimensions of the discursive 'space', which 'cultural terrain' occupies for the health visitors. Culture, as explored in chapter 2, has been conceptualised as synonymous with 'race' and ethnicity, reinforcing difference. In health care literature, culture is predominantly conceptualised in this way, constructed as a bounded and essentialised entity, with fixed properties which can be attributed to groups of people,

especially in terms of communities. Reimer-Kirkham and Anderson (2002) assert that:

> Culture has become a widely used metaphor for 'difference' within nursing scholarship, without an appreciation of the ways in which the concepts of culture and *race* operate in tandem, most often with *race* as a silent subtext to the discourses of culture (p.5, italics original).

Over the last decade, scholars working across the theoretical boundaries of health and culture assert that the essentialisation of culture in healthcare has become the normalised discourse (Culley, 1996, 2006; Dein, 2006; Gray and Thomas, 2006), where culture has been conceptualised as fixed, rigid and unchanging over time. Health care policy has been critiqued for the continual categorisation of clients into fixed ethnic groups (Bhopal, 2007). Discursive practice within health care has bound the cultural 'other' by time and place, and a substantial volume of the medical literature explores ethnicity and health within a disease process framework (Sedgwick, Pearce and Gullford, 2003; Hajat et al., 2004; Sriskantharajah and Kai, 2007; Burns et al., 2007).

Although scholars in recent years have explored the historical positioning of culture as synonymous with 'race' and ethnicity (Gunaratnum, 2003), and the ways this has served to gloss over the discursive practices through which these categories have been produced, culture within health care has remained a largely bounded

entity (Gustafson, 2005). Nevertheless, theoretical constructions of 'race', identity and culture have shifted through time and new cultural spaces have been created (Nayak, 2008; Dwyer and Bressey, 2008), a strong body of evidence asserts that the reality for many who are seen as the non-majority culture is that racism, racialization or the consequences of this are real and the daily lived experience of many people in the UK today (Hall, 2000; Sivanandan, 2000; Ahmad and Bradby, 2007). What is surprising in my research, is that despite a plethora of literature, which indicates racism in society and in health care, the majority of health visitors choose not to engage with it as an issue. Pon (2009) challenges the ways in which cultural competency has negated issues of power and 'race' in health care, and goes as far as to suggest that cultural competency has become the new racism, in reifying culture to fixed and measurable categories. Sakamoto (2007) adds to recent critical voices from the field of social work, which uncover the ways in which discourses of culture have constructed the 'other' without reference to issues of power and historical positioning (Gross, 2000; Baskin, 2006).

Cultural notions of the 'bounded' nature of ethnic groups are strong within public policy and fanned in to flame by the media. Stereotyping of the cultural 'other' has become pervasive and persistent. Within the field of health care practice, health visitors are working within an organisation that perpetuates discourses of essentialised culture and ethnicity, which objectifies the cultural 'other' (Gustafson, 2005). This is despite scholarly activity, which has been exploring hybrid cultural spaces for over a decade (Werbner and Modood, 1997).

Nonetheless, there have been encouraging signs that over the last 10 years, scholarly research in health care has engaged with other disciplines to explore how 'race', ethnicity and culture has been constructed within specific historical and political contexts, and consequently culture has taken on a more elaborate meaning. Discursive spaces to explore culture have become richly textured. Discipline borders have moved beyond a bio-medical paradigm of enquiry and, particularly within the field of nursing enquiry, health researchers have engaged with sociological, post-colonial, feminist and postmodern paradigms of enquiry, to explore new ways of conceptualising culture and health. New theoretical perspectives are being developed to push forward the boundaries of scholarly thought to explore not only what culture means *in* and *for* health care, but also the ways that the social production of knowledge reflects the socio-historical context of its production. Multilayered theoretical, epistemological and methodological processes are being explored in an attempt to uncover the social processes, which produce and sustain power and the voices of the silenced are allowed to speak. My research seeks to engage with this debate by considering the nature of culture with reference to cultural studies, post-colonial studies, feminist insights and sociology and to enter the discussion along with Anderson (2007) and Lynam et al. (2005) not only on the nature of culture but also the implications of this for future education (Duffy, 2001) and practice.

Discursive practice within health care has been to essentialise culture as static. The cultural 'other' has been bounded by time and place.

Contemporary nursing discourses are now drawing our attention to the multilayered way in which culture has been socio-historically produced, and is a fluid, reflexive and reciprocal project. Symbolic spaces are being created to explore culture beyond discipline boundaries, to draw on the rich and complex meanings of culture, as opened up within critical discourse. Gustafson (2005) challenges the essentialised nature of cultural competency education within health care and nursing, and my research concurs with her call for a non-essentialised space for culture to be examined. A space has been opened up within contemporary nursing discourses to explore issues of identity, and hybrid cultural meanings and how these intersect with nursing practice. The meanings, boundaries and 'nature' of culture are being explored, and my research seeks to engage with these discourses.

It is acknowledged that nurse-patient interactions are enmeshed in complex and interwoven social, historical and social relationships. Nonetheless, data analysis revealed largely two different constructions of 'culture' by the health visitors interviewed in my study, and these broadly reflect the theoretical debate within the wider discourse of culture. The central question remains as to whether culture is 'bounded' or fluid, and to what extent it is either or both. Lynam et al. (2006) draw attention in their research to the dynamic nature of culture but also highlighted the ways in which immigrants:

> Affirmed a view of culture as providing a link to the past and as way of seeing the self in continuity with history and the future (p.25).

Post-colonial writers have challenged the essentialised nature of culture as being historically constructed from the old ideologies of ‘race’. Post-colonial literature since the seminal work of Chinua Achebe [1958] (Whittaker and Mauka, 2007) in ‘Things Fall Apart’ have challenged the imperialist literature of Joseph Conrad [1902] (1989) and Rudyard Kipling [1866] (Jones, 2008), where the black person was constructed as inferior, passive and a savage. Feminist and post structural scholars have sought to interrogate the ways stereotypes are constructed, and post-colonial writers continue to construct multiple identities in their work. Political post-colonial writings have also attacked the historico-political construction of the non-European. In the UK, the Centre for Contemporary Cultural Studies published three decades ago the Empire Strikes Back (1982), which brought together a collection of writings that challenged the constructions of ‘race’, culture and ethnicity, and this has been expanded and extended in the intervening decades (Solomos and Black, 1996). Eduard Said was arguably the most influential post-colonial writer to challenge the construction of the cultural ‘other’ (Said 1979, 1993), and brought the cultural ‘other’ into a discursive space, where it still remains today. Post-colonial literature, political activism and the reconceptualisation of the cultural ‘other’ has brought issues of identity, cultural hybridity and new spaces of identity into the foreground of scholarly writing and issues of identity are conceptualised as a reflexive project (Hall, 1997; Sweetman, 2003; Skeggs, 2004). Current scholarship in nursing is calling for a new approach to culture, constructing culture as non-essentialised (Culley, 2006; Dein,2006), and by calling for new epistemologies to explore

discourses of colonialism, power and silence within nursing practice and praxis (Grant and Luxford, 2008).

4.4 Summary

The health visitors who participated in my study demonstrated that they understood the political and social construction of the context of the relationships they were required to develop. It was not only inter-personal relationships as 'communicating with strangers' (Gudykunst and Nishida, 2001), or as 'making connections' (Johnston, 1994), but that these happen within a culturally bound and historically defined social space. Fundamentally, as a contrast to much of the theorising within nursing discourses on interpersonal relationships, my thesis is not about the individual nurse-client relationship, which is disembodied from the complex and contested issues of culture, 'race', identity and ethnicity, but it is about firmly locating it within these socio-historical constructs. In 'envisioning the journey', the health visitors in my research were clearly aware that to work across cultures was not to 'communicate with strangers', but it was to make a journey, at times very tentatively, into 'cross cultural terrain'. The properties of this 'cross cultural terrain' were discussed as largely bounded, fixed and essentialised. In entering 'cross cultural terrain', the health visitors found that things could not only be 'hidden in culture', but that more fundamentally, this journey had the potential to challenge identity, beliefs and values. This 'cross cultural journey' evoked many challenges to their social identity, raised issues of power and was emotional work. The majority of health visitors felt ill equipped to deal

with the complexity and the challenges they faced in their day-to-day work across cultures, and chapter 5 explores these issues further.

Chapter 5: Discussion

5.1 Introduction

In recounting their experiences of working with people who are from other cultures, a story emerged from the narratives of the participating health visitors, which centred around three important themes. First, the formation of a 'relationship journey' was identified; second, 'cross cultural terrain' was conceptualised; and third, the dimensions of 'emotional engagement' were interrogated. These aspects of interaction emerged through the grounded theory analysis, as intersecting with each other, and developed into the conceptual theory 'emotional encounters through cross cultural terrain: shaping relational journeys through culture'. My research clearly demonstrates the largely unacknowledged power of emotions to shape professional practice across cultures. In this section, the literature on 'emotional encounters' within health and social care discourse is explored, and woven together with the results of my study to add to the body of scholarly debate on issues of emotion and culture. The implications of this for future theory, practice and education are considered in chapter 6.

A discussion unfolds in section 5.2 around the discourses of uncertainty and ambiguity in health and social care, comparing the disciplines of medicine and social work with nursing. This is followed in section 5.2.3 with an exploration of the strategies employed by health visitors in cross cultural work to manage emotions. Sections 5.3 and 5.4 then explore the concepts of uncertainty, anxiety and emotional capital in an attempt

to explicate the theoretical and practical issues, which are raised by the health visitors in my research. In doing so, the second research question will also be more fully answered, uncovering the difficulties health visitors experience when they are working with clients who are from a culture different to their own. These are broadly conceptualised as 'managing uncertainty' and 'stabilising cultural terrain', and will be explored within current scholarly discourse and the contemporary socio-political context of the National Health Service. This is followed in section 5.3 with an exploration of the theoretical dimensions of 'emotion work', and begins with a discussion around the seminal work of Arlie Hochschild in 1979 on 'emotion work'. Erving Goffman (1959) was initially considered for his potential to inform understandings of the complexities of the relationships between health professionals and clients from other cultures, but this was not a good theoretical 'fit'. While the distinction made between social performers and health professionals is recognisable, it was found to be inadequate to explain the socio-cultural geography of 'cross cultural terrain'. Recently, scholars writing within the field of cultural geography have begun to explore emotion but this work is in its infancy (Davidson, Bondi and Smith, 2005, Urry, 2005). It is to the work of Pierre Bourdieu (1977, 1984, 1989, 1993, Wacquant and Bourdieu, 1992) that I turned to link the concepts of *field*, *habitus* and capital in order to contribute to an ongoing dialogue about the nature of culture, health and relationship in professional practice. The themes explored in my thesis do not stand alone, but build upon work in recent years by scholars in sociology and health, as they have sought to expand the complex concepts contained within Bourdieu's work in relation to culture and health (Lynam et al.,

2006; Anderson et al., 2007). The dynamic interplay between relationship and cultural terrain, which has emerged in my research contributes to an ongoing dialogue on the fluid, dynamic and negotiated nature of cross cultural interactions (Holliday, Hyde and Kullan, 2004; Dein, 2006; Culley, 2006). Nonetheless, my research also draws attention to the ways in which emotion, and in particular uncertainty and anxiety, intersect with these cultural spaces conceptualised as 'unstable terrain'. The work of Gunaratnam and Lewis (2001) is a powerful contribution to the small, but expanding body of literature which attempts to transpose emotion, theoretically, onto conceptual cultural spaces. In exploring the theoretical complexity of Bourdieu and the conceptual linkages of *habitus, field* and capital, I have sought to grapple with ways in which emotion might be integrated, as an important component of cross cultural working. In this way, some of the theoretical challenges my research poses are made visible in an attempt to move scholarship forward on cross cultural working for health visitors and their clients.

Finally, section 5.5 interrogates the notion of culture as an 'art' rather than a measurable 'science', and explores the ways in which the work of health visitors in cultural care to manage their emotions becomes a hidden work.

5.2 Managing emotions through cross cultural terrain

5.2.1 Introduction

Initial exploration of the concept of uncertainty and ambiguity in professional health care practice uncovers disparate pockets of literature, which appear to lack conceptual integration or inter-disciplinary congruence. Comparing the three disciplines most aligned to health visiting, namely nursing, medicine and social work, it became clear from early explorations of the extant literature that the conceptualisations of uncertainty and ambiguity within these professions were notably different. An exploration of these differences offer the potential to inform this study.

In this section, the management of uncertainty and ambiguity as conceptualised by nursing, medical and social work discourse will be explored, along with the narrative experiences of the health visitors in their daily practice, to draw attention to the ways in which health visitors try to manage uncertainty in their daily practice. The concept of uncertainty is elaborated, disentangling the concept of uncertainty and its centrality to the 'art' of nursing. The practical possibility of this is explored within a wider nursing discourse of evidence based health care, a risk averse society, increased litigation and a media who interrogate 'caring' within an economically constrained UK National Health Service. By comparing health visiting discourse around uncertainty and ambiguity with allied professions in health, and by

situating the experience of the health visitors within social context and policy practice, possible routes through this contested arena can be negotiated and steps taken to move forward in cultural ‘competency’ education. Finally, the different ways of managing uncertainty as conceptualised by the health visitors in my study are explored.

5.2.2 Uncertainty and ambiguity in health and social care discourse.

Uncertainty and ambiguity are elusive concepts within scholarly discourse in nursing. Small sparks of dialogue exist in discrete corners of the literature, largely related to the patient experience of uncertainty, especially within the fields of oncology and uncertainty around diagnosis (Penrod, 2007). Although the health visitors in my study identified uncertainty and the associated anxiety, as important features of their professional practice, scholarly discourses of uncertainty in nursing practice if not completely silent, are reduced to a whisper. The majority of health visitors in my study identified anxiety and uncertainty as dominant emotions in cross cultural work, with ‘easy to cause offence’ emerging as a strong conceptual code.

In a piece of qualitative research with a variety of health professionals across many disciplines, Kai et al. (2007) found that all of the health professionals they investigated wrestled with considerable uncertainty and apprehension in responding to the needs of patients from different cultures. Kai et al. (2007) assert that professional uncertainty in practice should be acknowledged and interventions devised to help develop this.

They also found that there were few instances of professionals acknowledging their uncertainty openly with patients in relation to cultural knowledge and gaps in beliefs or values (Kai et al., 2007). They also found that professional uncertainty in working with patients of differing ethnicity was characterised by stress and anxiety, and led to inertia in their clinical approach. Concurring with Kai et al.'s research (2007), what is of particular interest for scholars is that an examination of uncertainty and ambiguity discourse in nursing literature is noticeably 'silent'. In one of a very few articles on ambiguity in nursing discourse, Kalli Stilos (2006) calls for nursing practice to build comfort with ambiguity and, yet, the concept of ambiguity lacks theoretical depth in nursing discourse or practice. She asserts that 'awareness that nurses cannot control how people experience their realities is growing' (Stilos, 2006, p.260), and yet the literature which supports this growth in nursing journals could not be found in more than a few cases. Thompson and Dowding (2001) highlight ambiguity as unavoidable in nursing practice, but the literature appears to centre around the way in which nurses label clients as 'noncompliant' or problem patients, as a way to manage their own uncertainty. Although nursing models highlight complexity and ambiguity as integral aspects of nursing and caring in particular (Hartrick, 1997; Parse, 2004), these concepts remain largely undefined and are left hanging in the theoretical air, lacking substance or interrogation. More recently, nursing models that call for a patient-centred care acknowledge ambiguity amidst the complexities of care (McCormack and McCance, 2006), but it is not particularly highlighted as a core concept. In realising that writing around ambiguity and uncertainty are notably absent from nursing discourse, I began a

literature search of other health related disciplines to further explore the concept of ambiguity in professional practice.

Stepping sideways to investigate more specifically the related fields of medicine and social work, the sparks of inquiry into uncertainty and ambiguity in professional practice, while not a roaring fire, are to be found lighting vigorous debate in various bodies of scholarly work. Medical discourses about uncertainty and ambiguity appears to be strongly associated with the oppositional concept of 'control' (Lingard et al., 2003; Griffiths, Green and Tsouroufli, 2005), while in social work, ambiguity is explored within a 'risk' agenda (Littlechild, 2008; Stanford, 2010). Alerted by scholars in post structural epistemologies to listen to the 'silences', this section not only discusses the concept of uncertainty and ambiguity across the related fields of medicine, social work and nursing, but also seeks to make these concepts visible within nursing, and to suggest discourses that operate to render experiences of uncertainty silent. By searching uncertainty discourses in nursing literature and the everyday experiences of the health visitors, in this section I question the concept of professional uncertainty and seek to move scholarship forward, particularly in relation to cross cultural education.

In contrast to nursing, the concept of uncertainty within medical discourse has been, and currently is, of scholarly concern and consequently there is a burgeoning literature related to many different aspects of medical uncertainty. Penrod (2001) gives a useful working

definition of uncertainty, which reflects both aspects of uncertainty and control:

> Uncertainty is a dynamic state in which there is a perception of being unable to assign probabilities for outcomes that prompts a discomforting, uneasy sensation that may be affected (reduced or escalated) through cognitive, emotive, or behavioural reactions, or by the passage of time and changes in the perception of circumstances. The experience of uncertainty is pervasive in human existence and is mediated by feelings of confidence and control that may be highly specific (event-focused) or more global (a world view) (p.241)

Penrod (2001) builds on much of the literature in medical discourse on uncertainty by advancing the relational concept of uncertainty, confidence and control. Medical education teaches students strategies to cope and to reduce uncertainties (Rizzo, 1993; Griffiths, Freen and Tsouroufli, 2005). Much of the medical literature focusing on uncertainty is built upon the classic work of Renee C. Fox (1957) (as cited in Light, 1979) who articulated three origins of uncertainty, namely individual knowledge and its limitations, the limitations of clinical knowledge and finally how to distinguish the two. Building on Fox's work, Light (1979) identified ways in which medical students 'train for control' through managing uncertainty in relation to the dimensions of their instructors, diagnosis, treatment and client response. Light's work (1979), although almost 30 years old now, appears to have been the foundation stone of

medical literature into managing uncertainty. The articulation of uncertainty as an important component of clinical practice has provoked a rich literature in medical anthropology. A plethora of literature within medical education and practice identifies the ways in which medical students learn to control uncertainty through professional relationships (Seaburn et al., 2005; Griffiths, Green and Tsouroufli, 2005), through learned strategies (Lingard, et al., 2003) and through reflective writing (Nevalainen, Mantyranta and Pitkala, 2010). In a piece of qualitative research, Lingard et al. (2003) examined the rhetorical and linguistic features of uncertainty and the strategies medical students learn to reproduce these in their own discourses. They ascertain that:

> For the most part, students in our study approached uncertainty as a condition to be avoided at all costs and, when not avoidable, to be disguised (Lingard et al., 2003, p.609).

They further argue that the students in their study, like those in Fox's study (1957), recognised that uncertainty is unavoidable, and that learning to handle it is part of becoming a professional. Medical students learn through apprenticeship education on the wards to develop techniques to manage uncertainty through guided and repeated learned practices. The 'art' of managing uncertainty and the development of professional identity are interdependent threads of the same cord. Medical literature indicates that student doctors, and subsequently qualified doctors, learn strategies to control uncertainty. Halpern (2001) found that emotional detachment, rather than emotional

engagement, helped to protect doctors from burnout. Other strategies to protect from burn out included the maintenance of impartiality, the rationing of time and the avoidance of emotions, as they were seen to potentially interfere with objective decision making. In his discussion on compassion fatigue in doctors, Huggard (2003) alerts us to the ways in which emotional detachment helps protect from traumatic observations or stories. Geller, Faden and Lavine (1990) argue conversely that, rather than controlling uncertainty, 'tolerance for ambiguity' is a necessary and important aspect of quality care. Lingard et al. (2003) found that medical students learned that some kinds of uncertainty were more 'safe' than others. Although there is convergence and divergence in the medical literature on strategies to manage uncertainty and ambiguity within medical practice, the acknowledgement of ambiguity as an integral aspect of medical practice is embedded within medical practice and educational discourses.

Health visiting is historically embedded within nursing discourse, although the practical reality of the day-to-day job aligns the profession strongly with social work. An investigation of the concepts of ambiguity and uncertainty within social work literature uncovered a plethora of literature interrogating both concepts. Social work discourses understand uncertainty largely in relation to 'risk' management. Risk assessment and risk management have become a major focus of government attention for the UK government, in terms of policy, practice and education (Thom, Sales and Pearce, 2007; Webb, 2007). Morgan (2007) argues that a culture of blame has arisen within the British media, and recent child protection scandals have resulted in the

dismissal of senior health and social care professionals and accusatory media reports. Corby, Doig and Roberts (1998) and Ayre (2001) argue that in recent decades social workers have been vilified by the media. Risk assessments have been developed across many areas of health and social care and are conceptualised as a way to reduce the risk of child abuse. Littlechild (2008) puts it thus:

> Central government appears to have taken a view that in order to reduce the risk of child abuse deaths, the production of mandatory guidance and checklists for professionals will ensure that agencies and professionals carry out risk assessments and plan their work in standardized ways, and therefore reduce their risk to children (p.663).

Theoretically, the development of the concepts of 'risk' and 'risk society' (Giddens,2003; Beck,1992; 2009) have led to a lack of trust in institutions and the need for government to regulate professionals more closely. Health visiting is not immune from these discourses or policy measures and health visitors are subject to similar policy directives in relation to risk assessments and the safeguarding of children, as social workers. There is a growing body of literature within social work policy, practice and theory, which critiques a positivist risk agenda that has no due consideration of the fear, anxiety and uncertainty associated with social work (Littlechild, 2008).There are calls for social work to move beyond such narrow risk assessments, which only collect statistical data, and to recognise the complexity of social lives (Goddard, Sanders

and Stanley, 1999; Parton, 1998). Littlechild (2008) urges social work to:

> Move beyond such restricted and restrictive risk assessments, and rediscover ambiguity and uncertainty… in the complex set of factors which drive human cognition, motivation and behaviour, we are often not able to predict risks fully, even with a wide range of actuarial information concerning risk factors (p.669).

Stanford (2010) argues that the consequence of managing risk in this way has led to social workers directing their energy to managing and securing against risk, rather than engaging meaningfully with the needs of their clients. McLaughlin (2007) notes that policy attempts to reduce uncertainty by way of managerial strategies has led to an erosion of professional confidence in assessment and in decision making. Social work practice operates in the UK in a culture of fear and blame (Smith, Nursten and McMahon, 2004). Stanford (2010) encourages social workers to engage with the fear they encounter in their daily work and to ‘speak back’ to those fears. It is acknowledged that to take risks is integral to social work practice and a healthy dialogue exists within the social work literature to explore, interrogate and critically engage with risk, uncertainty and ambiguity in both theory and practice (Parton and O’Byrne, 2000; Titterton, 2010).

The abundance of literature within social work education, policy, theory and practice around risk and uncertainty discourses is hugely

encouraging and engaging, but it also lies in stark contrast to the dearth of literature in health visiting around the same subject. Acknowledging the convergence at a practice level of the two professions, it remains pertinent to consider the reasons uncertainty and ambiguity remain largely silent within health visiting discourses. At the heart of my thesis a question emerges, as to why the day-to-day narratives of the health visitors interviewed in this study identified ambiguity, uncertainty and anxiety, as important feelings they were required to deal with when working across cultures, and yet why these subjects are largely absent from nursing discourse?

In the remainder of section 5.2, the strategies used by health visitors in my research to manage uncertainty are explained, before going on to examine the theoretical conceptualisation of this using the work of Pierre Bourdieu (sections 5.3 and 5.4). The ways in which health visitors managed uncertainty in 'cross cultural journeys' are explored and the notion of 'emotional capital' is scrutinised. Section 5.5 continues to interrogate the notions of uncertainty further, by exploring cultural engagement as part of the 'art' of nursing, and the ways in which this fits with medically dominated discourses of evidence based practice and a risk averse society (Beck, 1992, 1996).

5.2.3 Strategies to manage uncertainty

5.2.3.1 Managing uncertainty through avoidance: travelling to the perimeter fence of cultural terrain

Nursing scholars (Mitchell and Pilkington, 2000) assert that when nurses feel uncomfortable with ambiguity and uncertainty, they have diminished opportunity for meaningful dialogue. *Diminished opportunity for meaningful dialogue* seems woefully inadequate to describe the strength of feeling the health visitors in this study expressed when confronted with engagement across cultures. Research evidence from both within nursing (Kai et al., 2007) and within medicine (Merrill et al., 1994; Nevalainen, Mantyranta and Pitkala, 2010) suggests that health professionals actively avoid uncertainty. The health visitors in my study appeared to avoid meaningful interaction with their clients in two ways. Firstly, they 'approached the perimeter fence' of cross cultural ground, but did not fully enter that ground to develop meaningful relationships with their clients. Secondly, the health visitors avoided the consequences of uncertainty by 'not asking and not looking'.

Jessica described it as 'you just have to let them get on with it really' in the dialogue below:

> Jessica: It is just about listening really and make sure that everything they do is safe and there has been a problem with sterilisation and they haven't understood about sterilisation and have just used tap water and so we had to say, 'no you mustn't do that', but really we are not really strict, it is just about finding similar foods that are available to use. You give them information verbally and I have lots of translated stuff and pictures to show them and then you just have to let them get on with it really and if they come back with lots of tummy

> upsets then you have to think again but if they are alright then fingers crossed really (laughs) (Jessica:167-173)[sic].

Beth again left her interaction with her clients as 'give the information':

> Beth : I can't think of the things she would say, you know there were weaning practices we wouldn't recommend, I can't think of them off hand now but they were different to ours, so she was a challenge in a way and I kept having to (em) advise and initially with all of the points I was trying to discuss with her, I could see that this was the norm, this was what she had experienced her family doing for quite a while and she would be quite sort of, why is that not?'…, you know,… so I think it is a challenge but I think at the end of the day, all you can do is to give the information and explain the information (Beth:206-212)[sic].

Several of the health visitors expressed this fear of 'not asking and not looking' as a major stumbling block to moving forward into 'cross cultural terrain'. Rebecca recognised that fear could stop her from asking the right questions to enable her to move forward in a relationship with her clients:

> Rebecca: I think it is a case of asking and not being afraid to ask questions, sort of pry and ask otherwise you never move forward and you will never have that sort of trepidation that things aren't that right (Rebecca:162-164)[sic].

> Sophie: I have had health visitors say, 'I never, when I go to visit a Muslim family I never talk about contraception', and I would say 'but why?', and they would say 'but it is against their religion', and I would say, 'but it is their choice. I am a Catholic, but I would still use contraception you know and you are not there to judge whether or not I want it, but if you tell them and they say well actually I am not interested in that, then you have done your job'. There is some fear of asking the questions (Sophie:239-243)[sic].

Anxiety, fear and uncertainty were uncovered as pervasive emotions running through the majority of the narratives of the health visitors who participated in my study, and this prevented them from moving further in a 'relationship journey' with their clients:

In searching the literature on avoidance and uncertainty, the discipline of psychology reveals a wide and well developed literature on the subject. Medical scholars assert that the tolerance of uncertainty is an important issue in medical pedagogical discourse and in general practice in particular (DeForge and Sobal, 1991; Seaburn et al., 2005; Morgan, Jenkins and Ridsdale, 2007), but it is in the field of psychology where the exploration of the tolerance of uncertainty is theoretically explored in cross cultural relationships. Anxiety/uncertainty management (AUM) theory is concerned with the relationship between anxiety and uncertainty and the avoidance of interpersonal and intercultural communication (Duronto, Nishida and Nakayama, 2005).

Duronto et al., (2005) concur with others in the field of AUM (Gudykunst and Kim, 2003) that anxiety and uncertainty are associated with avoidance in communication with strangers from different cultures.

Gudkyunst and Kim (2003) describe strangers as those who are least familiar to us and have the lowest degree of familiarity. Duronto et al., (2005) concur, stating that:

> Communication between strangers is characterised by a limited amount of information about each other, by ignorance of the means to reach a goal, and by ignorance of the probable outcomes (p.550).

Citing research by Bull and Rokeach (1973), which they have built their work upon, Duronto et al. suggest that ambiguity is dealt with in new situations by two different means. Firstly, uncertainty is reduced by acquiring information and secondly, ways are sought to reduce tension and therefore reduce anxiety.

As discussed in section 5.3.2.5 in relation to ‘not having the tools of knowledge’, the health visitors were keen to acquire knowledge of the cultural ‘other’. Duronto et al. (2005) would postulate that this is a way of managing uncertainty in ‘cross cultural relationships’. The desire for knowledge of the cultural ‘other’ and the need for certainty are seen as a narrative thread running through the accounts of the health visitors in my study. The health visitors expressed a fear of appearing ignorant or not having sufficient knowledge to meet the needs of their clients. The

discourse of professional competence and knowledge is very strong for the health visitors, and there does not appear to be any space within professional discourse at a practice level to wrestle with uncertainty and ambiguity. This is discussed in greater detail in section 5.5 but it raises the question here as to whether, without such a discursive space, the temptation to avoid active engagement with clients across cultures is exacerbated. The answer to this question lies beyond the remit of my study, but points towards the necessity for further research to explore the nexus where anxiety, uncertainty and culture intersect within health care practice.

The limitations of AUM theory as an explanatory framework is that it fails to incorporate social, cultural or organisational discourse as contributing to anxiety management. AUM theory is based on the premise that managing uncertainty and anxiety are central processes that influence communication with others. This is both between interpersonal groups and between groups of strangers. Gudykunst and Kim (2003) have widened this to explore intercultural communication as an element of that. Gudykunst and Nishida (2001) state that:

> Other factors that might influence the effectiveness of our communications (e.g. expectations, perceived similarities, identities, self-esteem, ability to empathise, relationship with strangers) are superficial causes of effectiveness (p.56)

Nonetheless, they claim these are secondary to anxiety management. Duronto et al. (2005) state that:

> Managing uncertainty and anxiety, therefore, are central processes that affect our communication with strangers (p.550).

For Gudykunst and Nishisa (2001):

> Individuals can communicate effectively to the extent that they are able to manage their anxiety and accurately predict and explain others' attitudes, feelings, and behaviours (p.55).

Anxiety is defined within psychological theory as the effective (emotional) equivalent of uncertainty (Gudykunst and Nishida, 2001). Turner (1988) defines anxiety as a 'generalised or unspecified sense of disequilibrium' (p.61). AUM theory postulates that increased anxiety levels are experienced when people communicate with strangers and that uncertainty is the cognitive phenomenon associated with that anxiety. The assumption of AUM theory (Gudykunst, 1995) is that, in order to regulate anxiety and uncertainty, individuals change their behaviour. If anxiety is too high, individuals rely on simplistic information processing (e.g. stereotyping) and this, therefore, reduces the effectiveness of their communication. When uncertainty is too high, then there is reduced confidence to predict or explain others' attitudes, feelings or behaviour. Conversely, if anxiety is very low, then the motivation to communicate is very low. If uncertainty is very low, then individuals are overconfident in their prediction of the behaviour of others.

The health visitors interviewed avoided uncertainty, firstly by 'not asking' certain questions, and secondly by not engaging with their clients fully, conceptually termed 'approaching only the perimeter fence of culture'. The third concept I identified was 'don't push at the racism door'. The extensive and pervasive effect of racism in the UK National Health Service is documented in scholarly literature (Porter, 1993; Ahmad, 1993; Bhopal, 2001; McKenzie, 2003; Nairn et al., 2004), policy directives (NMC, 2004) and through the media (BBC, 2004). Mary was typical of many of the health visitors interviewed, in that she was very aware that racism existed, but she avoided confronting the issue, as the extract below illustrates:

> Fiona: Have you been able to ask about racism with any families?
> Mary: No, I've never asked that question directly. I might have asked how they felt in the local area or skirted around it, but not asked that question directly, no I haven't (Mary: 291-293)

Susan and Denise likewise avoided asking clients about racism, and the category 'don't push at the racism door' was established after many similar narratives.

> Fiona: Have any of your clients ever talked about their experiences of racism with you?

Susan: Em, no, em, they sometimes sort of say that they feel that if they go to the doctors or something then they don't take any notice of them. I mean I have a friend who is black and she has apparently been shouted at in the street 'black bitch' and that and she has obviously told me that because she is a friend but no, no-one else has told me that (Susan:167-171)

Fiona: have any of your clients talked to you about racist attacks they may have suffered?
Denise: Within their own culture?
Fiona: Any really. Do your clients disclose that?
Denise: I don't think it would be frequent and I certainly don't remember any (pause), em (pause), because that would be quite shocking really, it is the sort of thing that always comes up in the assessment framework around community resources and accessing community resources and about your neighbours and antisocial behaviour and personally I can't think of any families.
Fiona: Would you ask that question specifically or more generally?
Denise: More generally really. 'Do you like living here, do you get on with your neighbours?', that sort of thing really. 'Do you know people nearby?', that sort of thing really because obviously where you live and your home conditions affect your health as much as anything else really. So I don't think I

> would come out and directly and ask that question really (Denise: 127-138)[sic].

A substantial body of literature now asserts that issues of 'race' are avoided in health discourse (Myers and Williamson, 2002; Vydelingum, 2006), and that colour-blindness has become the 'new racism' of the last decade (Bonna-Silva,2003). When issues of 'race' are avoided during health visitor assessment or subsequent visits, then important issues can be left undisclosed and can impair the nurse-patient relationship. A growing recent literature highlights the effect of racism on health outcomes, and the multiple ways in which avoidance of talk on racism and discrimination negates the powerful consequences it can have.

5.2.3.2 Managing uncertainty through stereotyping. Fixing a culture: unchanging throughout time

The health visitors interviewed for my study not only managed uncertainty, firstly, through avoidance, but, secondly, through stereotyping clients into' identifiable' groups. Stereotyping was very common among the health visitors, as Mary demonstrates below:

> Within the Bangladeshi community because their culture does not believe in that (depression) anyway, so we wouldn't use, em , that form. They don't believe in depression (Mary: 39-40)[sic].

There were many instances in my study where the cultural ‘other’ was stereotyped. This concurs with sociological insights of the ‘otherisation’ process (Said, 1979, 1993) used by majority cultures in relation to minority groups.

Although research with health care providers in Canada and the USA (van Ryn and Burke, 2000) and the UK (Nairn et al., 2004) indicate that racial stereotyping is evident among health care providers, some of the health visitors had been surprised by the cultural ‘other’, and experiential learning indicated that both Leah and Annette had been challenged to change their stereotypes of the cultural ‘other’:

> You think, god, there are some good things to pick up and some of their attitudes to health are excellent and they don’t miss appointments or anything like that, they value health care, they value immunisations and they value their child getting weighed and advice and all that. Yeah, and they really value it more than, sort of like, people here just take it for granted (Leah: 213-216)[sic].

> Cultures evolve and you think, ‘is that still accurate years later?’ (Annette: 86)[sic].

Some of the health visitors moved from feeling confident to ‘losing confidence’, as uncertainty increased during the cross cultural encounter. As the fixed stereotypes became more fluid and dynamic, as

they got to know and understand their clients, Jane talked about ‘losing confidence’ within the complexity of culture:

> Well it’s funny, because sometimes I think was I kind of arrogant going into these families and thinking I could provide a service? I think that my naivety, I love the diversity and I think that is what kept me going and I was interested and I kind of felt privileged about kind of meeting very different people and it was just so like a really wonderful experience for me and I think that kind of saw me through that I was just excited and interested but kind of like, on reflection, I don’t know if arrogant is the word, but something like thinking how did I ever consider that I could do this and now I feel far less confident’ (Jane: 160-166)[sic].

> I just don’t know Fiona, it is just overwhelming, it is just too vast to…(pause) it is funny when I am talking about it, I am a little bit stuck but when you are working with it on a day to day basis you just get on with what you’ve got and I explore with families what it is that they have difficulties with and try to follow. For instance, I have a mum at the moment who, they are, the children are on the register and there are issues about toilet training and what I have to do is just purely focus on that on little issues and explore it and explore it until we both, the mother and I get a satisfactory outcome (Jane: 235-241)[sic].

When discussing issues of ‘race’, culture and identity, the health visitors in my study used terminology, which stereotyped their clients from cultures other than their own, largely in terms of national identity. Theoretical insights into the literature on culture and health reveal an essentialisation of culture within health discourses and culture becomes fixed, permanent and static (Gray and Thomas, 2006; Culley, 2000, 2001, 2006). The health visitors essentialised culture but often, as their experience changed, they began to understand the fluid, dynamic and non-essentialised nature of culture. For some, this appeared to enable them to move forward with their clients but, for others, they appeared to lose confidence and retreated from ‘cross cultural terrain’. What is of particular interest is that this ‘moving forward…retreating back’ was associated with ‘emotionally opening up…closing down’. Again the emotional investment the health visitors made in cross cultural encounters became apparent.

5.2.3.3 Managing uncertainty through equality. Re-working an equality agenda: the same throughout time

Running through the dialogue of the participant health visitors in my research were two very different discourses on equality. Equality was discussed in the context of material inequalities and the health visitors were unsure whether they were expected to operate within discourses of equality or equity. Equality was perceived as the guiding principle and yet, in their day-to-day work, they understood the need to give more time and visits to certain people but were constrained by an ‘equality agenda’. For Emma, equality meant treating everyone exactly

the same and for Cathy, there was a strong dialogue of ‘we are all the same really’:

> It just kind of goes in phases but I do think everyone would have, em, the same, otherwise it becomes quite a clique, doesn’t it? I think it just emphasises different people. Even saying the Bangladeshi health visitor, the families had all the access to the safety gates and equipment that, you know other families who were in the same area couldn’t have access to that, so that to me just generates ill feeling which is the exact opposite to what you are trying to do and I think just how illogical is that? (Emma: 165-170)[sic].

> Fiona: Thinking about some of the families you have worked with who are from another culture, what has been the best thing about that?
> Cathy: What do I like? Well obviously it gives you a better variety to the job and it gives you a better understanding of different cultures but also they are really just the same as us. It is not so much (pause) that I have enjoyed working with people who are different, it is that I have enjoyed learning that they are not that different really (Cathy: 13-18)

In an Australian context, Blackford and Street (2002) undertook research exploring the practice of liberal feminist nurses. They found that these nurses, in an effort to treat all people the same, ignored important cultural differences and consequently clients did not always

receive equity in care. Scholars looking at issues of whiteness alert practitioners to the danger of using discourses of equality to negate structural inequalities, which operate between white and non-white people in society. In confronting their own whiteness in the research process, Martin-McDonald and McCarthy (2008) assert that:

> White privilege and hegemony are maintained and reproduced through omnipresent structures that frame it as normative (p. 129)

Despite a plethora or research into health inequalities in relation to ethnicity and health in the UK (Ahmad and Bradby, 2007; Marmot, 2011) and in the United States, research by Kaiser (2001) identifies 71% of American whites who believe that blacks have ‘more’ or ‘about the same opportunities’ as whites, although all social indicators suggest that this is not the case and in many cases inequality is increasing. More than a century ago in *The Philadelphia Negro* [1899], DuBois chronicled the ways in which white domination resulted in black material deprivation, but asserted that this is a situation which the majority of whites do not see or want to see (Katz and Sugrue, 1998). Whiteness scholars argue that:

> Unlike the rather obvious patterns of discrimination and legally sanctioned state sponsored terror that characterized much of US history, contemporary discursive accounts of race and whiteness serve to make the material benefits of

> whiteness appear normal, natural and unremarkable (Twine and Gallagher, 2008, p.9).

Whiteness is invisible to those of us who are white. It is the:

> Epistemological equivalent of staring directly at the sun – the irreducibility of whiteness remains its blinding insight (Probyn, 2004, p. 8).

Criticism has been directed towards whiteness studies in recent years, asserting that, rather than directing the academic gaze towards the powerful ways in which whiteness produces, reproduces and maintains racial inequality, it reifies whiteness as a racial group (Alexander, 2004). Nonetheless, Ahmed (2004) poignantly reiterates the need for whiteness to be identified and 'marked' (Martin-McDonald and McCarthy, 2008) in order to address structural and social privilege and advantage. He states that:

> Whiteness is only invisible to those who inhabit it. To those who don't, the power of whiteness is maintained by being seen; we see it everywhere, in the casualness of white bodies in spaces, crowded in parks, meetings, in white bodies that are displayed in films and advertisements, in white laws that talk about white experiences, in ideas of the family make up of clean white bodies. I see those bodies as white, not human (p. 4)

In recent years, a large amount of policy attention has been drawn to the contested dimensions of inequalities in health (Marmot, 2011). The large body of scholarship of health inequalities in relation to ethnicity, indicates that those categorised as from Black Minority Ethnic groups, suffer poorer health outcomes compared to the majority population. While concurring with scholars who argue that health discourse should move towards a non-essentialised view, there remains a difficulty with conducting empirical research into tackling inequality and injustice within the health care system, while also recognising the need for categorisation in order to tackle issues of injustice. In examining the literature within health policy directives, research indicates that tackling inequalities in health is now high up the government priority agenda in the UK (DH, 2010). In different but overlapping ways, a body of concurring evidence now exists which indicates that not only do those from lower socio-economic groups suffer the worst health outcomes but that the gap between those at the bottom and the top of the social gradient is increasing (Wilkinson and Pickett, 2009).

Tracing the contours of the changing political environment for health visitors, issues of public health and strategies to reduce inequalities have become a part of government health care agendas. Reflections on the multiple and contingent ways in which health visiting is practiced in the UK, reveal confusion with the role both among health visitors and between front line staff and management. Nonetheless, a discourse of equity and inequality was evident in the accounts of the health visitors in recounting their work with people from cultures other than their own. Following an examination of the contradictory and complex ways in

which health visitors address inequality, it became evident that the health visitors were concerned about issues of equality in the narratives of their daily practice.

It became clear as the research progressed, and concurrent coding and conceptualisation of the data progressed, that equality was used by the health visitors in this study in ways which ‘re-work the equality agenda’. In ‘re-working the equality agenda’, the health visitors sought to manage diversity and difference by engaging in a dialogue where ‘all are equal..all are the same’. In exploring of such a conceptualisation of equality, scholars extend our understanding of the problem of such representation. Colour blindness can be utilised as a political ideology to perpetuate power relations and to negate institutional racism (Bonilla-Silva, 2003; Gallagher, 2003; Ansell, 2006).

Aranda (2000) highlights the ways in which two concurrent equity discourses operate in her examination of the UK National Health Service. The dominant discourse is that of ‘equal opportunities’. This can be seen in the mandatory ‘equality and diversity’ training organised yearly by Primary Care Trusts in the UK. Dominant is a liberal discourse, based on the principles of equity and fairness. According to Aranda (2005), this:

> Endorses the ‘same’ delivery of care whilst claiming to respect, assimilate or accommodate differences in order to develop multicultural mainstream services (p.132).

This can be clearly seen in the account of Rebecca:

> I quite often take a crib sheet, it is awful really but I don't want to miss anything and not give the level of service that I give to everyone else and I feel that they are entitled to that and I feel that it would be wrong of me to miss something out, so I just do that then I know I have given this mum 100% (Rebecca: 195-198)[sic].

Cultural 'competency' and cultural sensitivity educational programmes are based on this discourse, whether it is made explicit or not. Aranda (2005) situates this in juxtaposition to radical approaches to equity in health, which focus on anti-discriminatory practice or culturally safe practices. These approaches use post colonial, feminist and post modern approaches to foreground the silenced voices in the liberal discourse, and to uncover the ways in which unequal power relations contribute to oppressive practice. Equality discourses are always culturally and historically located, generated and communicated and, unless these are highlighted, normative practices of oppression can continue:

> Liberal and radical strategies of practice are therefore based on inclusion in one of two ways, namely of sameness or difference (Aranda, 2005, p.132).

For Stephanie, equity was the principle, but she felt this was only 'allowed' as she had a very understanding manager:

> They (cross cultural clients) really do appreciate a home visit and so we do it more but then we are sort of (pause),em, constrained, em, we are only supposed to offer a couple of visits but our team leader is very good and she just says 'so as often as you need to', which is what you do but sometimes people say to you, 'you know, you should just do your two visits', but you know, you can try them to come to clinic but you know they don't want to come out or can't come out so what can you do, especially if they are depressed (Stephanie: 105-110)[sic]

This stands in stark contrast to Helen and Sophie, who 'walked together against injustice' with the families they were working with across cultures. They were conceptualised much more as the 'activist self'. This concurs with the literature where health visiting is shaped much more by discourses of 'support' and 'caring' rather than emancipation. This lies in stark contrast to the field of social work, where a strong emancipatory discourse is evident.

Using participant observation in her research with district nurses, Gerrish (2000) highlighted the ways in which liberal equality discourses of individualised care can reinforce indifference to important differences, while claiming to treat everyone the same. Looking outside health, Forbes (2002) discusses the ways in which a politics of equal opportunities can render difference invisible. Concurring with the findings of research in which the majority of community nurses interviewed equated professional care and liberal equality (Aranda,

2005), my research also found ways in which the health visitors drew upon equality and dominant professional discourses to manage their practice.

Health visitors cope with uncertainty and anxiety when working across cultures by employing coping strategies, which include avoidance, stereotyping and treating everyone as the same. Nonetheless, many of the health visitors interviewed did deal with their uncertainty and moved forward onto ‘cross cultural terrain’. In the next section, I consider how some of the health visitors managed uncertainty by ‘positioning self’ as the ‘professional self’.

5.2.3.4 Managing uncertainty through ‘positioning self’. Asserting a professional identity: undermined over time

In an attempt to form a ‘relational journey’ with their clients across cultures, the health visitors who participated in my study ‘envisioned the journey’ as the initial step of the ‘relational journey’. As part of this ‘envisioning of the journey’, they ‘positioned self’ in several different ways. Two of the most important aspects of this were, firstly, they ‘asserted the professional self’ and, secondly, they normalised Western discourses of health and positioned them as invisible. Whiteness scholars again alert us to the ways in which white people position themselves as the ‘white self’, as normalised in relation to the cultural ‘other’ as different (Anderson et al., 2003).

One of the recurring themes of the narratives of the health visitors was of feeling undervalued as health professionals and that their role was unknown. They felt that their professional role was undermined over time. Sometimes this was by the family and at other times by the client. This was identified in the codes ‘under the gaze of the other’ as ‘unknown’ and ‘untrustworthy’. Several of the health visitors in my study said they introduced themselves as ‘qualified nurses’ as Cathy did below:

> Fiona: How do you describe your role as a health visitor to people who ask?
> Cathy: I, I start by telling them that we are qualified nurses, that is the first thing that I start by telling them and I usually go on to describe the difference between us and midwives. Whereas they go on to do further training after they are nursing in obstetrics and looking after pregnant ladies whereas ours is in child health and child development and child psychology, em, and then I go on to tell them about what sort of service we offer, Monday to Friday drop in clinics. We are generic health visitors even though we work predominantly with nought to fives etc., etc. (Cathy: 80-86)[sic].

As the research progressed, I began to ask questions in relation to ‘positioning self’ and several interesting categories were revealed (Figure 3.33). In ‘positioning self’, one of the ways some of the health visitors did this was to ‘assert the professional self’. This not only

uncovers issues of power in professional and client relationships, but also the ways in which these are intersected by discourses of ‘race’ and culture. Helen described it as:

> Well, in the end I am the professional and I have a professional responsibility to give the best care I can and that is what I do (Helen: 98-99)[sic].

An exploration of the literature around the area of ‘professional practice’ uncovered a plethora of literature within the field of nursing. Professional identity has been an area of contention for nursing over many decades, as it tries to separate itself from the dominance of the medical profession. Professional values are inseparable from discourses of evidence based practice and research based practice. Many of the health visitors used discourses of evidence based research to support their advice in contentious situations.

In ‘asserting the professional self’, the health visitors used the power of professional discourse, evidence based medicine and research based evidence as a means to silence difference. Nonetheless, this is not the whole story. The health visitors did not always feel powerful and, at times, they also felt very powerless when working across cultures. This concurs with research by Patricia Hill Collins in the 1990s (Collins, 1990), when she asserts that anyone can be both the oppressed or the oppressor, or both at the same time. Categories were identified where the health visitors felt ‘unsupported by management’ and ‘powerless in the face of a powerful system’, which was the National Health Service. Alice describes her experiences below:

A decision was made a couple of years ago now to make the Bangladeshi team move all of their clientele mainstream as well, so they don't exist at the minute because we were told they need to be integrated.

Fiona: How has that been for you as a health visitor?

Alice: It has been really difficult, really it was a case of overnight we were informed that we were going to be given the families back to us and they were just sent back to us.

Fiona: Were you given any help or training to help you?

Alice: We were told that the team as it stood, because by that time the specialist nurse for asylum seekers had been merged into the Bengali team to call them the BME team and what they said was that they would have responsibility for the training and teaching of the staff and they came and we were told that the case load responsibility would come back to us but it didn't work like that. (Alice: 20-30)[sic]

Powerlessness was not only felt by the health visitors as pawns in a powerful health care system, but at times they also felt powerless to influence their clients in the face of a 'powerful grandparent', and were often kept beyond the 'shield of the family'. Rebecca describes it as:

There is that tradition that is there from the grandparents and they are quite powerful. And they have that hold over their son and that reflects on the daughter-in-law. (Rebeccca: 42-43)[sic].

She goes on to say later in her narrative:

> I think there is quite a lot of resistance because they feel that that is how it should be done and this is the way it should be done (Rebecca: 214-215)[sic].

My research has uncovered the ways in which health visitors assert their professional identity in cross cultural encounters, and can position themselves as powerful holders of the knowledge in health care and child rearing practice. Discourses of evidence based practice and research based knowledge are used to support this stance. Nonetheless, it is too simplistic to assert that the 'health visitor self' was always the powerful self. Many times, the health visitors felt powerless in the face of a powerful health care system, and powerless to influence their clients behind the 'shield of the extended family' or a powerful mother-in-law. The implications of this for cultural education are discussed in chapter 6.4.

The final strategy used by health visitors in my study to manage uncertainty was to 'develop a toolkit' of knowledge, experience and assessment framework tools, and this is explored in the next section.

5.2.3.5 Managing uncertainty with a toolkit. Developing a toolkit: strengthening over time

In ‘envisioning the journey’ across cultures, all of the health visitors took a conceptual ‘toolkit’ with them on the journey. This consisted of three important elements, namely a ‘toolkit of knowledge’, a ‘toolkit of experience’ and ‘assessment framework tools’. The important outcome of my research is that, although the health visitors developed their ‘toolkit’ over time by increasing their knowledge and experience of the cultural ‘other’ and by adapting assessment frameworks, this did not increase ‘emotional flexibility’ to engage with different cultures in the future. ‘Emotional flexibility’ was identified as more important to effective cross cultural engagement than ‘developing a toolkit’ over time.

The ‘toolkit of knowledge’ was perceived by the majority of health visitors to be the most essential element of their conceptual ‘toolkit’. The health visitors wanted knowledge of the cultural ‘other’ when asked what they would like in educational packages, which explored cultural engagement. Knowledge of the cultural ‘other’ was a strong and persistent theme throughout the research. Scholarly literature in nursing supports this discourse, where much of nursing practice is built on nursing knowledge. A plethora of scholarly literature exists which builds on nursing knowledge. This is then translated into cultural ‘knowledge’ and the discourse of ‘cultural knowledge’ is strong within transcultural nursing approaches to cultural education. The health visitors all struggled with not knowing the cultural ‘other’ and the contrast with Helen and Sophie was noticeable, who did not expect to know their

clients but were prepared to ‘take the ball and see what you could do with it’. Helen and Sophie were able to embrace the fluid and changing nature of culture, without fixing it in time and space. They were comfortable with ambiguity.

The ‘toolkit of experience’ was a very interesting category, as a story emerged during the research where, although experience of working with clients across cultures resulted in increased comfort and confidence for the health visitors, it did not necessarily build ‘emotional flexibility’. This is important as ‘emotional flexibility’ was important for effective cross cultural engagement. This concept is developed further in section 5.4. Finally, ‘assessment tools’ were used by all of the health visitors in cross cultural work but there was a wide recognition that they did not really work and had to be adapted to be effective across cultures. This concurs with a search of the literature, where a vast array of assessment tools are continually being developed to try to assess health across cultures.

5.2.4 Emotional flexibility: treading lightly on cultural terrain

The previous three sections have described ways in which the health visitors in my study either avoided active engagement with their clients who were from cultures different to their own, or developed strategies to manage uncertainty. Nonetheless, this was not the whole story. In contrast to the accounts above, two of the health visitors interviewed did discuss their experiences of forming in depth relationships with their

clients across cultures. This was conceptualised as ‘emotional flexibility: treading lightly on cross cultural terrain’.

Coding and categorisation of the narrative accounts of these two health visitors in this study identified ‘emotional flexibility’ as a conceptualisation of the health visitors who appeared to engage most effectively across cultures. Utilising a Bourdieusian analysis of ‘emotional flexibility: treading lightly on cross cultural terrain’, questions are raised as to the forms of capital utilised by these two health visitors, in order to engage effectively with clients across different cultures. Some health visitors were able to engage with uncertainty and ambiguity, which is inherent in cross cultural working, while most others avoided, stereotyped or extended the equality agenda to reduce the depth of engagement with their clients. It is pertinent to ask what type of capital is used to enable some health professionals to engage actively with their clients across cultures and how does emotion, in particular anxiety and uncertainty, fit with this.

Concurrent coding and categorisation of the data uncovered several conceptual themes, which indicated ways some of the health visitors were able to engage with clients across cultures at a deeper level. These related to ‘emotional flexibility’ but also related to non-emotional ways in which the health visitors engaged e.g.‘lived abroad’ and envisioning their ‘cross cultural journey’ as a ‘journey against injustice’. Sophie described it as:

> I've always sort of fought for the underdog really and I will always root those people out and I have always sort of stood up for inequalities sort of things because I am very much about fairness. So if you can do this for one person you can do it for everyone and I suppose that is sort of my philosophy really and I think that is what has pushed me into ethnic minorities (Sophie: 58-61)[sic].

Olivia had only worked with one particular cultural group, so her story was difficult to examine in relation to 'emotional flexibility', but she did have a strong sense of social justice with her work:

> I think probably the most (pause), the thing that has kept me driven has been the fact that I felt that I made more of a difference there than I do with any other part of my caseload and to be perfectly honest I was quite shocked, em, and outraged really when I first took the post on just how much discrimination is out there against this particular group. I knew nothing about travellers and gypsies and to be honest as far as I knew 18 or 19 years ago there weren't people who lived in caravans and travelled around. I knew nothing about the culture and saying that, I had no judgements about them either , I neither felt positive nor negative, just interested I suppose but I was just so shocked by the prejudice out there amongst professionals, as much as anyone else, that maintained my interest, I felt as if I had a fight on my hands

and I enjoy a challenge. I like a good fight (laughs) (Olivia: 28-36)[sic].

The accounts of Sophie and Olivia stand in stark contrast to many of the other accounts of the health visitors in cross cultural work, where justice did not appear to feature at all. For example, Cathy was very reluctant to challenge the lack of female interpreters:

> Fiona: Can you ask for female interpreters?
> Cathy: I could, I could try but that may delay things because they are few and far between. I feel that sometimes you are lucky to have an interpreter at all and so you daren't be too fussy about it really (Cathy: 46-48)[sic].

Aranda (2005) uncovered ways in which community nurses:

> Drawing on an ethic of justice discourse meant that highly important differences could be ignored and discriminatory judgements and limited care were defined as acceptable, both morally and professionally (p.134)[sic].

Also, the health visitors who worked 'flexibly' did not 'meet in the middle' but used metaphors of 'explore and marry it up' and 'listening and learning':

> Where they perceive that the first breast milk is dirty in some cultures but we know from research that that is where they get their immunity from the colostrum, so you have to explore

what they think and marry it up and say this is what lots of people have researched and we work together (Helen: 154-156)[sic].

Fiona: Thank you. This is my final question. Have any of your clients disclosed racism with you?
Helen : Yes, all of the time, every day. You have to be comfortable to ask questions and to ask the right questions because to ask a question, you have to be comfortable with the answer. But every day I hear about racism. (Helen: 554-559)[sic].

Bourdieusian analysis suggests that certain levels of cultural and social capital are required in order to engage effectively with clients from other cultures. The question remains as to the ways in which cultural capital, and/or social capital, influences emotional engagement of the health visitors:

I do think it is about being able to think outside the box and I think I am lucky in that I am very good at processing things quite quickly and thinking of lots of alternatives and thinking outside the box really and it might be something outside the box really and my attitude is if you find an obstacle, then find a way round it (Sophie: 308)[sic].

'Emotional flexibility' was identified in my research as important for 'emotional engagement across cultures', and the following two sections

(5.3 and 5.4) explore these central concepts further, using the conceptual work of Pierre Bourdieu as a theoretical framework.

5.3 Theoretical conceptualisations of 'emotional engagement'

5.3.1Erving Goffman and the health visitor self

Since the publication of Arlie Hochschild's seminal work on emotional labour (Hochschild 1979, 1983), the study of emotions have moved from the fringes of sociological enquiry to take a more central stage. Douglas Massey (2002), in his exploration of the history of emotions states that:

> Emotionality remains a strong and independent force in human affairs influencing perceptions, colouring memories, binding people together through attraction, keeping people apart through hatred and regulating their behaviour through guilt, shame, and pride. (Massey, 2002, p.20).

My research has uncovered emotion, in particular uncertainty and anxiety, as important dimensions of the health visitor experience in working with people who are from cultures different to their own. A review of the literature in nursing reveals the concept of emotional engagement as largely focused in terms of emotional labour. Originating from the seminal work of Arlie Hochschild, where she delineates emotions in terms of how they interact with status hierarchies. Arlie Hochschild is largely credited as the leading scholar in

the field of the sociology of emotions, drawing on her classic study, *The Managed health: the commercialisation of human feeling* (1983). Developing the concept of emotional labour, her more recent work has moved to explore Marxist conceptualisations of exploitation in the labour process, in particular with a focus on women (Hochschild, 2000; Ehrenrich and Hoschschild, 2003). It is not to these recent works, which attention is focused in relation to the health visitors in my study, but the lens is turned back toward her original work in the 1970s on *Emotion work, feeling rules and social structures* (1972). It is from here that the body of scholarly work has diverged in several different but overlapping fields of study.

For Hochschild, emotions are performances enacted by individuals within organisational hierarchies and can then be marketed as 'emotional labour'. Individuals work to bring their own feelings in line with the cultural norms of the organisation. Although not without her critics (Wouters,1989), Hochschild differentiates between 'surface' and 'deep' acting performed by actors in organisational settings. In 'surface' acting, the outer expression is changed in order to achieve an alignment between feelings and the behaviour demonstrated. In 'deep' acting, a change of inner feelings is required to reflect the expressions required in the given situation. Using Hochschild's insights into the way individuals shape (and are shaped) by their emotional engagement in the world of air flight attendants, a plethora of nursing literature has emerged around the concept of 'emotional labour' within health care. The development of scholarship has been extended in two different ways. Firstly, they gesture towards conceptualising 'emotional labour',

as a performance or a role to be played out within health care discourse. This is particularly seen in scholarly enquiry, which interrogates the concept of 'the detached nurse' in managing stress in the workplace (Dowling, 2008). In particular, scholars within nursing highlight emotion as either the performance (Huynh, Alderson and Thompson, 2008), or the expected role nurses should perform (Henderson, 2001). The performance has been described as the way in which 'nurses manipulate and resist some of the emotional demands made of them whilst still presenting an acceptable face' (Bolton, 2001, p.86). Sharon Bolton (2001) describes these as the 'professional face', the 'smiley face' and the 'humorous face'. A burgeoning literature within organisational management has also interrogated 'emotional labour' as both a performance and a commodity. Scholars with feminist sensibilities interrogate 'emotional labour' as unpaid, female work.

Initial explorations of the accounts of these scholars offered valuable insights in order to conceptualise the 'health visitor self' as currently conceived. The underlying theoretical foundations upon which much of this perspective in 'emotional labour' is built explicitly (or at times implicitly) upon, is the symbolic interractionalist tradition and in particular the work of Erving Goffman. Arlie Hochschild work is informed by Goffman's theoretical perspectives, building her own conceptualisations of 'emotional labour'. In the field of organisational management, Bolton (2001) began her field of analysis with Goffman and moved 'beyond' this as a framework of analysis. Scholars in the field (Ehrenrich and Hochschild, 2003) use Marxist analysis to interrogate the concept of 'emotional labour' as capital. In different but

overlapping ways, each of these writers conceptualises emotion work as a unit of labour. In examining these accounts, they initially appeared to shed light on the 'health visitor self', but following further exploration, these conceptualisations proved inadequate in theorising the explanation of the health visitors in my study. The dynamic between the 'health visitor self' and the performance can certainly be found in my study, but attention needs to be drawn to the ways in which this work differs from other writers on 'emotional labour'. The key difference identified in my study is that the emotion experienced by the health visitors is in trying to negotiate 'cross cultural journeys' and to 'stabilise uncertain terrain'. Although salience is found with Goffman's performance self, when the focus of the lens is turned to the particularities of the 'emotional work' of the health visitors in this study, it became clear that rather than 'performing' a role, the health visitors were working to 'stabilise uncertain terrain'. In addition, this work was largely a hidden work (Section 5.5).

The expansion of the concept of emotional labour within nursing has both intersected and diverged with scholars in sociology. Within nursing, the focus is centred largely around emotional labour as caring. In engaging with the work of Hochschild, and concurring with the body of scholarship on professional identity, nursing scholarship on 'emotional work' engages with the complex dynamics of professional identity. Nicky James, working within the field of health sociology in the 1980s, spent 5 months as a nurse participant observer in a hospice, conceptualising care as labour (James, 1989). This turned the lens of nursing inquiry to the concept of care (and the emotional demands of

caring for the dying) as emotional labour. For James (1989), the emotional labour was not so much seen as a performance, but a giving of a part of oneself. Emotions such as grief, anger, loss, despair and frustration in patients were recognised as difficult for nurses to deal with.

The concept of 'care' as emotional labour began to emerge as an area of scholarly enquiry from the 1980s onwards in the UK. Pam Smith (1992) continued this line of enquiry with her exploration of emotional labour as a component part of caring. Smith's work with student nurses brought to the foreground several aspects of emotional work, which have been developed and expanded in the subsequent 20 years since she published *The emotional labour of nursing* (1992). 'Caring' as emotionally giving of the self, especially within the hospice setting or terminally ill in hospital, has become a focus of enquiry in the field of emotional labour. Recent scholarly enquiry has focused on the popular notion of emotional intelligence. Emotional intelligence is described as the ability to form connecting relationships with others easily, and to read other people's feelings and responses accurately (Goleman, 1998), and has begun to be explored within the nursing literature (McQueen, 2004). Emotional labour is seen as being central to establishing a therapeutic nurse-patient relationship. Emotional intelligence involves the expression, control and use of emotion to solve problems (Mayer and Salovey, 1993), but this is explored within nursing discourse in terms of professional skills such as counselling skills and empathy. 'New nursing' (Savage, 1990) has led to a whole lexicon of concepts now valued within nursing, which focus on the nurse-patient

relationship as central to effective practice. Holistic practice, empathy, the ‘therapeutic use of self’ and many nursing models focus on the ability of the nurse to meet the psychological, emotional, social and spiritual needs of the clients, as well as the physical needs. As the profession foregrounds these concepts, it is also concerned about retention rates within the profession and with ‘burn out’ due to emotional stress. Nursing discourses simultaneously promote the ‘giving of self’ in a therapeutic sense (Henderson, 2001), in which emotional labour is recognised as of therapeutic value (Gray, 2009), while also voicing concern for the ways in which nurses protect themselves to cope with the emotional stress of certain situations (MacKintosh, 2007). Henderson (2001) highlighted the ways in which nurses detach themselves from situations according to specific patient circumstances.

In examining the nursing and health care literature, there is a paucity of literature on anxiety and uncertainty, and research into the strategies that nurses use to deal with anxiety. Identified as ‘distancing’, ‘seen it all before’ and ‘labelling of the difficult patient’, Smith (1992, p.131) describes briefly some of the strategies she identified in her research with student nurses to cope with the emotional demands of nursing. There is resonance with this research in ‘emotional avoidance: travelling to the perimeter fence of culture’, which is describes in detail in section 5.2.3.1, the ways in which health visitors avoided emotional engagement with their clients and tried to ‘stabilise uncertain terrain’ in cross cultural work.

In examining these accounts of emotional labour, the dynamics between the role health visitors perform and the strategies they use to cope with emotional labour are themes which can be found in the analysis of this research. Nonetheless, attention also needs to be drawn to the ways in which anxiety operates and differs from other aspects of 'emotional labour'. The key difference identified lies in the ways in which anxiety is not towards an individual but around 'cross cultural terrain', and also anxiety as a specific emotion. Initial exploration of the accounts of the health visitors in my study suggests that in order to conceptualise their experience of working with people from other cultures, the concept of 'emotional labour' needs to be both refracted into its component emotional colours and also; it needs to be conceptualised beyond 'emotion as care'.

In contrast to much of the aforementioned body of scholarship, firstly this research found that 'emotional work' as 'caring work' was not an accurate descriptor of the work of health visitors. Although situated within health and nursing discourse, the role and perception of the health visitor is not the same as the 'caring nurse'. Secondly, the work of the health visitors was a *hidden* work of managing emotions against the organisational norms and expectations. Rather than performing 'surface' or 'deep' acting in the manner identified by many scholars in organisations, the health visitors were hiding their emotions *against* the organisation. McQueen (2004) acknowledges in her work on emotional intelligence in nursing work, that emotional work can include 'emotions such as disgust, annoyance or frustration in patient interactions' (p.104), but there is no mention of anxiety or uncertainty. Thirdly,

concurring with and drawing on the conceptualisations of Gunaratnam and Lewis (2001), there is a 'disembodied and unreflexive nature of much of the theorising around emotions' (p.133). The work of Goffman and much of the nursing scholarship on 'emotional work, is based on a humanitarian philosophy which foregrounds the role of agency and leaves issues of structure in the shadows. This is based on the concepts of trust and the goodwill of others (Baier, 1986). Bell and Duffy (2009) contend that in nurse-patient relationships:

> Goodwill is an essential feature of trust, enabling the necessary distinction between trustworthy individuals and 'trust pretenders' (a person pretending to be worthy of trust, but with an ulterior motive for their behaviour), discerning good trust from misplaced trust (where the person trusted is not deserving of trust). (p.48).

I was challenged by readings in the fields of critical cultural studies, white studies and poststructuralist writings to find a theoretical framework, which moved beyond theories of individual agency to interrogate the ways in which structure and agency interact. It is to the work of Pierre Bourdieu that I turned to explore the relationship between health visitors, 'cross cultural terrain' and emotions further.

5.3.2 Pierre Bourdieu and cross cultural terrain

Recent scholarly writing on the re-conceptualisation of culture and health, using the writings of Pierre Bourdieu (Lynam, 2004; Lynam et

al., 2006; Anderson et al., 2007) were brought to my attention, as I grappled to find theoretical resonance with the conceptualisation of health visitors in ‘cross cultural journeys: stabilising uncertain terrain’.

The theoretical conceptualisation of this research suggests that the health visitors in this study were not merely performing a role-play, but that their work in cross cultural encounters with their clients was to negotiate and to ‘stabilise uncertain terrain’. The health visitors conceptualised ‘cross cultural terrain’ as unstable in many intersecting ways (Appendix H6). In entering a relationship journey with their clients across cultures, the health visitors were aware they were journeying through the political history of ‘race’ in the UK, through the culture of the organisation within which they operated (the British National Health Service), and through health discourses of ‘competency’ and ‘evidence based practice’. To conceptualise the health visitors as active agents without due regard for cultural spaces, organisational discourse and professional normative values appeared to be too simple an explanation. It became clear to me, that to foreground agency to the detriment of structure would operate to negate the complex ways in which the health visitors acted and interacted with their clients who are from other cultures. It was to the work of Pierre Bourdieu, who favoured a position that is stucturalist without losing sight of the agent (Ritzer and Goodman, 2003) that I ultimately turned. Bourdieu’s theoretical perspective aligns with a social constructionist stance, as individuals engage with others in their social worlds and in doing so, make sense of that world.

In studying the ways in which health visitors, as social agents, account for and represent the social world through their narratives, it is clear that the structures through which these processes exist are equally as important. The health visitors discussed relationships and social structures, particularly in terms of 'cross cultural terrain', and Bourdieu's theory of the dialectical relationship between objective structure and individual (or collective) agency is a fitting theoretical framework with which to consider this research. For Bourdieu, day-to-day practices were not objectively determined, nor were they the product of free will, but rather they were dialectically structured (Schwartz, 1997). At the heart of his work, in trying to theorise this complex and dialectic relationship between structure and agency, Bourdieu's concepts of *habitus* and *field* were conceived.

The work of Bourdieu has salience for several reasons, which will be interrogated and developed in this chapter. Bourdieu's work was rooted in practice and he grappled to understand the ways in which everyday practice shapes the social world, and also the ways in which the social world is also shaped by day-to-day practice. He also turned his gaze of inquiry to the ways in which practice and the social world are shaped, moulded and stretched (or indeed shape, mould and stretch) through time and history (Bourdieu, 1977). My study, which attempts to capture not only the everyday narrative of the health visitors in their daily work, but also the historical constructions of 'race', culture and ethnicity does not fit within one discipline or field of enquiry. Bourdieu's central concerns were with a wide range of relationships across disciplines, from sociology, philosophy, economics, history and politics (Bourdieu

and Wacquant, 1992). My research is about grappling with the historical construction of 'race', with the politics of 'race' within the UK, with organisational culture, with health economics and resources, with the complexity of multiple discourses, which is the lived experience of the health visitors in this study. The work of Bourdieu is complex and has been critiqued for its contradictory nature at times, but in order to push forward scholarship in any arena, theory need to be stretched and remoulded, in Bourdieu's own words, to make them 'groan and protest' (Bourdieu and Wacquant, 1992, p.xiv). This section not only attempts to describe the work of Bourdieu in relation to 'cultural terrain' and the experiences of the health visitors, but to stretch his work to ask whether 'emotion' can become an element of Bourdiuean theory. I ask many questions but fall short of any adequate answers, although the following sections chart my journey and point to further areas for research into the notion of emotional flexibility, emotional capital and emotional *habitus* in the future.

In searching for a theoretical construct to help develop the conceptual theory 'emotional encounters through cross cultural terrain: shaping relational journeys through culture', the work of Bourdieu was recognised as a good fit. Bourdieu rejects the notion of the duality between individuals and society, between structure and agency and his ideas of *field, habitus* and capital are attempts to grapple with the complexities of how agency and structure intersect in dynamic, conscious and unconscious ways to shape both actions and outcomes. The health visitors in this study were only to some extent active agents in their dealings with their clients who are from other cultures, but the

‘cross cultural terrain’ they entered was defined by uncertainty and anxiety, which arose from the political and historical discourses within which they worked. It became that the work of the health visitors to ‘stabilise uncertain terrain’ was not only important in terms of ‘emotional engagement’ but also significant in that it was also a ‘hidden work’. A detailed examination of ‘emotional engagement’ as ‘hidden work’ in current cultural discourses in health around ‘competency’ is explored further in section 5.4

Bourdieu describes his theory as *constructivist structuralism* or *structuralist constructism* (1989, p.14), although his work is often put into a poststructuralist epistemological framework (Ritzer and Goodman, 2003). *Structure* has a wide range of sociological meanings but for Bourdieu, *habitus* is formed by encountering the structured space which exists around individuals. This structured space within which *habitus* is formed is both social and physical, and is often unconscious. The health visitors in this study conceptualised their relationships with clients from other cultures as existing in **‘**cross cultural terrain’. In engaging with clients from other cultures, the health visitors moved towards this ‘otherised’ terrain. Annette described this in terms of both a ‘comfort zone’ and as needing to ‘cross paths’ with her clients:

> You do feel very ignorant when you first visit people in their own homes and I think I was a bit like a sponge, I think I was very keen to lean about different cultures but also a bit intimidated as well and a bit scared. In hospital, it is very

> much in your comfort zone and they are out of their comfort zone but in the home it is a complete reversal when you are visiting them, and you think 'I don't understand what is going on here' and you would ask but then some are better than others at explaining it, so it is more about understanding what is normal for them and then, em, where we need to cross our paths a little bit (Annette: 78-84)[sic].

Jessica described working with Polish families as 'a whole new set of problems' as the vignette below demonstrates:

> I've actually got mostly Polish families on my case load and I have set up a Polish group and there are so many things that they don't seem to address that, em I just thought I haven't really come across the problems that I was facing so I set up a group but it has been a bit slow to get going, if I am honest because you find a whole new set of problems if I am honest, definitely (Jessica: 5-9)[sic].

For Bourdieu, this structured space within which *habitus* is formed is made up of different bounded *fields*. Ritzer and Goodman (2003) describe *habitus* as:

> the 'mental, or cognitive structures' through which people deal with the social world. People are endowed with a series of internalized schemes through which they perceive understand, appreciate, and evaluate the social world. It is

> through such schemes that people both produce their practices and perceive and evaluate them (p.520).

Habitus can be described as 'life rules'. The *habitus* of the health visitors interviewed will be considered in the following paragraphs in detail, but what is interesting to note at this point, is that the work of the health visitors in this study was of leaving their *habitus*, as described by Annette as a 'comfort zone' and entering a different, cross cultural *habitus,* which was characterised by instability and uncertainty. In order to manage this, the health visitors tried to find some shared elements of *habitus* and this was conceptualised during data analysis as 'finding common ground'. Mary described trying to find the 'norm':

> Speaking to Bangladeshi families, they take the children into bed with them, for quite long periods until the child is quite old, in Britain we don't really advocate doing that, em, but you know I have heard comments like, but 'why should I put my child in a cage, because the cot has got bars on it?' And things, so again it is just, you can give the advice and just leave it really, but it is really interesting you know to get that information as well, you know because that is obviously the norm in their country you know (Mary: 93-97)[sic].

For Mary, it was also about trying to 'get that balance' as the vignette below demonstrates:

> culturally that is what they did and that is what they would do if they were at home, but obviously that is not what we do and it was a lot of work around how to get that 'happy balance' really (Mary: 204-206)[sic].

Annette and Jane and Mary described the difficulty in knowing how far to improve their own *habitus* on their clients:

> Who am I to go in and to say that 'you have to do something' in a very English way (Annette: 71)[sic].

> What I am really struggling with is imposing our values on them, but at the end of the day, you want the best outcome for that child' (Jane: 280-281)

Bourdieu (1984) described *habitus* as 'internalised 'embodied' social structures' (p.468), which are acquired through the long-term occupation of a specified social space. *Habitus* reflects a particular point in history and is produced through individual and collective practices over time. Not everyone has the same *habitus* but those who share a similar social position, share the same *habitus.* The health visitors in this study all occupied the same professional group, embodying similar values and beliefs in relation to their occupational status and its norms and values in relation to health. They were all white, British, were employed by Primary Care Trusts as part of the National Health Service, and lived in the North East of England. They all shared common values in relation to their occupational status that the

‘needs of the child’ were paramount over all other considerations. Beliefs in health practices such as weaning, sleeping routines for babies and nutrition were all shared. In this way, they can be described as occupying the same *habitus.* The challenge for the health visitors in working across cultures, was that they had to move beyond their own *habitus* and into a different *habitus,* where norms and values and what was considered as ‘common sense’ was challenged. This was conceptualised as entering ‘unstable ground’ and was suffused with emotional anxiety and uncertainty. Mary described this clearly below:

> My biggest fear would be finding out I had to move to an area with a high BME group in a short space of time, I wouldn’t like to have to do it suddenly. I would need time to prepare and find out about that group of people, to sort of, em (pause)
> Fiona: What would you like that preparation time to do?
> Mary: Just to look at what their beliefs are , what their culture is, how, you know , is there someone already working there, if there was someone already working in that area, if I could shadow them (Mary: 260-266)[sic].

The body of literature examining culture, ‘race’ and ethnicity has in recent years moved to explore issues of identity as central to expanding scholarly understanding. In ‘envisioning the journey’, the health visitors spoke of things they took with them for the ‘relational journey’, such as a ‘toolkit of knowledge’ and an ‘assessment tool kit’ but they also spoke of ‘leaving things behind’. The things they left behind were related to

beliefs and values and challenged their core identity as a health visitor and as a woman.

According to Bourdieu (1998) the task of sociology is to:

> uncover the most profoundly buried structures of the various social worlds which constitute the social universe, as well as the 'mechanisms' which tend to ensure their reproduction or their transformation (p.7).

If *habitus* is formed within structured spaces in social history, Bourdieu also sought to engage with the question of how much social agency individuals have to shape that social space. Wacquant (1996) describes this as Bourdieu's 'double life of structures':

> They exist twice: in the 'objectivity of the first order' constituted by the *distribution* of *material* resources and means of appropriation of socially scarce goods and values (species of capital, in Bourdieu's technical language); and in the 'objectivity of the second order,' in the form of systems of *classification*, the mental and bodily schemata that function as *symbolic* templates for the practical activities – conduct, thoughts, feelings, and judgments – of social agents. Social facts are objects which are also the object of knowledge within reality itself because human beings make meaningful the world which makes them' (p.7, italics original).

According to Bourdieu's schema, the health visitors did not work as performers, but they worked as both active social agents in their day to day work, but their actions were shaped by the worlds which also made them - both the NHS world, the colonial world, the white world, the professional nursing world, and a myriad of other worlds in which they live and work within (Appendix E). These worlds are termed 'fields' by Bourdieu. For Bourdieu, social agents construct social reality, individually and also collectively but that 'they have not constructed the categories they put to work in this work of construction' (Bourdieu, 1989, p.47). Individual health visitors are social agents who construct the social reality of their day-to-day interactions with their clients and also of the health visiting profession, both constructing and being constructed by their whiteness, their class position, their historical legacy of colonialism or the political structure of 'race' in the British NHS. Nonetheless, they operated within these structures and interact with them in complex and contested ways. It is these:

> unconscious principles of (di)vision that agents engage in their practice that are constituted (Wacquant, 1989, p.13).

The *habitus* occupied by the health visitors in this study was conceptualised as a structured space, whereby the principles by which they made their choices and chose the strategies that they employed in the social world were played out. In the research study to which this thesis refers, the health visitors occupied a *habitus,* which was multilayered and complex, but some of these could also be teased out

for comment. In ‘envisioning their journey’, the health visitors prepared to leave their *habitus* in order to journey towards another *habitus*. This new *habitus* was conceptualised as journeying towards ‘middle ground’ or ‘common ground’, but they were aware that common sense rules pertaining to their professional position did not necessarily apply. Common elements of *habitus* for the health visitors were embedded in their ‘race’, class and gender. For Bourdieu, *habitus* not only is acquired through a long term occupation of a certain position in the social world, but *habitus* provides the principles by which people take decisions and point to the strategies that they will employ in the social world. The strategies the health visitors used to engage with their clients who were from cultures different to their own were shaped by their *habitus.*

Ritzer and Goodman (2003) point out that for Bourdieu:

> *habitus* is *not* an unchanging, fixed structure, but rather is adapted by individuals who are constantly changing in the face of contradictory situations in which they find themselves’ (p. 522).

Sophie explains the ways in which she had changed over time and this became a conceptual thread in the research:

> Fiona: In what ways do you think you have changed since you first started working with people from other cultures?
> Sophie: I am sure I have changed, because you know, you sort of, you are probably treading on egg shells a bit when

> you are a new health visitor... I think I can understand why people feel as if they are treading on egg shells but I don't think I was feeling that more so with ethnic minorities than with anyone else, because to me people are people and it doesn't matter where they come from and it is about you building up your knowledge and I would read stuff and I would ask questions and in (a large city) we used to , we didn't have interpreters, we had health advocates, who would come out with you and they were from the same community and they would give their phone number to the clients and that, so if I did a weaning visit and the baby was losing weight and I was concerned about them and we would go out with the health advocate and we would go through you know, what I thought the parent should do and why and then the health advocate would do a follow up visit and then come back to me if there were any problems, so I would often ask the health advocate if there was any problems , you know what the difficulties were, you know and really being open to all of that and you adjust your practice to your knowledge really and sort of think, am I looking at this in a blinkered way and you try and open that up (Sophie: 177-195)[sic]

In describing how she has changed over time, Sophie described in the interview how she felt more confident now, and how she felt much less anxious than she had in her early years of working across cultures. She was also more open, both emotionally within herself, and also her view of culture had opened over time.

Closely linked to *habitus*, and mutually constituting each, is Bourdieu's concept of *field.* Field has already been touched upon when discussing the ways in which health visitors occupy different social spheres, such as a professional sphere, NHS policy rhetoric and educational spheres. Grenfell (2004) describes the relationship between *habitus* and *field* succinctly as thus:

> Individuals are surrounded by space – physical and social – with degrees of proximity – close and distant. This space is differentiated and is structured. It is in encountering this structured space that *habitus* is formed. Moreover, this structured space is made up of recognizable bounded territories: for example, the professional (various professions), personal (families, social networks, residence) and political (administrative institutions, political agencies). For Bourdieu, these are all examples of *fields* (p.27, italics original).

In conversation with Pierre Bourdieu, Louis Wacquant describes *field* as 'a network of relations among the objective positions within it' (Bourdieu and Wacquant, 1992, p.97). Bourdieu thought of *field* as relational rather than structural, but relationships were not conceptualised as interactions amongst individuals. *Fields* are networks or configurations and include power relations, but these relations exist apart from individual consciousness and will. Ritzer and Goodman (2003) are clear that fields are *not*:

> Interactions or intersubjective ties among individuals. The occupants of positions may be either agents or institutions, and they are constrained by the structure of the field (p.522).

Fields can be large or small, and *fields* can exist within *fields*. For the health visitors in this study, there are a number of simultaneous fields which can be identified as operating within the social world they occupy, for example, Westernised medicine, the British National Health Service and the Health Visitor profession.

The initial 'social world maps' (Appendix F) that were drawn during the analysis stage of this research project, helped to identify both the *field* and the *habitus* of the health visitors in this study. Bourdieu laid out a three step process for the analysis of a *field*, which appears to have resonance with the situational and positional maps of Adele Clark (2005). For Bourdieu power is also important as Wacquant summarises:

> The socially constituted classificatory schemes through which we actively construct society tend to represent the structures out of which they are issues as natural and necessary, rather than as the historically contingent fallouts of a given balance of power between classes, 'ethnic' groups, or genders' (Wacquant, 1989, p.14).

Bourdieu's steps of analysis involve identifying the sources of power by, firstly, tracing the relationship of any specific field to the political field. Secondly, the structure of the relations among positions in the field

should be mapped and, finally, the nature of the *habitus* of the occupants of the *field* should be determined (Ritzer and Goodman, 2003).

It is central to Bourdieu's theory that the structures of *habitus* and *field* are mutually constituted. Bourdieu (1989) writes of the relationship between *field* and *habitus* as:

> On the one side it is a relation of conditions the *field* structure the *habitus*…on the other side, it is a relation of knowledge or cognitive construction: *habitus* contributes to constituting the field as a meaningful world (p.47).

All *fields* connect with each other, but the relationship between field and structure is a dynamic and changing. Grenfell (2005) describes it as:

> The homology between *field* and *habitus* meant that their constituting structures need to be understood in a dynamic sense – they are structured and structuring structures and they include both the material, social organisational and personal' (p.28).

In many ways, 'mapping the terrain' was a 'mapping of the *field* and *habitus*' in Bourdieuian terms. 'Not having a language to use' was identified as problematic within a professional health care *field* within the UK, where 'communication' is a central tenant of both national policy and professional nursing practice. In identifying 'politicised

terrain', 'communication' was not identified as operating within a vacuum but within a very politicised *field*. Health care policy requires a 'toolbox' to help health visitors to navigate social space as part of their daily work, but moving into a different *habitus* the health visitors realised that their 'toolkit was rendered ineffective'.

Over time both *field* and *habitus* evolve, continually interacting, refining and shaping each other. The narratives of the health visitors was that with time, they adapted to working within the new *habitus* of their clients, and were both shaped by and also shaped the new cultural space in their relational journey towards health.

Using the theoretical work of Pierre Bourdieu, I was able to interrogate some of the conceptual codes in the theory 'emotional encounters through cross cultural terrain: shaping relational journeys through culture' in terms of *habitus* and *field*. Nonetheless, as some questions are answered, so others it seems are opened up. Firstly, it is pertinent to ask why some health visitors were able to negotiate 'cross cultural terrain' effectively, by 'moving forward on to cross cultural terrain', and yet others remained at the 'perimeter fence' of 'cross cultural terrain'. Continuing a Bourdieuan analysis, the question remains as to what forms of capital the health visitors used in order to negotiate the 'relational journey' with their clients through culture. It is clear that 'emotional engagement' was a strong conceptual category in data analysis and, yet, Bourdieu never refers explicitly in his writings to emotional capital.

5.3.3 Conceptual development: emotional capital, emotional *habitus*

In recent years the study of emotion has witnessed an upsurge in interest across many different fields simultaneously, and consequently the conceptualisation of emotion has been critiqued and stretched to challenge not only the historic dichotomy of reason and emotion, but also the epistemological foundations of the study of emotion. Emirbayer and Goldberg (2005) writing from the field of social politics explore the ways in which collective emotions are involved with political social movements. In doing so, they have sought to 'rethink and re-evaluate the significance of emotions in contentious politics' (p.470). Scholars writing from the discipline of geography are seeking not only to explore the significance of place and emotional space, but to interrogate emotion within symbolic spaces (Davidson, Bondi and Smith, 2005; Urry, 2005). The sociology of emotions has gained momentum over the last decade and as a consequence the theoretical foundations of the study of emotion have been opened up, critiqued and re-formulated in some exciting and challenging ways. Nonetheless, in studying emotions across diverse scholarly disciplines, many are involved in debates, as to the extent to which emotions are involved in the mind and body, innate or socially constructed, private or public or whether these dichotomies can be transcended (Lupton, 1998; Emirbayer and Goldberg, 2005; Zemblas, 2007). Zemblas (2007) suggests that the study of emotion has always proved problematic as, firstly, there is no agreement on what constitutes emotion by researchers. Secondly, the 'elusive' nature of emotion makes it very difficult to use traditional research methods to

‘measure’. Finally, it is suggested that because emotion has links to many diverse areas of social life, it has tended to be studied in small areas, and as a consequence parallel approaches have been developed, which are independent of each other.

In making the epistemological foundations of my research, as based broadly within social constructionism, the study of emotions is explored within this framework and made explicit throughout the ensuing discussion. Nonetheless, it is pertinent to situate a social constructionist approach to emotion within the wider theoretical context of the study of emotions. Fineman (2000) asserts that historically emotion research has been ‘imbued with biological and psychological determinism’ (p.3) articulated in the publication of Charles Darwin’s, ‘*The Expression of the Emotions in Man and Animals*’ published in 1872, where emotion was conceptualised as an individual and biological phenomenon. In the field of psychology, both cognitivist (Nussbaum, 2001) and psychodynamic approaches conceptualise emotion as an individual and psychological phenomenon. Both approaches have been critiqued for taking emotions to be physical sensations or feelings, and negating the sociocultural context within which these feelings are developed (Lupton, 1998). Feminist scholars (Skeggs,2004; Reay, 2004a, 2004b) and post structuralist scholars of emotion (McNay, 1999) have also challenged these approaches for negating to consider the ways in which history and culture operate to uncover the ways in which power operates and emotions are developed.

Over two decades ago Rom Harre (1986) emphasised the situated nature of emotions, of the importance of cultural situation and the cultural relativity of emotions. Since that time, scholars writing in a social constructivist epistemology have explored the ways in which emotion is constructed through time and space (Lupton, 1998). Central to social constructionist approaches to emotions is the idea that:

> The experience and expression of emotions is dependent on learned convictions or rules and that, to the extent that cultures differ in the way they talk about and conceptualise emotions, how they are experienced and expressed will differ in different cultures as well (Cornelius, 1996, as cited by Zembylas, 2007, p.61).

Recently scholars in a number of divergent contexts have sought to respond to the theoretical challenges, which an analysis of emotion within sociology presents. Mary Holmes (2010) in a study on the 'emotionalization of reflexivity' (p.139) gives an interesting account of beginning to explore the way individuals draw on emotions to interrogate themselves and their lives. Very few scholars have as yet explored emotion and 'race', but the work of Yasmin Gunaratnum (2007, 2009) and her work in collaboration with Gail Lewis (Gunaratnum and Lewis, 2001) opens up a discursive space to wrestle with the concepts of emotion and 'race'. Primarily concerned with the ways in which the emotions of anger, fear and shame are produced in 'race' discourses, Gunaratnum and Lewis,2001) argue that 'the irrational and unconscious aspects of racial dynamics cannot simply be countered by

appeals to the rational' (p.131), but that there must be a recognition of both the positive and negative effect of emotions on 'race' discourses and practice. Drawing on research within health and social care, specifically among hospice staff and users, Gunaratnum and Lewis (2001) attempt to explore the ways in which 'working with diversity and difference' are 'felt' (p.133). For Gunaratnum and Lewis (2001) 'emotions are an integral part of how 'race' is produced and experienced in social care organisations' (p.134).

In undertaking this exploration of the difficulties health visitors experience when working with clients who are from a culture different to their own, 'emotional encounters through cross cultural terrain', emotion was also identified as integral to how 'race' was conceptualised and experienced. Many of the health visitors interviewed felt either afraid to engage with culture or were emotionally closed. For health visitors who did engage with their clients across cultures, their work was to 'stabilise uncertain ground'. With an awareness of the boundaries/constraints of different theoretical traditions, my research raises several questions, particularly in relation to the ways in which some health visitors are 'emotionally flexible' and others are not. As I grappled with the concept of 'emotion' and culture within a Bourdieusan analysis, I was able to raise questions as to whether this could be conceptualised as 'emotional capital' or 'emotional *habitus*' and what were the constitutive parts of this.

Over the last 20 years, a small but growing number of scholars in a number of contexts have sought to engage with the concept of

‘emotional capital’. Dianne Reay (2004a, 2004b) credits Helga Nowotny (1981) as coining the term ‘emotional capital’ within a Bourdiuesian context, and described it broadly as the emotional resources women hand on to those they care about. She conceptualised ‘emotional capital’ as constituted as part of social capital but resting within the private, as opposed to the public sphere of life. Since that time, the studies of emotions have acquired enhanced importance not only within the private sphere but significantly within public policy and organisational management. In interrogating the ‘public life of emotions’, Squire (2001) has investigated the concept of emotional literacy as a prerequisite for applicants to many job applications. Burman (2009) notes that:

> Increasing public attention to the importance and exchange value of emotions can be seen within management – where ‘people skills’ are increasingly being recognised as central to the demands of a knowledge-based society that relies on the smooth functioning of interpersonal relationships, rather than on individual skills (p.139).

As a consequence, emotional literacy and emotional intelligence have become regular currency within educational discourse and management rhetoric. Emotional literacy and emotional intelligence are often sold as a set of competencies that can be taught as skills, and are seen as essential to the modern workplace. Burman (2009) alerts scholars to the ways in which emotional intelligence, self-esteem and mental health individualises and privatises social relations. Emotional

intelligence can then only be recognised as an essentialised, inner and individual feeling.

> We need to attend very closely to the epithet ‘emotional literacy’ as the metaphor that it is, i.e. as a process of schooling the production of *discourse about* emotion, rather than the discovery or recognition of some essential inner, individual feelings that require naming in order either to be better tamed or communicated (although this may happen too). Rather than becoming *literate about* emotions, the task is to *analyse the models of writing* emotions in circulation (p.150).

A review of the literature within the field of nursing revealed a dominant discourse of emotional intelligence as individualised, essentialised and residing within the nurse themselves (McQueen, 2004).

In trying to further scholarship and to grapple with this elusive concept of ‘emotional capital’, I struggled with the problem of how to theorise beyond ‘emotional capital’ as an essentialised individual characteristic, as conceptualised in much of the literature on ‘emotional literacy’. Feminist scholars have likewise attempted to extend a Bourdieusan theorisation of emotional capital, which lies beyond the individual attributes of individuals. Dianne Reay (2004a, 2004b) in an analysis of emotional capital, women and social class theorises emotional capital as that which mothers invest in their children in relation to schooling. Emotional capital is conceptualised within several feminist analyses as

constituted within either social or cultural capital. Reay (2004b) concludes that emotional capital is being forfeited in the pursuit of cultural capital for middle class women. Although Reay (2004b) is careful not to develop a theory of emotional capital as residing within individuals or families. My analytic response has been to question whether emotional capital can be seen in my research with health visitors, as residing in either cultural or social capital. In recounting their experiences of working with people from cultures different to their own, Helen and Sophie drew on cultural capital to work across cultures, as they had both lived in other cultures. Nonetheless, they still expressed some anxiety in cross cultural working but this did not prevent them from either entering 'cross cultural terrain', but they did appear to 'tread lightly on cross cultural terrain' and the 'cultural terrain' was not so unstable. Likewise, health visitors who had worked in a different *habitus* to their own were less anxious about cross cultural working, but they recognised that if that was to change, their reaction might be very different and include anxiety. Helen, Sophie and Olivia also drew upon social capital to engage across cultures, conceptualised as a 'journey against injustice'. They clearly saw themselves as being in a social position, which was able to advantage a 'journey against injustice'.

The conceptualisation of 'emotional capital' as thus far conceptualised in the literature as either 'emotional intelligence' (innate and essentialised quality) or as part of social or cultural capital appears to be problematic in relation to 'emotional hesitation: stabilising uncertain ground'. 'Emotional capital' in this research with health visitors refers to the ability of the health visitors to emotionally adapt to continually

shifting and unstable terrain. The question remains as to the extent to which ‘emotional flexibility’ can be conceptualised as emotional capital? The emotional ability to ‘stabilise uncertain terrain’ becomes problematically conceptualised as ‘emotional capital’, without essentialising it as a within social or cultural capital, either as learned or innate. Matthews et al. (2002) are possibly closer when they point out that in relation to emotional intelligence:

> whether people cope effectively or ineffectively is often dependent on both the context, and on the criteria chosen to define effectiveness (p.538).

For all of the health visitors in this research, their work to ‘stabilise uncertain terrain’ was central to a health care discourse, which requires certainty, competence and control. The possibility then opens up that what should rather happen is that health professionals who engage with their clients across cultures are those who, rather than ‘stabilise uncertain terrain’, emotionally adapt to uncertain terrain and demonstrate ‘emotional flexibility’ across cultural terrain. The further implications of the development of ‘emotional flexibility’ are discussed in chapter 6.2

5.3.4 Summary

‘Emotional flexibility: treading confidently through cross cultural terrain’ has emerged as an important conceptualisation in cross cultural working for health visitors. ‘Cross cultural journeys’ conceptualise a

relational journey between health visitors and their clients, and the discussion focuses around the ways in which the health visitors were able to engage in this 'cross cultural journey'. The health visitors identified emotional engagement as of the utmost importance and, yet, for many of the health visitors in this study, they employed strategies to reduce their emotional engagement with their clients who were from cultures different to their own. These strategies included avoidance, stereotyping and extending the equality agenda. What is of particular interest in this thesis is the emotional expenditure the health visitors gave in their daily work, either by 'emotionally opening up' or by 'managing uncertainty'.

In recent years, scholarly attention has been drawn to the shared and contested dimensions of culture using Bourdieu's conceptualisation of habitus and *field* (Lynam, 2005, Lynam et al., 2006, Anderson et al., 2007), but little has been written which addresses emotion within a Bourdiuean perspective. Nonetheless, Bourdieu does raise questions in relation to the ways in which different types of capital can be used by the health visitors to negotiate 'cultural journeys', and has the potential to extend scholarship to investigate the complex and contested ways in which culture, capital and emotion intersect.

Moving from a theoretical conceptualisation of emotion, I now consider the practical work of health visitors in 'emotion work', by exploring the ways in which 'stabilising uncertain terrain' becomes a hidden work within health care discourse and practice. In doing so, my study offers

insights for both health care practitioners, managers and educationalists. The implications of these are explained in chapter 6.

5.4 Emotional engagement through culture: 'stabilising uncertain terrain' as the hidden work of health visitors

5.4.1 Introduction

In engaging with the complex dynamics of the ways in which culture, capital and emotion intersect in the narrative accounts of the health visitors in this study, scholars in post structural and postmodern epistemologies assert the centrality of locating the subject within the wider socio-political context of research. Adele Clark (2005) employs the use of positional and situational maps in order to locate the wider political, social, cultural and historical situatedness of the research subject. Bourdieu urges scholars to analyse the *field* of study to interrogate the ways in which any specific *field* is positioned in relation to the political *field*. In this section, the ways in which the health visitors are located and locate themselves within different and intersecting *fields* will be explored and, in doing so, a space will be opened up to consider the ways in which health care discourses of professional competence intersect with emotional engagement and 'cultural terrain' in daily practice.

In seeking to explicate the complex tangle of everyday practice and to answer the first research question in this study, the conceptual theory of 'emotional encounters through cross cultural terrain: shaping relational

journeys through culture' emerged. As discussed in chapter 4.2, it was not surprising that communication, trust and relationship building were raised as the most pervasive issues, but what has been of particular interest is that a window has opened to the high levels of emotional expenditure and anxiety experienced by the health visitors in my study. In recounting their experiences of working across cultures, as the research developed, uncertainty and anxiety emerged as important themes. The health visitors recognised that working in the community and across cultures is not only complex and dynamic but it is suffused with uncertainty and ambiguity. The discussion in section 5.3.2 sought to draw attention to the ways in which discourse around uncertainty and ambiguity within nursing is largely invisible, and yet there remains a danger that this will gloss over the reflexive practices through which such categories are produced.

Health visitors are enmeshed in complex and interwoven social relations, and in this section the discussion will help to locate the health visitors within these social and political relations. In doing so, I examine the ways in which the discourses of professional competence, evidence based practice and risk averse society (Beck, 1992, 2009; Giddens,1999, 2003) all converge in a way, which can make the work of the health visitors across cultures not only that of 'stabilising uncertain ground' but rendering it as a hidden work.

5.4.2 Cultural ‘competence’: science or ‘art’?

Communication, trust and relationship were raised as important issues by the health visitors in this study, and scholarly literature within nursing discourse addresses these loosely connected concepts as the ‘art’ of nursing (Norman and Ryrie, 2004). Although the day-to-day work of health visitors is strongly aligned to that of social work, health visiting discourse is embedded within nursing discourse. Fuelled by the work of scholars exploring the concepts of intuition, trust, empathy, communication, relationships and care, the ‘art’ of nursing has emerged as an overarching and yet contested term. Critics from a positivist perspective condemn the subjective, imprecise and unreliable nature of measurement and evaluation. For example, Gerck (1998) describes ‘trust’ as the ugly duckling of science. Other critics, while acknowledging the ambiguous nature of trust as a scientific concept, call for an understanding of the scientific meaning of trust to be uncovered in order to further professional training and patient care (Hupcey et al., 2001). Nonetheless, although some scholars are polarised in their conceptualisation of nursing as predominantly a science or an ‘art’ (Barker, 2009), the majority of nursing scholars concur with Norman and Ryrie (2004) when they assert that ‘in reality, practising nurses must be artists and scientists simultaneously’ (p.xiii).

By definition, art is neither stable, nor measurable, nor fixed. Expanding the concept of nursing as an ‘art’, Rolfe (2009) challenges nurses to consider the philosophical dimension to the ‘art of caring’ and to define what terminology the ‘art’ of nursing points towards. ‘Art’ is not only that

which is distinguished from ‘science’ but ‘art’ can also be a performance, something to be mastered (such as the art of public speaking) or a creative work. Embracing all of these possible definitions, what appears to be clear is that the ‘art’ of nursing is something that must be tried, practiced, refined, moulded and shaped until it is expertly delivered. This involves creativity and failure, uncertainty and risk taking, and trial and error in order for success to be achieved. Nurses are required by their regulatory body to ‘recognise and work within the limits of your competence’ (NMC, 2007, p.6), and so this leaves a nagging question as to how this ‘art’ can be practised within a wider health care discourse, which must ensure professional competence and foregrounds evidence based practice contextualised within a risk averse society (Beck 2009).

Ann Keen, Chair of the commission on the Future of Nursing and Midwifery (DH, 2010) recently said:

> The Commission is clear that high quality, safe and compassionate care must rise to the top of the agenda for a 21st century world-class NHS. Nurses and midwives must review their pledge to deliver this and employers must take responsibility for supporting them in this.

Health care providers are enmeshed in the political relations they find themselves in, and the rhetoric of ‘high quality’ and ‘safe’ alert scholars to the ways in which discourses of ‘value for money’ and risk aversion permeate health care practice. Commercial pressures in the UK

National Health Service necessitate that resources are used efficiently and targeted towards the most effective treatments. Efficiency and effectiveness have become the mantra of the NHS and the government has become increasingly interested in evidence based practice as a means of measuring effectiveness and quality. Jessica was very aware of this when setting up a Polish health group:

> Obviously we have to target certain areas with the resources we have but that was one of the reasons to set up the Polish group to try and target our resources better really, em you know especially if you have arranged a visit with an interpreter (Jessica: 250-252)[sic].

Rolfe (2009) reminds us that:

> the words we use to describe what we do are of huge significance when it comes to thinking about how we present ourselves to the outside world, as well as how we attempt to pass on what we know and do (p.146).

The way in which nursing portrays itself as a profession is held within discourses of both scientific rigour and artistic endeavour and, although held in some ways simultaneously, the political context of health care delivery cannot be divorced from the theoretical considerations of nursing. Although the nursing literature presents a robust debate into the ‘art’ of nursing, and ‘caring’ in particular (Corbin, 2008; Flatley and

Bridges, 2008; Griffiths, 2008) the political context of what nursing should be and what nurses should do is very different.

Nursing has sought over the years both to define itself and to distinguish the profession from that of the medical profession by conceptualising itself as an ‘art’ and a ‘science’. In relation to mental health, Norman and Ryrie (2009) capture the contradictions when they state:

> nursing in the UK and other developed countries has been shaped by a creative tension between two traditions – an ‘artistic’ interpersonal-relations tradition which emphasises the centrality of nurses’ therapeutic relationships with ‘people’ ’in distress’ and a ‘scientific’ tradition concerned with delivery of evidenced-based interventions that can be applied to good effect by nurses to ‘patients’ suffering from ‘mental illness (p.1537).

Pioneered within the field of mental health nursing, the conceptualisation of nursing as both a scientific enquiry and an artistic endeavour is embedded within nursing discourse across all areas of nursing theory and practice. Nonetheless, extending Bourdieu’s concept of *field*, nursing can be located within a professional *field,* which intersects with medical and political *fields* and is set within the wider socio-political *field.*

5.4.3 The ‘art’ of culture within current health care discourse

Medicine has been historically dominated by bio-scientific discourses, and today evidence based practice dominates health care practice in the UK and industrialised nations. The increased emphasis over the last two decades in evidence based medicine has arguably been used by policy makers to foreground certain types of evidence, to the detriment of other types. Evidence based medicine encompasses all aspects of health care delivery and includes delivery at individual practitioner level, policy or organisations level (Evans, 2008). Morago (2006) comments that the rise of evidence based practice is the result of increased information technology, a culture of risk aversion and economic considerations, including economic effectiveness, transparency and consumerism. Evidence based practice has focused the attention not only on the decisions made in the delivery of health care, but the focus has also been on the quality of the scientific basis of health care. Initially focused on health care and medicine, there has been a rapid expansion of evidence based medicine into other disciplines, such as nursing, social work, education and probation (Morago, 2006).

The UK regulatory body for nurses, the Nursing and Midwifery Council, states in ‘*The code: standards of conduct, performance and ethics for nurses and midwives’* (2007) that nurses must ‘deliver care based on the best available evidence or practice’, and must ensure that ‘any advice you give is evidence based if you are suggesting healthcare products or services’ (p.6). Although evidence based practice was originally described as ‘the conscientious, explicit and judicious use of

current evidence in making decisions about the care of individuals' (Sackett et al., 1996, p.71), it has become a platform from which the power of the professional and of scientific knowledge is asserted, and has led to a definition of evidence based practice, which includes clinical expertise and patient values (Sackett et al., 2000). Gunaratnum and Lewis (2001) capture the central tenents of the argument when they state that:

> a significant part of the discursive formation of welfare services is that they have been constructed as sites that deal with and also intervene in matters of the emotional lives of service users – often in highly intimate and 'private' arenas. Yet, 'bureau-professional' imperatives, encompassing both systems (policies, procedures and organisation structures) and practices (action and inter-actions) are based upon an ambivalent and uneven privileging of rationality over emotion (p.135).

The history of medicine is littered with examples of practices, which were based on tradition and intuition and it is acknowledged that, where questions of validity and relevance can be answered with empirical evidence, then they should be used. Although few would dispute the worthy nature of evidence based practice, Rolfe, Sergrott and Jordan (2008) point out that there is as yet no evidence for the effectiveness of evidence based practice itself. Indeed, Trinder and Reynolds (2000) highlighted a decade ago that:

> it has not escaped the notice of either critics or champions (of evidence based practice) that there is not, nor is likely to be, any empirical evaluation of the effectiveness of evidence-based practice itself (p.213).

Evidence based practice is used not only to form a critical appraisal of the most appropriate evidence, but to also form clinical questions. These questions are frequently based on service user's needs, clinical expertise and service users values, and preferences should be integrated in both clinical practice and policy (Sackett et al., 2000). A critique of evidence based practice is that the focus has been on the search for literature, which is the best research derived evidence to guide practice, at the expense of research that interrogates service user's needs (Morago, 2006).

Evidence based practice has emerged today as practice which maintains the highest standards of scientific rigour. Hierarchies of evidence are now embedded within research discourse. Pioneered by British epidemiologist, Archibald Cochrane, evidence based practice was developed to ensure that, in a climate of limited resources, health care resources were only allocated on the basis of proven clinical effectiveness. The Cochrane Collaboration, of which the Cochrane library is part, came into existence in 1993 to disseminate high quality research in health care. This has been followed by centres of evidence based medicine across the UK and the world (e.g. McMaster University, Canada).

Dominated by the positivistic epistemology of medicine, hierarchies of scientific evidence were created and can operate to silence other more subjective voices within health care, such as those using post structural, postmodern, critical or feminist epistemologies, and also knowledge gained through experience, intuition and folklore. Within the positivistic medical paradigm, hierarchies of evidence have developed which rank bodies of evidence into four levels, from the gold standard of systematic reviews and randomised controlled trials (RCTs) at the top, to case reports at the bottom. In recognising that the validity and reliability of all research methods are not equal, hierarchies of evidence give weight to more reliable evidence. RCTs are considered the most reliable evidence, as they minimise the risk of confounding factors influencing the results.

In the UK, The National Institute of Health Care Research contributes substantial funding to work based on high quality research, much of which is dominated by scientific, positivist paradigms. Although there is some evidence that this is changing and some qualitative, participatory or action research is now being funded, the large research grants remain embedded within positivist scientific frameworks. Research funding that looks at service user needs and uses qualitative research methodologies has been largely pushed to the bottom of these positivist hierarchies of evidence. In particular, within the field of mental health, scholarly voices are calling for the defence of clinical judgements and reflective practice (Zeldow, 2009), which have become buried. Likewise in the discipline of social work, while recognising the value of evidence based practice, challenges are being made to the scientific imperialism,

which has dominated evidence based practice in social work courses (Morago, 2006).

The Nursing and Midwifery Council *Standards of Proficiency* (NMC, 2004) states that nursing practice, integrated with theory, needs to be evidence based and, therefore, safe. Rolfe, Segrott and Jordan (2008) argue that evidence based practice has been welcomed into nursing in a rather uncritical manner and that:

> there is conflict and confusion about what should be considered to be best evidence, about which aspects of practice it should be applied to, and about how it should be applied, that is, precisely what it means to claim that practice is based on evidence (p. 441).

Their research also concluded that in practice it was a mixture of national and local guidelines, practitioners' own experiences and patients' preferences, which were the main influences on nurses' practice.

The health visitors in my research study were keen to base their practice on current evidence, as Susan articulates below:

> Well I am really very interested in people generally and I think that is why I like being a health visitor so much and it is really fascinating to find out what other people do in their child care practice, em, for example, em, I visited a lady

> from France and their ideas on breast feeding were completely different and winding babies and everything and it makes you think, all of the things that we do, what is the evidence behind it and do we do it because we always have done it ? (Susan: 12-16)[sic].

I do not disagree that evidence based practice has an important role to play in health care policy and practice, but rather contend that the dominant discourse of evidence based practice, as perpetuated within a medical positivist paradigm, has quashed the creative, intuitive and 'artistic' side of nursing. Concurring with several nursing scholars, I contend that there should be a re-consideration of what constitutes evidence in health care (Evans, 2003; Morse, 2006; Pearson et al., 2007). The 'art' of nursing is still evident within scholarly literature, but within healthcare policy it has been reduced to barely a whisper. Advances in technology mean that the assimilation of large amounts of research based evidence, and collections such as the Cochrane collection, allow health care practitioners to access the most recent research findings. The original hope of evidence based practice was that individual evidence based practitioners would emerge who could assimilate this information. However, time demands in the workplace, and the complexity and volume of research produced today, mean that this is left to experts. Scholars writing from a critical sociology and health perspective highlight the ways in which certain types of evidence based practice are becoming instituted across health care delivery as policy (Paley, 2006; Mantzoulcas and Jasper, 2008).

The health visitors in this study entered into daily client/professional relationships with a host of policy and procedural ‘tools’ at their disposal. Nursing scholars have developed a plethora of assessment tools to aid comprehensive client assessment and, yet, the health visitors interviewed lacked trust in the assessment tools to really elicit valuable information. Helen described this clearly below:

> I am here standing here and I am saying I am here and this is my experience and this is what you should include in your practice and also the…the. .it is not met by government kind of like. I can’t think of the word, with regard to post natal depression, we are following NICE guidelines at the moment and they do not include symptoms, so we use the Whooley questionnaire and it doesn’t incorporate somatic presentation of depression, so you know for a considerable population that we provide a service to, the south Asians, the Africans, and the Chinese, you are missing a key part of detecting depression (Helen: 31-37)[sic].

Helen then went on to describe it as a ‘nod to cultural awareness’ as the vignette describes below:

> NICE you know, there is a nod to cultural awareness but you know, it is just words (Helen: 44-45)[sic].

Beth and Rebecca were trying to use government guidelines and 'evidence' to negotiate cultural difference in weaning practice, but in an attempt to use the guidelines, had found them rendered ineffective:

> I think, you know, I had to have a lot of evidence to why breast feeding was better than artificial because she kept thinking that, well artificial feeding has everything in it, sometimes they see the artificial products like Heinz feeds as better than fresh foods because they want to get them on to all of these juices and all of the deserts and you have to push that fresh is much better because I think they have this inkling..you know…because I think … I know for one Sikh family, they gave me a bag of sugar and they said that everyone who comes into this house, we give a bag of sugar so that, sugar in their religion must be very, em…so they like to give lots of sweet, so I think that they think that they are giving the baby the best opportunity, em, so I think they are the challenges, when it is their experiences of how they have seen their families parent and traditions (Beth: 220-229)[sic].

Many of the health visitors tried to rely upon evidence based practice and local or national frameworks to guide assessment and practice in their 'cross cultural journey' onto 'unstable terrain'. However, using a Bourdieuan analysis, when moving from their normalised *habitus* onto a culturally different *habitus*, their tools were rendered ineffective. It is argued that, although the concept of evidence based practice, as originally conceived was intended to supplement professional practice

and experience, it has become a dominant discourse, and can drive policy to the detriment of professional judgement and skill. The majority of health visitors tried to rely on assessment tools to negotiate cultural difference in practice, in particular around weaning practices and advice, and yet found that their 'toolbox' was 'rendered ineffective'. This left them feeling vulnerable and uncertain. Nonetheless, a few of the health visitors were able to successfully and confidently work within assessment frameworks and evidence based practice guidelines, while combining this with their professional experience and intuition:

> Helen: The health professional should be confident that everything she does should be research based so everything that she does should be put forward as best practice, so she is delivering, as I say, guidance and best practice, but she should say that, 'you don't have to do this', if she can be courteous enough to let them know that this is help and guidance, as long as it is in the best interests of the child and that is what she has to do, that is what you have to do as a health professional is to promote the best interests of the child above all.
>
> Fiona: What 'framework' do you rely on when there is a 'clash of cultures'?
>
> Helen: For anything, for your work and that is 'safeguarding children' and you must work within that framework, so you have a framework to work from and you have something like 'Every child matters' policy documents, so that is what you have to work with, that is your tools but with different cultures

> you have to try and find out what is familiar to them and try and say this is how, this is the advice, or guidance and it is only guidance and at the end of the day, it is only guidance, every child is an individual (Helen: 98-109)[sic].

As nurse scholars interrogate established mechanisms of knowledge production (Freshwater and Rolfe, 2004) and the role of evidence based practice in health care, questions are raised about exactly where the space to practice the 'art' of nursing will come from in practice today. As explored in the literature review in section 2.3, culture is conceptualised within much of health care discourse as a 'science', something to be described, to be measured, to be quantified and to be 'known'. As a consequence, cultural 'competency' programmes attempt to assess culture as known and measurable, but problems persist with assessment and definition. I contend that in order to move away from nursing knowledge about the cultural 'other' and to engage meaningfully with clients across cultures, culture needs to be reconceptualised as non-essentialised and dynamic. Culture is an 'art', not a science. Culture is fluid and in flux, neither quantifiable, nor measurable. Cultural 'competency' cannot be determined by a set of measurable assessment skills nor competency frameworks. As Barker (2009) describes mental health nursing as 'the craft of caring', so we should be reconceptualising cultural engagement as 'the craft of culture'. A craft needs to be practiced, and refined. Until culture becomes an 'art' or a craft, in much the same way as 'caring' is currently conceived, then cultural 'competency' risks essentialising culture as static and fixed. Within a healthcare arena which is dominated by discourses of

evidence based practice, the problem remains as to where a space can be created, in order for health care practitioners to be able to practice and the ‘art’ and ‘craft’ of culture?

5.5 Summary

In recounting the experiences of health visitors in the North East of England who are working with clients who are from cultures different to their own, the health visitors experienced an ‘emotional encounter through cross cultural terrain’. An emerging story told of the way in which many of the health visitors negotiated this journey in terms of a ‘relational journey’, which took them to ‘cross cultural terrain’. The accounts of the health visitors suggest that this journey was filled with uncertainty and associated anxiety. Taking direction from Bourdieu’s concept of *field*, *habitus* and capital, and the ways in which they are all conceptually linked, the researcher highlighted the ways in which this ‘cross cultural journey’ on to ‘unstable terrain’ occurred within a *field* of professional discourse, which renders ambiguity silent. This discourse foregrounds professional competence and evidence based practice as the ‘solid ground’ upon which health care delivery is delivered.

In explicating the complex ways in which *habitus* and *field* intersect, the health visitors employed different measures to try to ‘stabilise uncertain terrain’. Some of the health visitors avoided entering ‘cross cultural terrain’ by ‘approaching the perimeter fence’ of culture, but did the minimum required and retreated back to their normalised *habitus.* Health discourse around the cultural ‘other’ is widely articulated in the

field of professional discourse as essentialised, and consequently some of the health visitors tried to ‘stabilise uncertain terrain’ by fixing culture as static, defined and solid. Health visitors also tried to ‘re-work the equality agenda’, in order to make the *habitus* of their cross cultural clients the same as their own *habitus.* Much of this work in ‘stabilising uncertain terrain’ was hidden within a professional *field,* which neither allows room for ambiguity nor trial and error. Nonetheless, some of the health visitors did move on to ‘cross cultural terrain’, and in doing so managed to engage in a more meaningful way with their clients.

The emotions experienced by the health visitors in cross cultural engagement included anxiety, anger and empathy, and these emotions have the power to shape practice across cultures. ‘Emotional flexibility’ was uncovered as the most important factor in cross cultural engagement, although this requires further empirical and theoretical exploration.

Chapter 6: Conclusion and implications for theory, practice and education

6.1 Conclusion

In engaging with the complex dynamics of health visitors, as they work with clients who are from a culture different to their own, this research has uncovered ways in which health visitors in the North East of England conceptualise their work as ‘emotional encounters through cross cultural terrain: shaping relational journeys through culture’. This substantive theory not only conceptualises the day-to-day work of the health visitors, but can be used to challenge theory, practice and education in the arena of cultural ‘competency’ and emotional engagement.

In answering the two research questions posed at the outset of this research (Section 1.4), the health visitors in this study expressed their concerns around ‘relational journeys’, as the most important aspect of their work with clients across cultures. This was particularly in relation to the nurse-patient relationship and centred on issues of communication, trust and interpretation. These concerns are already well documented in the health care literature, but what is particularly interesting in my research is that these relationships did not occur in a vacuum, but the socio-political and historico-cultural landscape in which these relationships were developed was of prime importance to the health visitors. This was metaphorically conceptualised as ‘cross cultural terrain’. ‘Cross cultural terrain’ was suffused with instability, uncertainty

and at times danger. The emotional reaction of the health visitors to either entering or avoiding this ‘cross cultural terrain’ was what shaped their practice. The central theme of the research then became an exploration of the ways in which emotions shape practice in health care across cultures.

Emotional encounters in health care are not kept internally, but the power of these emotions can shape practice across cultures. The most frequent emotions expressed by the health visitors in this research were anxiety, uncertainty and at times fear, but anger and empathy were also evident. The two health visitors who expressed anger and empathy were distinguished in the narratives of their practice, as having ‘flexible emotions’. They did not focus on ‘cross cultural terrain’ but rather were ‘treading lightly on cultural terrain’. They were flexible in adapting to different cultures, conceptualising culture as fluid and changing over time. The work of Pierre Bourdieu was drawn upon to explore these ‘flexible emotions’ in an extension of the conceptualisation of emotional capital and emotional *habitus*.

The majority of health visitors interviewed were ‘emotionally hesitant’ in cross cultural engagement, and several strategies were uncovered, which they employed to help to ‘stabilise uncertain terrain’. These included avoiding uncertain terrain, stereotyping, re-working the equality agenda and viewing clients as ‘all are equal…all are the same’. In order to do this, they also ‘asserted the professional self’ and developed a ‘toolkit’ of knowledge, education and experience over time. Interestingly, developing experience over time did not increase emotional flexibility.

‘Emotional flexibility’ was identified as the most important dimension of cross cultural working, and was conceptualised as being able to ‘take the ball and see what you could do with it’. The health visitors who were identified as being ‘emotionally flexible’ were able to work with any cultures without being hindered by the fear of uncertainty, and they enjoyed the challenge. They could take any metaphorical ball and were able to run with it, to engage and to form meaningful relationships.

The results of this research have implications for current theoretical development, for health visiting practice and for future educational programmes in cultural ‘competency’. These are discussed in the following three sections.

6.2 Implications for theory

‘Emotional flexibility’ was uncovered as the most important aspect of emotional engagement across cultures for the health visitors in this study. ‘Emotional flexibility’ is a new conceptualisation of cross cultural work and, although ‘emotional work’ is an extensively (re)worked concept within nursing discourse, ‘emotional flexibility’ is something new in the context of cross cultural working. Scholarly insights into emotion within health care are concentrated on emotion as labour, as ‘care’ and as performance (section 5.3 and 5.4), but ‘emotional flexibility’ could not be reconciled to any of these theoretical strands.

The popular notion of emotional intelligence was also investigated for theoretical 'fit', but it was found to be largely built upon a positivist epistemology, which was at odds with the social constructionist foundations of my research. The work of Pierre Boudieu and the insights of scholars working on 'emotional capital' appear to offer insights into the concept of 'emotional flexibility'. Future research is required to extend and explore the dimensions of 'emotional flexibility', and the theoretical concept of emotional capital and emotional *habitus*.

6.3 Implications for practice

The findings of this research uncover emotion as a powerful driver in shaping practice for health visitors, as they seek to engage with their clients across cultures. This was conceptualised as 'emotional encounters through cross cultural terrain: shaping relational journeys through culture'. Although two of the health visitors were identified as being propelled forward in their practice by the emotions of anger and empathy, the majority of health visitors discussed anxiety, uncertainty and at times fear, as the dominant emotions in their practice with clients across cultures. This was conceptualised as 'emotional hesitance: stabilising uncertain terrain' and at times the health visitors avoided active engagement with their clients, conceptualised as 'emotional hesitation: travelling to the perimeter fence of culture'. The discussion in section 5.4 revealed uncertainty and anxiety to be hidden emotions within professional nursing discourse. Nursing theory and practice is dominated by discourses of evidence based medicine and professional competencies. Buried under these dominant discourses of professional

competence, cultural issues become a science to be objectified and assessed, rather than an ‘art’ to be practiced and refined. The result is that the emotions of uncertainty, anxiety and fear become ‘unacceptable emotions’ and are consequently hidden emotions.

The health visitors hide these ‘unacceptable emotions’ and yet these hidden emotions have the power to both drive and shape practice, and ultimately impact negatively on cross cultural engagement. The strategies the health visitors employ to manage their emotions across cultures include avoidance, ignoring difference, stereotyping, asserting professional power and developing a ‘toolkit’ (Appendix H6).

The implications of my research for the day-to-day practice of health visitors is three fold. Firstly, health care discourse must take direction from developments in the fields of sociology, cultural studies and critical studies to understand that engagement across cultures is not as simple as ‘communication with strangers’. The socio-cultural context is a metaphorical ‘cross cultural terrain’ where health professionals and their clients ‘meet in the middle’. This metaphorical terrain is political, uncertain and unstable and requires emotional flexibility and yet, for the majority of health visitors in this study, their practice was negatively impacted by emotional hesitation. Their work was shaped by uncertainty, anxiety and fear. Health care discourse negates these emotions as unacceptable for professional health visitors, and the management of these emotions, thereby, becomes hidden work. Nursing practice and discourse must begin to acknowledge uncertainty

in professional practice and to actively work with these emotions, rather than to keep them hidden.

Secondly, once uncertainty and anxiety are acknowledged as valid emotions in cross cultural work, health care managers, practitioners and educators must work together to develop meaningful strategies to help health professionals to manage these emotions in a positive way. It is only by acknowledging these emotions, and the power they have to shape practice, that meaningful strategies can be developed which will ultimately enhance cross cultural engagement and health outcomes for clients of health visiting services.

Thirdly, culture needs to be re-conceptualised within health care discourse to become an ‘art’ to be practiced, in much the same way as the concepts of care, empathy, trust and presence are currently. In this way, culture becomes fluid, changing over time and nebulous. It becomes an ‘art’ to be practiced, crafted, refined and developed. Under the current conceptualisation of culture as a science, it is something to be measured, defined and ‘competencies’ assessed against. Culture becomes easily essentialised, fixed and static over time and a measure of professional ‘competence’. In this way, cultural ‘competence’ becomes a component part of professional competence and uncertainty becomes hidden, or certainty leads to essentialisation. It is only when culture is allowed to be practiced as an ‘art’ that health care practice can move forward to engage with the complexity, dynamism and excitement of culture in a meaningful way for both health care practitioners and their clients.

6.4 Implications for education

Educational programmes in cultural education are plentiful and diverse across all health and social care fields. They range in content, delivery and ontological perspective from the positivist to the emancipatory, from teaching cultural competence as a set of measurable skills to a reflexive project. As already extensively examined (section 5.5.2), cultural education within the field of nursing has largely been adopted from discourses of transcultural education. The acquisition of cultural knowledge, skills, sensitivity and values is the dominant discourse and these have been widely adopted across the UK, USA, Canada and Australasia. In recent years, scholars working within feminist, critical and post colonial epistemologies have sought to challenge the essentialist nature of much cultural 'competency' discourse, and to open up spaces for dialogue on critical, non-essentialised and emancipatory education.

The health visitors in my study had all experienced some cultural education, but they largely found that it lacked depth and complexity. For the majority of health visitors, post qualification education in culture consisted of a one day 'equality and diversity' session outlining the legal framework for equality and diversity in the UK (Equality and Human Right Commission, 2011). Some of the health visitors had experienced cultural education based on a transcultural education package, exploring issues of knowledge, values and skills in cross cultural work. The danger of this type of educational package is that it has the

potential to increase anxiety around issues of ‘race’ and culture, without acknowledging uncertainty, and is thereby unable to give health professionals strategies to cope with uncertainty in their day-to-day work. It also runs the risk of simplifying the complexity of culture, thereby fixing culture in place and time and further essentialising it as bounded and static. Stereotyping then becomes a logical outcome.

In recent years, many scholars are challenging transcultural educational programmes and innovative cultural education packages, which are based on emancipatory frameworks and critical epistemologies are growing. The notion of ‘cultural safety’ has become popular in New Zealand, Canada and Australia, as a response to the assertion that issues of power, dominance and post colonial histories must be examined and explored in order to achieve cultural engagement. Educational programmes which de-construct the white or colonial self are flourishing across the disciplines of education and social work. Theoretical developments in the fields of white studies and post colonial studies are exploring ‘normalised terrain’ and the hidden power of the white self. These developments are welcomed in bringing to the fore issues of marginalisation and power, and the ways in which practice is shaped and must be explored within cultural education.

Nonetheless, my research indicates a cautionary note in relation to issues of power and marginalisation in cross cultural work. The health visitors in my study did not always feel powerful and, indeed, at times felt very powerless. They felt powerless in relation to the ‘power of the family’ and that things were ‘hidden in culture’. Using the theoretical

conceptualisation of ‘emotional encounters through cross cultural terrain: shaping relational journeys through culture’, the health visitors ‘envisioned the journey’ and as part of this, they were active in ‘positioning self’, ‘positioning client’ and ‘taking and leaving’. Concurring with many scholars in the field of white studies, the health visitors did locate themselves as the powerful white self, where white norms and values were normalised, and yet the picture was much more complex than that. The health visitors also felt very powerless at times. They had to ‘leave norms and values’ behind and felt vulnerable entering ‘cross cultural terrain’. They often felt very powerless within a powerful health care system. The position of nursing as historically defined as subservient to medicine was also identified in the situational analysis maps (Appendices E-G). The health visitors also felt uncertain within a wider society where issues of ‘race’, culture and ethnicity are highly politically charged and felt afraid they could be accused of racism by clients ‘playing the ‘race’ card’. ‘Cross cultural terrain’ was uncertain, unstable and they didn’t feel secure when working across cultures.

The implications of this for cultural education is that, while welcoming emancipatory and critical education, a space must be created to acknowledge that not all majority, white health visitors feel powerful and secure but, conversely, feel very vulnerable at times and insecure when working across cultures. As already discussed, this uncertainty cannot be acknowledged within current competency discourses in professional health care practice in the UK, so the anxiety becomes hidden. Emancipatory education and packages, which are based on the concepts of ‘cultural safety’, must acknowledge that all white, majority

culture nurses do not feel safe themselves. If they feel as if they are standing on ‘unstable terrain’, how can they then provide a ‘safe’ environment for their clients across cultures? Emancipatory education must explore issues of power and marginalisation, but also engage with the complexity of these contradictions, or it risks reifying the binary nature of the powerful white nurse and the client as the powerless ‘other’.

Finally, cultural education must engage with culture as an ‘art’ form, rather than as an essentialised science. This research challenges the notion of ‘competence’ within cultural discourse, arguing that the concepts of culture and ‘competence’ are incompatible bedfellows. If culture is an ‘art’, changing and fluid over time and space, then ‘competence’ measures only serve to fix and reify it. Culture must be taught as an ‘art’ and refined as a ‘craft’. Competence must be a craft to be practised, to be tried and most importantly, health practitioners must be allowed to try, and at times to make mistakes.

It is only when health care practitioners are allowed to acknowledge uncertainty, to learn cultural engagement by trial and error, to be given the space to practice the craft of cultural engagement, and to develop the ‘art’ of culture that benefits will be seen for both the health care practitioners and clients. Emotional flexibility has an important role to play in this and remains as a concept which requires further exploration in future research.

6.5 Strengths and weaknesses of the study

In presenting my study, there are several strengths and weaknesses which should be highlighted.

6.5.1 Strengths

This is the first study in the North East of England, which explores the experiences of practising health visitors when working across cultures. The study is also unique in that it identifies ‘emotional flexibility’, as a key component to effective working across cultures by health professionals. The study benefits from using a grounded theory methodology, which is a firmly established research methodology within the fields of nursing, health care and education, to explore at ground level the experiences of practising health visitors. Although the quality of my study is discussed elsewhere (Section 3.4), the originality of the results led to a new conceptualisation of cross cultural working for the health visitors involved. The coding and categorisation of the data remained fresh throughout, and new insights are presented into the multiple ways in which culture and emotion intersect in cross cultural work. The final conceptual theory is unique, emerging from my interpretation of the data, to contribute some new theoretical and practical insights into cross cultural working.

My study has social significance for health visiting as a profession, and urges health visitors to examine the ways in which emotion shapes practice across cultures. The health visitors who were involved with the

study have read my results and emergent theory, and have found it acceptable as a way to describe the work they do across cultures.

The theoretical strength of my study is that it builds upon the work of an established social theorist and attempts to extend his conceptualisations further. My study make explicit from the beginning the epistemological perspectives of the research, and adheres to those throughout the whole research process. Nonetheless, there are weak areas in my study and these are outlined in the section below.

6.5.2 Weaknesses

One of the main limitations of my research was the small and limited sample of health visitors I was only able to recruit to this research. This was the result of restrictions placed on me by the NHS Ethics Committee in relation to participant recruitment. All of the health visitors were invited by letter of invitation from nurse managers and this was then cascaded down to staff. As a consequence, the health visitors who participated in my study were all practitioners who were interested in cross cultural working. I was not able to interview health visitors who were negative about cross cultural working, as it can be assumed that they did not volunteer to be involved in this type of research. It also led to difficulties with theoretical sampling, as the health visitors I was able to approach, were limited to the original volunteers. I would have liked to have spoken to health visitors who were negative about cross cultural working, but this was not possible. The results of my study, therefore, are not applicable to all health visitors in the North East of England. My

research cannot comment on the emotional engagement of health visitors who are negative about cross cultural working or hold racist views. A consequence of this is that my conceptual theory can only be used to conceptualise the work of health visitors who are, firstly, interested in cross cultural working and secondly, are keen to improve their practice.

A further limitation of my study was that it was based on self-reported engagement across cultures, which can be subjective and perceptions of effective engagement can be different from the perspective of the health care professional and the client. Observational techniques to collect data on cross cultural engagement would have enhanced the study, although observation can also influence practice. In terms of research design, observation of the health visitors in their work across cultures would have enhanced this study, but this was not possible, and also it would have influenced the practice of health visitors to have an outside observer present. Health visitor managers were happy to allow me to interview their staff, but were not comfortable with home visits for observational purposes.

This is a small piece of qualitative research and cannot therefore be generalised to other areas or practice settings. Nonetheless, it opens up areas for discussion, theoretical interrogation and future research.

Finally, this study is my interpretation of the data, opened up to me by the participating health visitors. Although I have adhered closely to constructivist grounded theory methodology, others may have

interpreted the data in different ways. In studying the lived experiences of health visitors in the North East of England, I have tried to take their stories and weave them together to co-construct a conceptual theory which is recognisable to all of the health visitors who were involved in the study. In acknowledging the reflexive turn in social research, I have tried to be a reflexive and critically aware researcher. As Nayak (2006) asserts:

> We are now much better informed about the kaleidoscopic relations of power that permeate all aspects from our research from initial design through to the write-up, interpretation and reading of these narrative accounts (p. 414).

Nonetheless, issues of power and identity, which will have permeated my study, may remain uncovered. I have tried to be as transparent as possible, using memos, diaries and a clear audit trail to chart my research journey, but every researcher must acknowledge 'blind spots' in research.

6.6 Suggestions for future research

'Emotional flexibility' emerged as an important factor in the ability of health visitors to engage effectively across cultures, but this was only evident in the narratives of two of the health visitors and consequently poorly defined. Although the theoretical work of Pierre Bourdieu was used to explore this concept, emotional flexibility requires further

conceptual interrogation. I believe that the exploration of 'emotional flexibility' within the theoretical framework of Bourdieu's capital, *field* and *habitus* was a good starting point for future research. The aim is not to replace Bourdieu's concepts but, along with Anderson et al., (2007) to:

> Continue to open up a discursive space for theorizing, with the possibility of reframing and strengthening our own theoretical perspectives (p.178)

Future research is required to explore the concept of 'emotional flexibility', in particular in relation to the popular notion of 'emotional intelligence'.

Secondly, future research is required to explore the experiences of non-white health visitors working in the UK. This was not possible in my study, as only white health visitors volunteered to be interviewed. In particular, to ask the ways in which emotions shape practice across cultures, when the cultural background of the health visitors is not white.

Thirdly, my research opens up a space to explore emotions within cultural 'competency' education. Further research is required to explore the ways in which emotion can be explored within educational frameworks and within cultural education.

Finally, the emotions of anxiety, anger and empathy were uncovered in my research, but these were crudely defined. Further research is

required to explore the multiplicity of emotions, which operate in cross cultural work and the ways in which these shape professional practice.

APPENDICES

Appendix A Initial theoretical memos

A1 - Summary memo: Joy 29 July 2008

29th July 2008_Interview 4_Joy
Summary theoretical memo

Interview 4 brought up many similar themes to those in interview 3, again in contrast to interviews 1 and 2. Culture was viewed as fluid and changing over time.

> Joy: Well, I've done quite a lot of work with people from other cultures and also I am doing a Masters course, where I have studied this a bit more, but I think the problem with culture is that it usually means colour or country or whether you speak English well or not but then it can be boiled down to completely individual things, like the culture in my family is different to the culture with my sister's family, but I suppose you mean here culture as in different , em sort of , em (pause), this is difficult but different ethnic groups. The culture here is different to the culture in …….(next town) and even this estate and the one over there. It is easier something though, I think, there are some things which are to do with cultural groups but then there are so many exceptions to the rules, maybe there are no rules, Oh I don't really know but you know what I mean? Am I making any sense? (Joy:13-22)

Culture as fluid was the basis for all interactions between the client and health visitor. **'Feeling comfortable and relaxed'** was another strong theme and this related to a new category, which was labelled as **'learning to ask'**. The health visitor had felt anxious when she first started working with people from other cultures, but the key to 'feeling comfortable and relaxed' was **'learning to ask'**. She was also **'confident to challenge'** and aware of the **'negotiated identities'** of her cross cultural clients. If difficult issues arose, she found it helpful to **'explore and learn'** together with her clients. The extended family were very important and along with Helen, **'working in partnership with the extended family'** was identified as central to working with the young parents. An interesting and new category which emerged with interview 4 was the **'need for respect'** on both sides of the relationship. **'Mutual respect'** was the basis for a client/professional relationship and the **'emotional work'** of working with people from other cultures (especially those who were seeking asylum or refugees) was highlighted.

A2 - Theoretical memo: learning to ask 2 August 2008

2nd August 2008_Interview 4_Joy
Compare and contrast memo 'learning to ask' and 'exploring and marrying it up'

'Learning to ask' can be compared to the category **'exploring and marrying** it up' in interview 3. Both interviewees highlight the importance of **'asking'** and **'not being anxious to ask'.**

> Joy: I used to be really nervous about saying or doing the wrong thing, of offending people but now I just ask if I don't know and no-one seems offended. They probably just think I am an ignorant English woman but if you ask, people are happy to tell you what they believe and why they do certain things. I used to get really worried I'd say the wrong thing or do the wrong thing, but not really now. I mean it used to be, like I was worried, would I take my shoes off or not, or touch the husband, I mean to shake hands or not or would I offend and I just ask if it is OK and people tell me. I think that so often we are scared to ask and manage to get ourselves into a real fix and do offend, when if we'd just asked, it would have been OK in the first place(Joy:40-48).

'Asking' appears to be the key for this health visitor to not feeling anxious. This assumes that **'anxiety'** and **'not asking'** are in some ways linked. Can this be explored further in the literature or in subsequent interviews? Helen also stressed the importance of **'asking and exploring'** as a basis to building up trust. Are these related and conversely, what happens if health visitors **'don't ask'**? Do relationships flounder?

It is also interesting to note that this **'asking'** has been learned over time. **'Learning to ask'** is a progression from anxiety to confidence. How does this work and is this the experience of other health visitors? Is it possible to 'ask' and yet still feel **'anxious'** for other health visitors? Is there something specific should be asked? **'Asking'** is a strong theme in interviews 3 and 4 but **'anxiety'** are the main themes in interviews 1 and 2. Are these related and in what ways? Explore the literature to see if there are any further insights there.

A3 – Theoretical memo: interpreter as barrier 25 October 2008

25th October 2008_Compare and contrast memo
'Interpreter as barrier'

Mary discussed the **'interpreter as barrier'** on several occasions, as two of the interview extracts below illustrate.

> Fiona: Can you tell me why you felt uncomfortable with an interpreter there?
> Mary: Just because, em, I think it takes away, it is quite difficulty when you have an extra person there, when you are trying to have a conversation with somebody and you are trying to, you want to talk to the interpreter and then get them to talk to the person, rather than talking to the person and it is really quite difficult I feel and it takes that communication away (Mary:116-120)

> Fiona: In what ways does your relationship change with the client, if you are using an interpreter?
> Mary: I think I have still built a relationship with them, but I wouldn't say 'as well as' and sometimes if you are going back to see people, it is not always the same interpreter and I think that is more difficulty I suppose. The person you are going to see, you build up a relationship and with the interpreter as well, so it is more difficult (Mary:124-128)

Mary's experience is similar to that of Rebecca (interview 2) who described **'interpretation as a three way conversation'**.

> Rebecca: I have to be honest, I never feel as if I know my families as well when I have used an interpreter. You know you can go away and chat to them but I never feel I can get to the stage when I can say OK, so how are you feeling today, em and mums will say, oh, I've had a really bad day and I just never get to that stage and I think it's because it is a three way conversation (Rebecca:285-289)

Rebecca and Mary stand in contrast to Alice (interview 5) who clearly describes **a 'lacking of trust with interpreters'**;

> Alice: It is awful, talking rumours and everything, but em, what we are being told is that there is either a mistrust because they know the interpreters, there can be an area of mistrust and people who have worked in other areas as interpreters tell us that people have also sat there and the interpreters haven't interpreted properly. There is a Bengali mum who actually interprets as a part time job said that she sat with a family and the interpreter brought by the person didn't actually relay the message that she was told to relay, so there is a lot of issues around that and we are finding that families are refusing interpreters so we are left with the English speaking members of the family or those who speak the most English within the family are doing that, which isn't ideal but if they are not letting anybody else in then? (Alice: 120-128)

Communication across cultures is important to the health visitors and communication and trust are issues not only in relation to the clients themselves, but also with the interpreters. If communication across cultures involves a **'three way conversation'**, how does that affect communication? If trust is not there with the interpreters, how does that impact on the ability health visitors have to build up meaningful relationships with their clients. 'lacking trust with interpreters' has already been identified in interview 5 with Alice but the categories of **'trust'** and **'untrusting'** need to be opened up and explored further.

A4 Stumbling over the vocabulary of 'race' 28 March 2009

28th March 2009_Compare and contrast memo
'Stumbling over the vocabulary of 'race'

There appear to be several 'spaces' which the health visitors interviewed so far view as **'dangerous spaces'** in cross cultural encounters. One of these spaces is around **'stumbling over the vocabulary of 'race'**. It is **'unstable ground'** upon which to stand. Other areas of **'unstable ground'** are **'using the 'race' card'** and **'political correctness'**.

'Unsafe ground' appears to be **'dangerous ground'** but there is a similarity to the **'skidding on ice'** identified after interview 4 with Joy. **'Uncertain ground'** was identified as unstable, changing and with **'loosing confidence'**, although **'dangerous ground'** does not necessarily appear to be necessarily associated with **'loosing confidence'** but it is perceived as a threatening and politically dangerous place to be. Both **'loosing confidence'** and **'dangerous ground'** are **'unstable ground'**. There is a certain amount of anxiety associated with **'uncertain ground'** but not **'anxiety not to offend'** but **'anxiety for self'**. **'Anxiety for self'** appears to be much more dangerous ground to be standing upon as a health visitor, than a potential **'anxious not to offend'**.

> Fiona: What areas would you really like training on?
> Denise: (Pause) I think about the Muslim culture and different sort of , em , that sort of , (pause) we have done a bit in domestic violence in other, em (pause) em, cultures and things, we have done a bit but I think more about that and the em (pause) the …em, different religions and cultural beliefs and attitudes regarding the family and more information (Denise:91-95)

Joy and Cathy asked literally what language they could use and Joy asked how to describe her clients from other cultures, as the vignette below shows.

> Fiona: How would you describe this area?
> Joy: Well, it's a city centre area and fairly deprived socially or economically, you know what I mean. It is fairly mixed but there are a lot of BME people here. Is that the right way to describe them? You know what I mean. It's so hard to know what terms to use to describe people, I'm bound to get it wrong (Joy:7-11)

> Fiona: What is your experience of working with the extended family in some homes?
> Cathy: Fine, no more difficult than with a British family really. Sometimes it is harder to talk to the mother in law through mum but actually from my experience, I think that it is fantastic that some cultures, especially the Asian families have far more support, far more family support than British families. Am I allowed to say that? (laughs)
> Fiona: Yes, of course, you can say anything. This is completely confidential and anonymous.(Cathy: 50-55)

> Rebecca: I worry about (em) I am careful what I say (Rebecca:168)

Political context very important.

A5 Theoretical memo: establishing trust 4 July 2008

4th July 2008_Interview 3_Helen
Theoretical memo 'establishing trust'

Initial data analysis reveals **'establishing trust'** to be a strong theme in this interview and pivotal to many successful cross cultural encounter. **'Establishing trust'** is very important to Helen, for the basis for all future work. It appears to involve **'mutual respect'** and **'being relaxed'.**

> Helen: I have no anxieties meeting these people because I do it on a daily basis and within that, you know how to build up a trust with them and with all of them, the one thing I find in common is that, once you have introduced yourself and explained who you are and you can show that you are relaxed whatever they say, is although it is personal to them, it is something you can take on board and you can help them with and that will get them to relax (Helen:35-40)

'Establishing trust' is not only important, but it is also something the health visitor has to be open to. **'Taking it on board'** requires active opening up. This can be compared to **'not being as open'** (Rebecca) and **'closing down; protecting self'** (Jane) where the health visitors were closed to making themselves vulnerable in cross cultural relationships.

A6 Theoretical memo: empowering clients 10 July 2008

10th July 2008_Interview 3_Helen
Theoretical memo - empowering clients

Issues of power are not made explicit in interviews 1 & 2 but in interview 3, Helen talks on many occasions of **'empowering clients'**. The underlying assumptions is that they do not have any power, and that can be theoretically challenged. Why does she feel they are 'powerless'? How is that demonstrated? Is it only in relation to certain client groups such as people seeking asylum? Political control and sites of resistance can be examined through the literature.

> Helen: what you then have to do is to empower them to take some of that back and to move on. Em (pause) they will go, they will venture out, they do become more empowered but you will find that any sort of stress within that and especially if they are asylum seekers they will revert back, like a child, with illness and they do that and they will go back to the trustee so although they do have the ability to move forward and to do lots of things, they will quickly under any little stress that deviates from their day, they will come back to you as the trustee and expect or with you to resolve the problems (Helen:127-135).

This is interesting because although the health visitor is talking about **'empowerment'** she is placing herself in a 'parent role' in relation to people seeking asylum. There are many issues which need to be interrogated here including sites of resistance, power to manipulate the system and negotiated power.

A7 Theoretical memo: feeling comfortable and relaxed 11 July 2008

11th July 2008_Interview 3_Helen
Theoretical memo – Feeling comfortable and relaxed

Helen appears to work in a very contrasting manner to the health visitors interviewed in interview 1 & 2. She repeatedly says she feels 'comfortable' working with people from other cultures and 'relaxed'. This appears to be in contrast to **'anxiety in cross cultural encounters'**, which has been a strong category in the first two interviews.

> Helen: I have no anxieties meeting these people because I do it on a daily basis and within that, you know how to build up a trust with them and with all of them, the one thing I find in common is that, once you have introduced yourself and explained who you are and you can show that you are relaxed whatever they say, is although it is personal to them, it is something you can take on board and you can help them with and that will get them to relax (Helen:35-40)

It is particularly interesting here that the health visitor not only feels comfortable herself, but one of her goals is to 'get them to relax'. Why is **'feeling comfortable and relaxed'** so important? Can this be contrasted to being **'under the gaze of the 'other' ?'** (Rebecca). If the health visitor recognises that there might be some anxiety on the part of the client, her goal should be to diffuse this anxiety. This is in stark contrast to feeling that you are **'feeling devalued'** as a health visitor or that you are under suspicion. Compare this with these two categories in interview 1 & 2, with Rebecca and Jane.

Helen attributed her lack of anxieties to her personal experience of living in another culture, as the following extract shows

> Helen: But for me, personally, I have personal experience, I have lived abroad, talked different languages, I had some experiences that helped me in my professional life, my personal life certainly came into my professional life and that relieved me of some of the anxieties another professional might have had if they have had no contact with people from other cultures. I have lived with people from other cultures, so that was a benefit to my professional career, because I have personally gone through it (Helen:69-75)

A8 Theoretical memo: importance of extended families 11 July 2008

11th July 2008_Interview 3_Helen
Theoretical memo - importance of extended families

Helen stands in stark contrast to Rebecca and Jane in relation to working with extended families.

> Helen: Look at cultures where you, where the extended family all stay together as one unit and see and look and see how they function and work with them. I would never separate them, because I look at cultures from abroad where the family is not just mam, dad and the children, but it is aunties, uncles that will all live in the same house or the same area of land and that is how it works out there, so to exclude them is to go against the cultural norm. And you are setting up that young mam and husband into a probably more antagonistic house and family and failing and you will never achieve any health promotion if you separate them (Helen:239-247).

In sharp contrast to standing **'behind the shield of the extended family'** (Rebecca), Helen views the extended family as a positive support and it is important to **'work in partnership with extended families'**. Why does Helen not see the extended family as a shield and barrier?

Helen acknowledges power issues within the household and yet again works with the grandmother to **'moving the whole family forward'**. This concurs with the theoretical Figures on **'exploring and marrying it up'**.

> Helen: In some ways acknowledging that the grandmother is the powerful person in the house, then by working with her, you will actually move the whole family forward(Helen:248-249).

'Working in partnership with extended families' becomes an important theme here. Previous interviews have perceived the extended family to be controlling, negative and a barrier but in interview 3, the extended family is viewed as a positive influence.

> Helen: I have personally seen it, how families work and I can take that into my own professional background and after working with lots of people, I know how important families are in the functioning of many people (Helen:256-259).

Again participant 3 attributes her ability to work with families with her experience of having lived in another culture. What does the literature say about cultural sensitiveness and the experience of living in another culture? Explore this further.

A9 Theoretical memo: culture as fluid 12 July 2008

12th July 2008_Interview 3_Helen
Theoretical memo – culture as fluid

Helen defined culture in a very different way to the previous two participants. Culture is defined in terms of fluid, changing and negotiated. A much more non-essentialised view of culture is described. This can be seen in the following extract at the opening of the interview.

> Fiona: Can you tell me a bit about your experience of working with people from other cultures?
> Helen: Well, it depends what you mean by the term culture. The estate we are in now, they are part of that culture, because that is who they are and how they act is different to if you go onto the next estate, so that is their culture itself, so are you talking about culture as people who have been brought up with different cultural patterns and histories or are you talking about from different countries and within that, different ways of living and life?(Helen:7-14)

Culture is defined as a pattern, a history, a country and a lifestyle. The fluid, changing nature of culture is highlighted. The question here remains, does 'culture' exist or is it only socially constructed? This will be explored in the literature review.

Helen is also very aware of the complexity of culture, as the next extract demonstrates.

> Helen :they come with a multitude of different cultural backgrounds, different ways of practicing, different expectations, em (pause) because I deal with families, it is different family life and it is lots of different variants within that (Helen:20-23).

Again culture is complex and negotiated. Why does this health visitor have such a non-essentialised view of culture, when the previous two interviewees have a very static and essentialised perception of culture? For both Rebecca and Jane, culture was defined as 'other'. Is it because this health visitor has chosen to work with people from other cultures or because she has lived in another culture herself?

Appendix B Interview schedules

B1 Initial interview questions

Initial interview questions

Initial open-ended questions

1. Can you tell me about your experiences of working as a health visitor with people who are from other cultures?

Intermediate Questions

1. What have you found to be the best things about working with people who are from other cultures?
2. Tell me about your feelings during this encounter.
3. In what ways, if any, do you feel you may have changed over time in your approach to working with people who are from other cultures?
4. What have you found are the most difficult things about working with people who are from other cultures?
5. Tell me about how you managed to resolve that issues.
6. Could you describe the most important things you have learned through that experience?
7. What training or education have you had to help you work more effectively with people who are from another culture?
8. Who is there to support you in this type of work?

Ending Questions

1. How have your experiences helped you cope with any issues now?
2. Is there anything else you would like to say which we haven't already discussed today?
3. Is there anything else you think I should understand better?
4. Do you have any more question

Thank you very much for your time today.

B2 Interviews 5-8: Guided interview questions

Interviews 5-8 Guided interview questions

Interview questions to guide interviews 5, 6 and 7

1. Can you tell me about your experiences of working with people who are from another culture?
2. Can you tell me about your experiences of working with extended families in a cross cultural context?
3. What are the difficulties you have experienced in building up a relationship with mums who are from other cultures?
4. Have you felt anxious or uncertain when working with clients who are from another culture?
5. How do you think you are perceived as a health visitor by your clients?
6. Do your clients ever disclose any incidents of racism they have experienced?
7. Do you think racism exists in the area you work in?
8. What is your experience of training in cultural competence, or something similar?

Appendix C Ethical approval documentation

C1 Ethical approval: University of Sunderland Ethics Committee

RV1

University of Sunderland

ETHICS COMMITTEE

APPLICATION REVIEW FORM

Application Number: 2007.145b

Project Title: Opportunities and barriers for community nurses in health & social care.

CONDITIONS: These conditions must be completed before you commence the work.

APPROVED

RECOMMENDATIONS: The committee recommends the following are completed before the research commences:

Note: If you wish to make any significant changes to this approved protocol, you must re-apply for ethical review.

Ethics Chairperson

C2 Ethical approval: NHS Ethics Committee

NHS
National Research Ethics Service
Northumberland Research Ethics Committee
Room 144, TEDCO Business Centre
Viking Industrial Park
Rolling Mill Road
Jarrow
Tyne & Wear
NE32 3DT

Telephone: 0191 4283561
Facsimile: 0191 4283432

09 April 2008

Mrs Fiona Cuthill
Post Graduate Academic Assistant
University of Sunderland
Priestman Building
Green Terrace
Sunderland
SR1 3PZ

Dear Mrs Cuthill

Full title of study: **An investigation into the opportunities and barriers experienced by community nurses in the North East of England when delivering health and social care to people from different cultural groups.**
REC reference number: **08/H0902/16**

Thank you for your letter of 03 April 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	2	29 February 2008
Investigator CV		26 November 2007
Protocol	1.0	20 February 2008
Covering Letter		20 February 2008
Summary/Synopsis: Recruitment Procedure	1.1	02 April 2008
Peer Review		27 November 2007
Interview Schedules/Topic Guides	1.3	02 April 2008
Letter of invitation to participant	1.1	02 April 2008
Participant Information Sheet	1.3	02 April 2008
Participant Consent Form	1.2	20 February 2008
Response to Request for Further Information		03 April 2008
Sunderland University Ethics Committee review form		
Educational Supervisor CV		27 November 2008

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following

a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website.
b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk .

08/H0902/16	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

VEggleston

pp **Dr Saul Miller**
Chair

Email: verity.eggleston@suntpct.nhs.uk

Enclosures: *Standard approval conditions*

Copy to: Mr Simon Kerridge, R&D Office, Sunderland University

Alison Emslie, R&D Office, Newcastle PCT

Claire Kelly, R&D Office, Sunderland Teaching PCT

C3 Primary Care Trust Approval

Primary Care Trust approval was granted in accordance with local research and governance regulations. The documentation is not included here, as it discloses the location of health visitors involved in this study and in doing so, confidentiality may be breached. A copy of the original documentation is available on request.

C4 Letter of invitation

Fiona Cuthill
Post Graduate Academic Assistant
University of Sunderland
Priestman Building
Green Terrace
Sunderland
SR1 3PZ

Tel: 0191 515 2402
e-mail: fiona.cuthill@sunderland.ac.uk

Invitation to participate in a research study

Title of study: An investigation into the opportunities and barriers experienced by community nurses in the North East of England when delivering health and social care to people from different cultural groups.

I have worked as a community nurse for many years and I am now at the University of Sunderland undertaking a PhD. I would like to investigate some of the issues you experience as community nurses while working with patients who are from other cultures.

I am writing to ask if you would be willing to participate in this study, which would involve a face-to-face interview of approximately one hour duration. Further information is available in the 'NHS information sheet' enclosed.

Your participation in this study is voluntary and you would be able to withdraw from the study at any time, without explanation.

Please contact me at the address above if you are willing to be involved or would like some further information.

Yours sincerely

Fiona Cuthill

NHS STUDY INFORMATION SHEET

Study Title

An investigation into the opportunities and barriers experienced by community nurses in the North East of England when delivering health and social care to people from different cultural groups.

Researcher

Fiona Cuthill

I am a student at the University of Sunderland studying for a PhD and this research project described below, forms part of this course. I would like to invite you to take part in this research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What will happen to me if I take part?

You will then be asked if you would be willing to take part in a face-to-face interview lasting no more than one hour. This will be an informal discussion exploring your experiences of working with patients who are from a culture different to your own and take place at your convenience. It will be tape recorded, to enable future analysis of results.

All information will be anonymous and confidential. No personal identifiable information will be used in this study.

Upon completion of the study, you will be given a summary of the overall results in written format. You will also be given the opportunity to feed back any comments to me, if you want to.

Do I have to take part?

No, you are under no obligation to take part in this study. I will describe the study and go through this information sheet, which I will then give you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. Due to the nature of the research, interview tapes will be transcribed within a week of the interview and destroyed as soon as they have been transcribed. As a consequence of this, you will be unable to withdraw from the study, should you wish to, after this point.

What are the possible disadvantages and risks of taking part?

I do not anticipate any risks or disadvantages to you taking part in this study.

What are the possible benefits of taking part?

I cannot promise the study will help you but the information we get from this study may help improve the way we, as community nurses, work with people from cultures other than our own. It could also contribute to the future training of community nurses in culturally competent care.

What if there is a problem?

If you have a concern about any aspect of this study, you should contact me, Fiona Cuthill, at the contact details at the bottom of this sheet.

If you remain unhappy and wish to complain formally, you can do this through the University of Sunderland by contacting my research supervisor, Dr Anne Charnock, using the contact details at the end of this information sheet.

Will my taking part in this study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence.

All data collected as part of the interviews will be collected and stored at the University of Sunderland. It will be kept in password protected electronic sites and paper documentation will be kept in locked filing cabinets. Data will be anonymised and coded. It will be kept for three years and destroyed upon completion of my PhD.

If, during the course of the interview, any information relating to malpractice or criminal activity is disclosed to the researcher, then this information will be passed on to your manager.

What will happen to the results of the study?

Results will be made available to the participants. The results may be published in academic journals. You will not be identified in any report or publication as all information you give will have been anonymised.

Who has reviewed this study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Northumberland Research Ethics Committee.

How long do I have to decide?

Please could you let me know within two weeks of receipt of this information sheet, if you are willing to be involved in this study. If you do not want to take part, you do not need to do anything further.

Thank you for your time and participation in this study.

For further information please contact:

Researcher:

Fiona Cuthill
Post graduate academic assistant
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School of Health, Natural and Social Sciences
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Academic supervisor

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Sunderland
SR1 3PZ

Tel: 0191 515 2575
e-mail: anne.charnock@sunderland.ac.uk

C6 Consent form

Centre Number:
Study Number: 08/H0902/16
Participant Identification number for the study:

CONSENT FORM

Title of the project: An investigation into the opportunities and barriers experienced by community nurses in the North East of England when delivering health and social care to people from different cultural groups.

Name of the Researcher: Fiona Cuthill

Please initial each paragraph below:

1. I confirm that I have read and understand the information sheet dated 20 February 2008 (version 1.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

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

3. I understand that relevant data collected during the study, may be looked at by the researcher and her academic supervisor. Data may also be looked at by the Research and Development Department of the Primary Care Trust, for research governance purposes. I give permission for these individuals to have access to this data.

4. I agree to take part in this study.

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix D: Initial open coding

D1: Open codes following interview 5 (Alice)

1. When to probe..when to accept
2. Culture as 'other'
3. Behind the shield of the extended family
4. Anger in cross cultural encounters
5. Homes of confinement...public spaces of freedom
6. Integration vs specialist provision
7. All equal but different services..or the same?
8. Unsupported by management
9. Universal provision...meeting specialist needs
10. They don't understand us
11. Gaps in interpretation
12. Lacking trust with interpreters
13. Professional status devalued
14. They don't know what our role is
15. Racism exists but it's not the norm
16. 'Other' cultures beyond reach
17. Intimidated by the extended family
18. Beyond interpretation – hidden cultural meanings
19. Learning on the job
20. Thrown in at the deep end
21. Anxiety in cross cultural encounters
22. Getting mum alone
23. Need someone to explain the little things

D2 - Open codes following interview 7 (Emma)

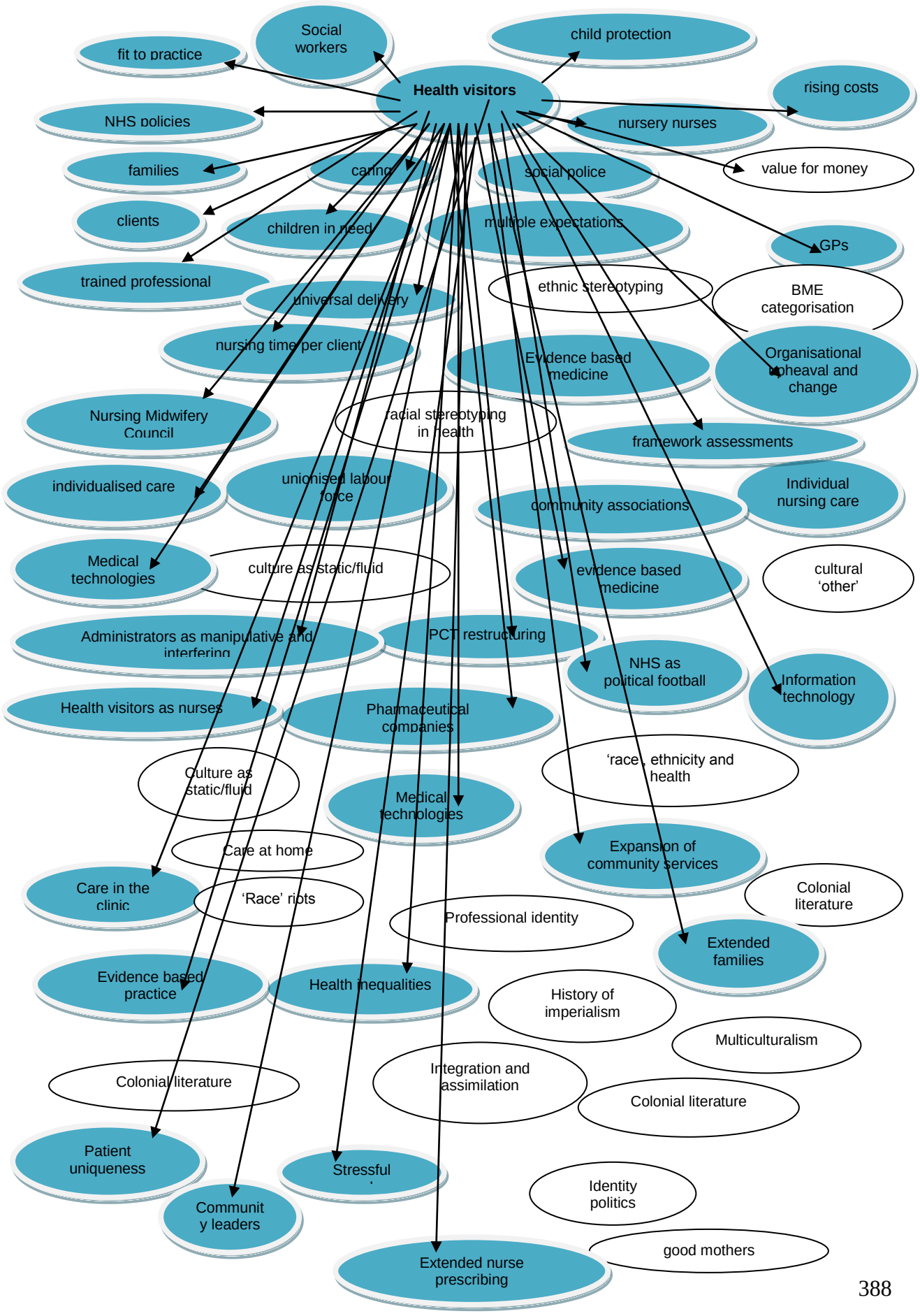
1. Things lost in interpretation
2. Unsupported by management
3. Lacking knowledge and back up
4. Working in partnership with extended families
5. Changing over time – becoming more comfortable and relaxed
6. Picking up the little things
7. Things lost in translation
8. Things lost in culture
9. All equal...all the same
10. Frustrated with framework assessments
11. Damage caused by specialised BME teams
12. Specialist provision unfairly advantages BME groups
13. Treading on glass
14. Anger people won't integrate
15. Problematic political correctness
16. Protecting your back
17. Not pushing forward on child protection
18. The contradiction of equality and diversity training
19. Waiting to be tripped up

Appendix E – Situational analysis maps

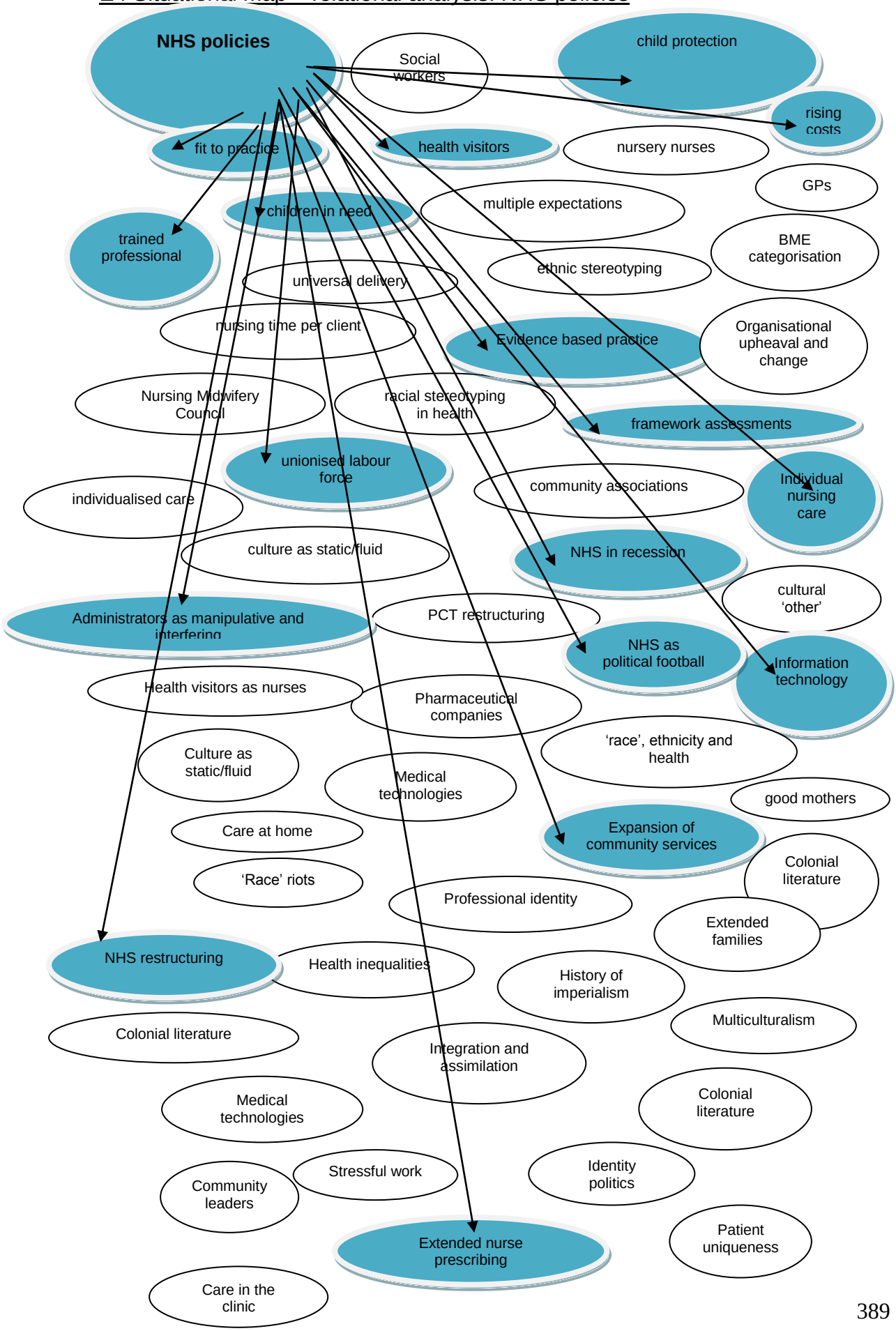
E1 – Initial messy situational map

E2 – Situational map - relational analysis: white health visitors and culture

E3 – Situational map – relational analysis: health visitors and the NHS

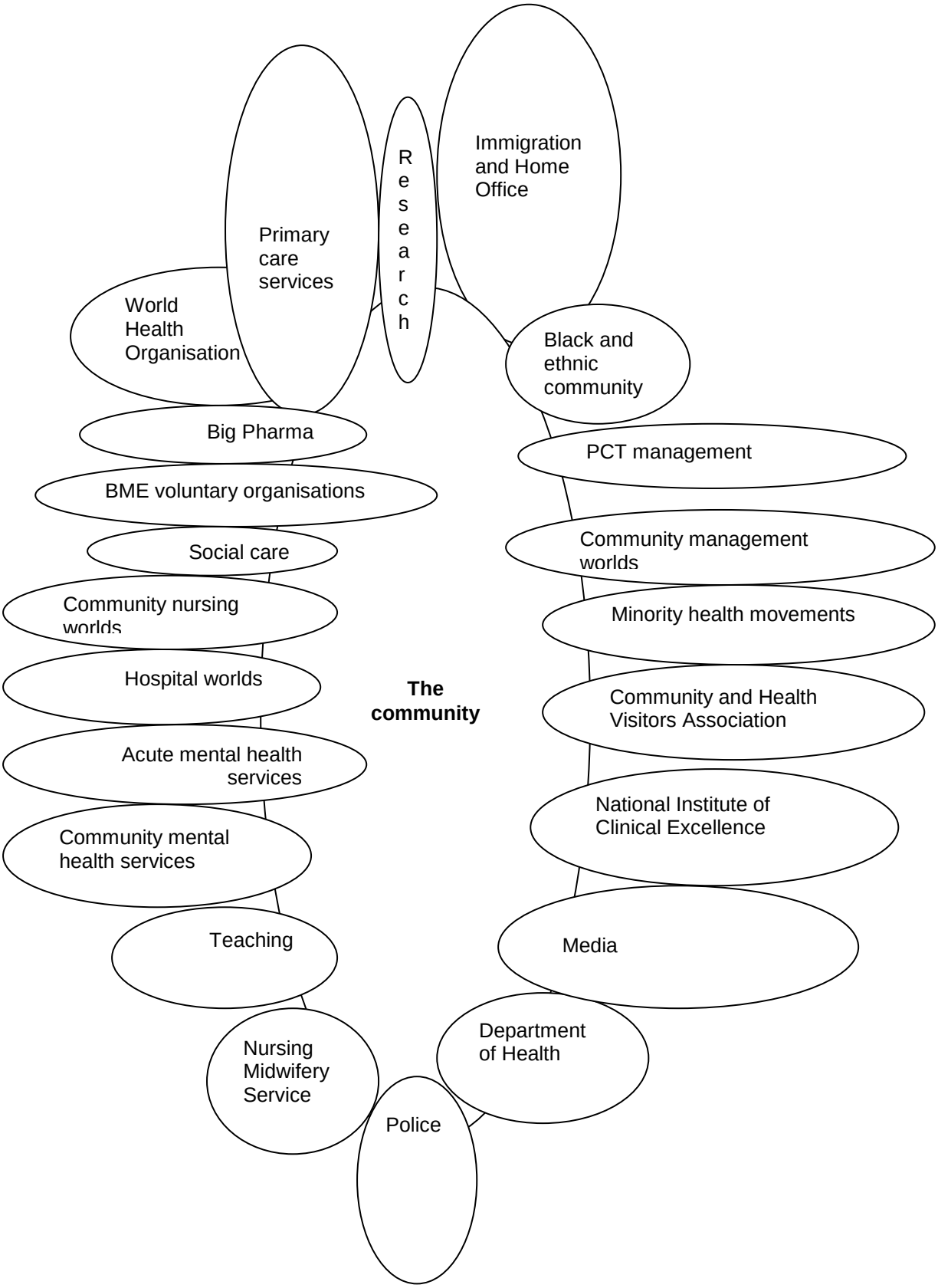


E4 Situational map – relational analysis: NHS policies



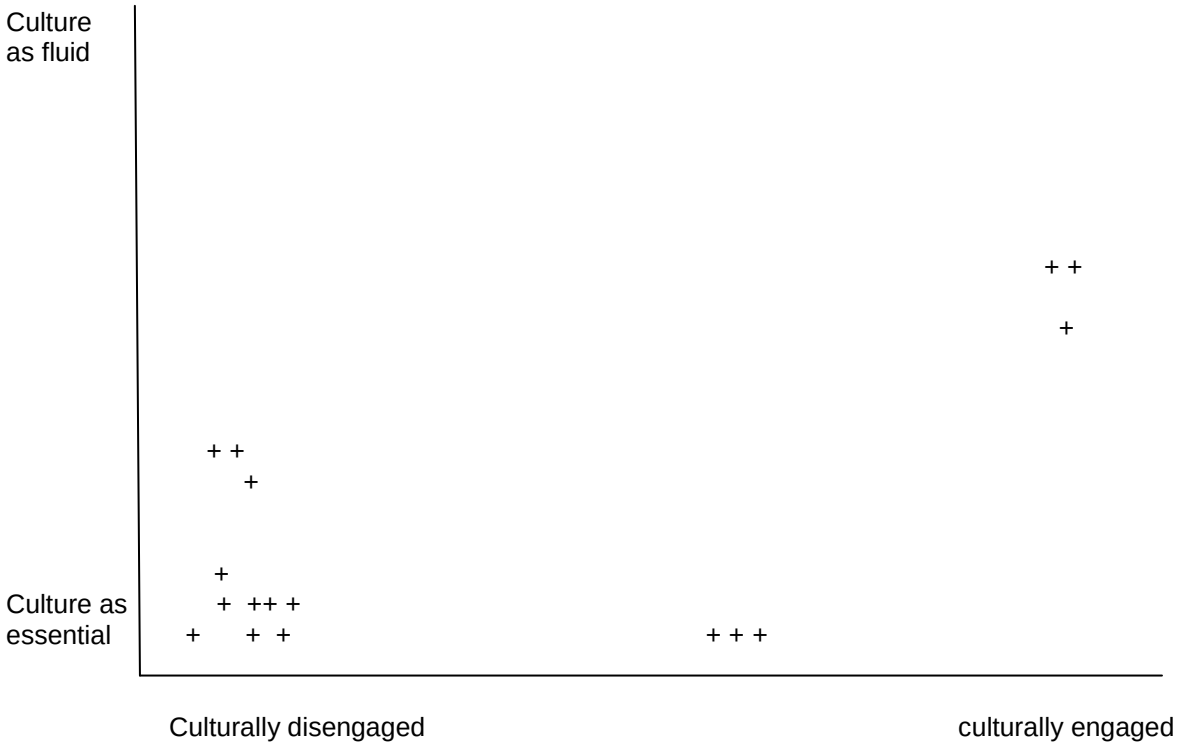
E5 – Situational analysis: historical discourses of 'race'

Appendix F Social worlds maps

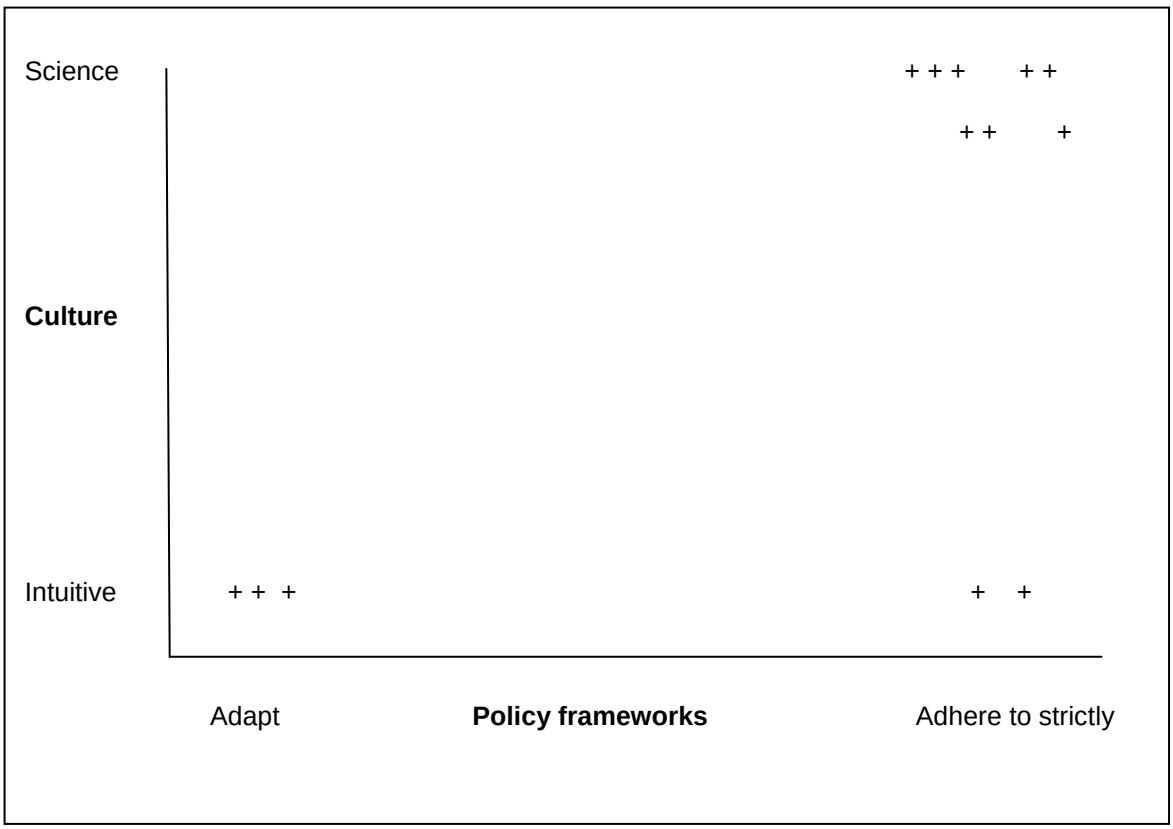


Appendix G Positional maps

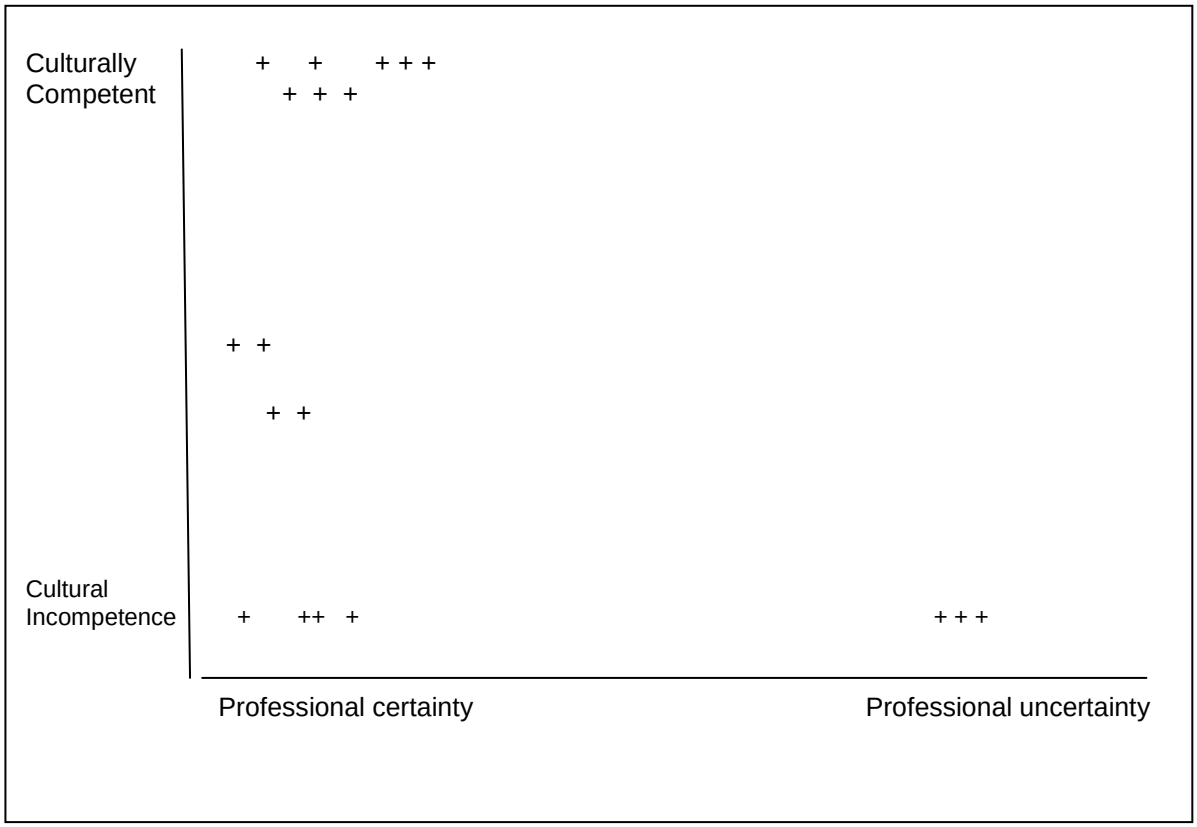
G1: Positional map – discourses of cultural fluidity and cultural (dis)engagement



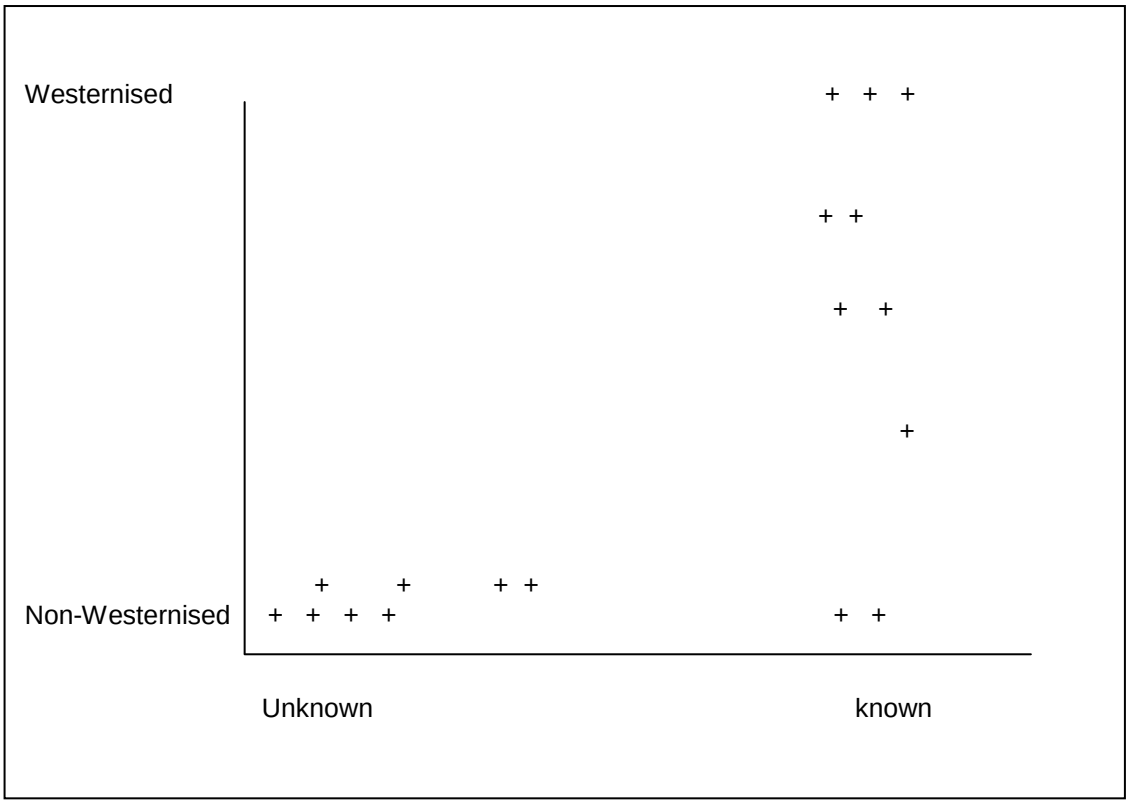
G2: Positional map – discourses of culture and policy frameworks



G3: Positional maps: discourses of cultural competence and professional (un)certainty



G4: Positional map: discourses of the Westernised 'other' and knowing the cultural 'other'



Appendix H – Advanced theoretical memos

H1 – Advanced theoretical memo: cross cultural terrain 26 March 2009

26 March 2009_Advanced theoretical memo

'Cross cultural terrain'

The health visitors appeared to all describe entering a metaphorical 'domain' when working across cultures and the most important category was the **'foundation of the terrain'**. The space which they entered in cross cultural relationships was either **'solid ground'**, **'uncertain ground'** or **'dangerous ground'**. **'Solid ground'** was characterised by confidence and certainty. The health visitors entering **'solid ground'** felt as if they had the tools to equip them to carry out the job they were required to do. This was either a universal framework they worked with which applied to all clients or their skills and experience as health visitors. The 'solid ground' was initially divided into two different types of 'solid ground'.

a. 'Solid essentialised ground' was where the health visitors perceived the client as the cultural 'other'. Stereotypes were evident and culture was defined as by nationality of origin or by community groups. Culture was perceived as fixed, rigid and static. The health visitors here did not question a fixed conceptualisation of culture and culture was defined by difference and 'otherisation'. Confidence was high within this domain, as the 'other' was felt to be known, although not understood but defined.

b. Initially this category was named **'solid non-essentailised ground'** but following data analysis became **'treading lightly on cultural terrain'**. Although it was characterised by confidence and certainty, this was a very different type of confidence to that on essentialised ground. The health visitors here described culture as fluid, in flux and a dynamic concept. Culture was defined as individual, they actively tried not to define culture as into people groups or by community and were aware of the individual and changing nature of culture. Culture was non-essentailised and dynamic. They worked confidently within this concept of culture and were very comfortable with this. Individualised care was a strong professional discourse and subsequently the health visitors were **'treading lightly on cultural terrain'.**

c. 'Uncertain ground' had many different features. Important features of this included fear and anxiety. The health visitors found that their 'toolbox didn't work' and they lacked the **'tools of knowledge'** and/or **'tools of experience'**. This was especially so with the area of mental health assessment. Assessment frameworks were not appropriate and their **'framework and assessment tools'** did not work across cultures. The foundation of the interaction lacked common features of reference. There was a lack of knowledge and a large amount of anxiety. This domain was characterised by a lack of confidence, uncertainty, anxiety and fear. **'Uncertain ground'** was conceptualised as **'common ground'** and somewhere to **'meet in the middle'**.

One feature of **'uncertain ground'** is the confusion around issues in **'re-working the equality agenda'**. The health visitors who described this as their primary domain of cross cultural encounters, were confident but confused as to how the concept of 'equality of provision' and 'specialist services' operated. There was uncertainty as to how individualised care should be given within cultural difference. Questions of integration and specialist provision, which causes segregation were dominant and confusing. One of the consequences of standing on **'uncertain ground'** was that some of the health visitors were **'not asking'** difficult questions when they entered a cross cultural relationship and did not feel able to ask questions which they normally would, in order to build up a relationship with the client. This led to uncertainty and a possible fear of slipping into dangerous ground.

c. 'Dangerous ground' was a frightening territory to be entering. It is dangerous territory. It was a place of dis-trust and anxiety. It is characterised by high anxiety and fear. Health visitors struggle to find the vocabulary to articulate 'race' and the fear of accusations of 'racism' is high. Clients were capable of **'playing the race card'**. In analysing this data on 'ground' it became clear that the 'ground' was not only the confidence of the terrain, but something else was going on with the health visitors. It wasn't only as if they felt confident on the 'ground' they were standing but it was also something to do with the expectation of the client/professional relationship.

H2 – Advanced theoretical memo: emotional encounters through culture

10 Sept. 2009

10 Sept. 2009_Advanced theoretical memo

Development of theoretical concept _emotional encounters through cross cultural terrain

Several things appear to be going on in the data and the health visitors can be loosely divided into three categories, although these are porous categories because something seems to happen over time. This is explored in Figure **. The health visitors embark on relational journeys with their clients across cultures (Figure **). This is a requirement of their work but they don't necessarily have to engage emotionally with their clients. I have already explored how some health visitors avoid engagement with their clients and only **'approach the perimeter fence of cultural terrain'**. There are many reasons in the literature as to why health professionals avoid engagement with clients from 'other' cultures, including racism, but the health visitors in this study all came forward to participate in the study and said that they were interested in culture and ethnicity. Emotional engagement has emerged as a very strong conceptual category in this research and the ways in which the health visitors emotionally engage with their clients across cultures, shapes their practice. Emotional engagement is in three different ways:

- **Emotional flexibility** – anger (against injustice) and empathy (having lived abroad)
- **Emotional hesitation** – uncertainty, scared to offend, fear, opening up…closing down, anxiety
- **Emotional avoidance** – fear, anxiety

'Cross cultural terrain' has already become a saturated conceptual category (Figure **) but the inter-relationship between **'cross cultural terrain'** and **'emotional engagement'** appears to be getting to the core conceptual category in this research.

'Emotional flexibility' – the health visitors can work across different cultural groups and do not need to know everything about every culture to be able to engage effectively. They are comfortable with 'asking and learning' and can move flexibly in and out of different cultural spaces. This is in contrast to many of the health visitors who need the **'tools of knowledge'** about the cultural 'other' before they can engage. **'Knowing before engaging'** is a strong conceptual category for many of the health visitors in this study, but for the health visitors who demonstrate **'emotional flexibility'** they do not have to know about the other, they are comfortable engaging without knowing. They were **'treading lightly on cross cultural terrain'**. They were propelled forward by emotion but these emotions were anger (fighting injustice) and empathy (having lived abroad). What causes some health visitors to demonstrate **'emotional flexibility'** and other to be **'paralysed by fear'** when working across cultures? Why do some health visitors need to have a 'toolbox of knowledge' and others are happy to **'take the ball and see what we can do with it'**? This needs to be explored further. These concepts can be brought together into a core variable category of **'emotional flexibility: treading lightly on cross cultural terrain'.**

'Emotional hesitation' – the majority of health visitors interviewed were categorised as this. The emotions of fear, anxiety and uncertainty were what drove (or hindered) their practice. They were **'scared to offend'** and **'cross cultural terrain'** was conceptualised as **'unstable terrain'**. The health visitors were **'moving forward…retreated back'** into and away from this unstable terrain, depending on their experience within the **'cross cultural terrain'.** There were several aspects of the terrain which made it unstable:

- Politicised terrain
- Things hidden in cultural terrain
- Active resistance within cultural terrain ('shield of the family' and 'client resistance')
- 'Race card' could be played

The work of the health visitors when working across cultures is to **'stabilise uncertain terrain'**.
There are several strategies which they use to do this including **'stereotyping'** (Figure**), **'re-working the equality agenda: all equal…all the same'**, **'asserting the professional self'** and **'developing a toolbox over time'**. These concepts can all be brought together into the conceptual category of **'emotional hesitation: stabilising uncertain cultural terrain'.**

'Emotional avoidance: approaching the perimeter fence of culture' – this is already a well-developed conceptual category.

These three conceptual categories of **'emotional flexibility: treading lightly on cultural terrain', 'emotional hesitation: stabilising uncertain terrain'** and **'emotional avoidance: approaching the perimeter fence of culture'** all contribute as variable categories to the conceptual category **'emotional encounters through cross cultural terrain'.**

H3 Advanced theoretical memo: taking and leaving 17 January 2009

17 January 2009_Advanced theoretical memo

Taking and leaving

As the health visitors engage on a **'relational journey'** with their clients across cultures, there are several things which they both take, and leave. **'Taking and leaving'** is part of **'preparing for the journey'**.

'Taking' relates to:

- Taking a toolkit (knowledge, experience and frameworks)
- Taking professional values
- Taking evidence based practice discourses and research which supports this
- Taking cultural 'norms'. This is a normalised white discourse. It is really shocking in the interview with Ruth, the racial hierarchical views held! The literature in white studies is interesting in this – I need to read further to inform this area of study

> Fiona: Can you think of times you haven't felt accepted by communities?
> Ruth: Well, I did speak to a community worker and she told me that white women are sort of accepted because there is this accepted sort of order from a white man, then a white women, then an Asian man and woman and then a black man and woman, well I think that was the way round it was but I think as a white woman you have some sort of position really (Ruth: 81-85)

'Leaving' relates to:

- Leaving cultural norms and values
- Leaving gender norms
- Silencing your voice

> Ruth: I think I find it difficult when the male is there, you know. You sort of feel as if you can't be yourself as a woman, you know what I mean.
> Fiona: Can you explain that a bit further?
> Ruth: Well, you know when you are in a house and if it is the male in the house who is there and especially if they are interpreting, you sort of feel you are, (pause) you are betraying yourself, your values, you know.
> Fiona: In what ways?
> Ruth: Well, you know you have to respect their values but you sort of feel like you have to leave your own values outside and sort of do what they want and that sort of sticks in the throat at times. You feel as if you're not really being true to yourself. I mean you want to respect the views of other people but it is hard when you feel you have to leave yours behind. I find that really difficult at times (Ruth: 30-41)

How does this relate to **'positioning self'?**

The health visitors appeared to **'position self'** in relation to the **'professional self'** and I was really struck by the ways in which some health visitors **'asserted the professional self'**. Why did they rely on professional qualifications or 'attributes'? What did they mean by the **'professional self'**? I need to explore this further (Appendix H10).

H4 – Advanced theoretical memo: taking a tool box 20 April 2009

20 April 2009_Advanced theoretical memo

'Taking a tool box', 'developing a toolbox over time' and **'Toolbox rendered ineffective'**

The conceptual category **'taking a toolbox'** has emerged as an important category but needs more exploration. There seem to be three important elements to the toolbox – **'tools of knowledge'**, **'tools of experience'** and **'framework and assessment tools'**.

All of the health visitors are involved in **'taking a toolbox'** on their **'relational journey through culture'** but for the health visitors who rely on this toolbox, they find that the toolbox is often **'rendered ineffective'** in **'cross cultural terrain'** and their tools don't work. In contrast to this, the health visitors who were **'treading lightly on cross cultural terrain'** do not rely on their toolbox…or not nearly as much. They are very comfortable with **'taking the ball and see what we can do with it'** – taking what they have and adapting it to meet the needs of the client. These health visitors did **'take a toolbox'** with them, but didn't seem to rely on it, it was in the background but they were not **'necessary tools for the job'**.

The **'tools of experience'** which were most useful to the health visitors who were **'treading lightly on cross cultural terrain'** were their experiences of having **'empathy having lived in another culture'.** In discussing this experience with these health visitors, they had not lived in an 'ex pat' world but had really lived and worked in a culture very different to their own here in the UK. What took them to another culture? In what ways does that shape their experience here in the UK and engagement across cultures? The answers to these questions are beyond the scope of this study but a body of scholarship does exist into these questions.

Many of the health visitors clung to their **'toolbox'** as containing **'necessary tools for the job'** and found it difficult when their **'toolbox doesn't work'** or worse, their **'toolbox'** was **'rendered ineffective'.** One of the things which almost all of the health visitors wanted was the ability to **'develop knowledge over time'. 'Developing knowledge over time'** and **'developing assessment and framework tools'** were two conceptual categories which became a selective code of **'developing a toolbox over time'** and was identified as a strategy used by many of the health visitors to **'stabilise uncertain cultural terrain'.** The health visitors wanted knowledge and certainty in their '**relational journeys through culture'.**

'Tools of knowledge' was a very interesting conceptual category. The health visitors wanted to know about the 'cultural 'other' (**'knowing the cultural 'other'**) and wanted to **'fix culture'**. This is not surprising, as nursing literature is saturated with discourses of knowing in professional practice. This needs to be explored further – in what ways is this quest for knowledge about the 'cultural 'other' reinforced by discourses of knowing in nursing and health care. What about evidence based medicine? Where does this fit in? I need to use positional maps to figure out where this all fits in (positional map **).

What happens when this changes over time? Does increased knowledge and experience, increase engagement with clients across cultures over time? Is the 'emotional flexibility' demonstrated by the health visitors in the conceptual group 'emotional flexibility: treading lightly on cultural terrain' a product of time, experience and knowledge? …or something else? I really feel as if I am getting to the central questions in this research now and it is very exciting to be so close.

H5 – Advanced theoretical memo: knowing the cultural 'other' 20 July 2009

20 July 2009_Advanced theoretical memo

Knowing the cultural 'other'

Right from the very beginning of this research, the **'tools of knowledge'** were identified as important. In interview 1 with Rebecca this was identified and coded as **'knowledge as the key to unlocking the door'**.

> Rebecca: I have grown so much but I still don't think that we give what we should to these families and I think that is just because of our lack of knowledge. I am really lucky because I started off in the (multicultural area of the city) and I am aware of the cultural differences and I am aware of how these people feel, the young girls that come here into arranged marriages and I thought if this research could shed any light on new approaches to access and engage these people, then it is definitely worth an hour out of my day. (Rebecca:321-326) [sic]

> Emma: because to me, especially now there are so many different groups coming in and we can't possibly know everything about everyone and to me, that says 'what does this mean' and 'what kind of taboo over these' and 'what is not' and 'what should I be trying to do' because you try and be culturally sensitive as you can but unless you have access to specialist advice then (pause) it is tough. (Emma:160-164) [sic]

> Annette: I felt that I didn't always understand sometimes their religion well enough, for all I would ask and try and be involved, I think I did feel ignorant and I think if you feel ignorant you do always worried you are going to get it wrong. (Annette:175-177) [sic]

> Susan: sometimes you think you don't want to ask questions in case they think you are being ignorant. (Susan:154) [sic]

These health visitors all crave knowledge of the cultural 'other' and they all wanted to '**fix culture in time'** and become comfortable with **'knowing the cultural 'other'.** What is important here is also the ways in which fear, uncertainty and anxiety in 'not knowing the cultural 'other' affected practice in quite worrying ways, largely through avoidance. Denise clearly articulates that below:

> Fiona: What areas would you really like training on?
> Denise: (Pause) I think about the Muslim culture and different sort of , em , that sort of , (pause) we have done a bit in domestic violence in other, em (pause) em, cultures and things, we have done a bit but I think more about that and the em (pause0 the em, different religions and cultural beliefs and attitudes regarding the family and more information, we are obviously getting more information about honour based violence and a lot of the stuff I have got is from reading books, you know stories of women you know around domestic violence but even something quite simple, including other cultures including African and Chinese, even if it was a list of bullet points and just some basic information about the differences about, em so you wouldn't be disrespectful or say the wrong thing or whatever and maybe something like that, in a pack so that you could reference it really.(Denise: 88-97) [sic]

Denise is not only **'stumbling over the vocabulary of 'race'** but also tries to **'fix 'race'** with bullet points and basic information. That is not to say that basic cultural information is not important, but a reliance on information of the cultural 'other' surely reifies 'race' further.

Sophie warns of the danger of feeling that **'lacking knowledge of the cultural 'other'** and **'feeling uncomfortable with the cultural other'** can lead to **'not asking'** and the **'race' card could be used';**

> Sophie: They are frightened of it. It is scary and you are out of your depth. I remember when I first started to do the asylum seeker work and I was asked to go to a group of professionals who are engaged in sexual health and I had no idea of basic stuff but in that room , they were the ones who were delivering the sexual health services in (this city), when you went round the room, each one of them admitted they had decided not to do something, because they were frightened to get it wrong.
> Fiona: Just to clarify, do you mean with clients from other cultures?
> Sophie: Yes, they realised that there were problems and they know the work that needed to be done but they didn't want to do it, because they didn't want to offend people or they thought they might be seen as racist and didn't want to single them out. (Sophie: 238-246) [sic]

H6 Advanced theoretical memo: strategies to stabilise uncertain terrain 10 October 2009

10 October 2009_ Advanced theoretical memo

Strategies used in 'stabilising uncertain terrain'

The health visitors appear to employ several strategies to **'stabilise uncertain terrain'.** I have already identified 'avoidance' as a strategy, but for the health visitors who are **'moving forward…retreating back'** on to uncertain cultural terrain, there are strategies they employ to **'stabilise uncertain terrain'**. It was exploring the time dimension, which really brought these conceptualisations to light.

I have conceptualised these as:

1. Fixing a culture: unchanging throughout time (see Appendix H7)

- Stereotyping
- Essentialised terrain
- Culture as 'other'

2. Re-writing an agenda: strengthening over time (see Appendix H9)

- All equal…all the same
- Universal provision..meeting specialist needs

3. Asserting and identity: undermined over time (see Appendix H10)

- Professional status devalued
- Positioning self
- Asserting professional self
- Reduced professional power and increased personal frustration

4. Developing a toolkit: strengthening over time (see Appendices H4 and H5)

- Toolkit of knowledge
- Toolkit of experience
- Toolkit of frameworks and assessments
- Toolkit rendered ineffective

These are strategies used by the health visitors to **'stabilise uncertain terrain'** and they also work against cultural engagement.

H7 Advanced theoretical memo: fixing a culture over time 26 September 2009

26 September 2009_Advanced theoretical memo

Fixing a culture: unchanging throughout time

The majority of health visitors, when asked about working with other cultures, described their clients in terms of nationalities or in large ethnic groups, such as Asian. Groups of people were commonly stereotyped and essentialised.

> Fiona: What is your experiences of working with people who are from other cultures?
> Lisa: Actually it is increasing I think, there were just a few to start with, Indian and Pakistani, actually you get quite a few Indian and Pakistani cricketers over and they stay for the summer and sometimes they stay on their own and I've had a few lodgers like that but with this job it seems to be slowly increasing and there seem to be a lot more immigrants coming in and people trying to move and looking for work, so I've had quite a few Polish, a French mam, Lithuanian and Romanian and Italian and Greek mams at the moment, that is what I have on my caseload (Lisa:14-21)[sic]

> Fiona: So when we are thinking about people from other cultures, what is your experience?
> Rebecca: The populations that we normally have would be Asian populations, Bangladeshi, em, Indian, em, in (this area) itself, we have started to get quite a large Polish population' (Rebecca:3-5)[sic]

> Fiona: And just thinking about people who you have worked with from other cultures, what experience have you had of that?
> Leah: I would say in this area that we haven't particularly had a lot. We have had a family of asylum seekers from Angola and asylum seekers from the Congo, we have had the odd Asian, we have mostly Asian families, mostly third generation Asian families here…the hospital took on a lot of Phillipino staff (Leah:17-22)

> Mary: The area is quite British but there are other areas of the city where you will find pockets of ethnic minorities. We have got quite a few European families now who are coming in to the area and we have got quite a few from Poland and Russia and Lithuania, so we have quite a few of those families migrating into the area, em but other cultures very few of (Mary:13-16)[sic]

Nonetheless, it appears that Annette recognised that things do change over time. For many of the health visitors above, they still essentialised cultures, even though they had worked with BME groups for many years. Why is this? Do they just not want to see the differences in cultural practice? Health care discourse essentialises BME ground into defined categories – is this the reason?

> Annette: cultures evolve and you think, is that still accurate years later (Annette:86)

26 September 2009_ Advanced theoretical memo

Emotional flexibility…capacity to accommodate uncertainty

There is something really interesting going on here, because when I looked at changes in practice over time, it became clear that for many of the health visitors, they changed their practice over time, as they became more familiar with the client group and gained confidence, but this did not generate flexibility. Their biggest fear was to have to move suddenly to a new client groups. **'Inflexibility over time'** has become a very interesting theoretical category. Helen and Sophie were identified as being very 'emotionally flexible' but even if knowledge and experience increased for many of the other health visitors, it did not result in 'emotional flexibility'.

'Knowledge builds experience but not emotional flexibility' is important concept here. This research is unable to answer the question as to why some of the health visitors were **'emotionally flexible'** and others were unable to move across cultures. Is the capacity to accommodate uncertainty related to **'emotional flexibility'**? I need to look at the literature and some of the literature in psychology, Avoidance of Uncertainty Theory may give insights into this. This is a research question to put forward following this research and post doctorate work…my next research project might be to look at 'emotional flexibility' and the elements of that.

All I can really say just now is that the health visitors who were **'emotionally flexible'** and who were not trying to **'stabilise uncertain terrain'**, had **'lived abroad'** and demonstrated empathy and **'anger against injustice'** as the dominant emotions in the narrative of their practice. I cannot say through this research whether they had lived abroad because they were emotionally flexible or had the **'capacity to accommodate uncertainty'** or their experience in living abroad had increased their capacity for emotional flexibility and **'accommodation of uncertainty'**. Which is the chicken and which the egg?!!

H9 Advanced theoretical memo: re-writing an agenda over time 26 September 2009

26 September 2009_ Advanced theoretical memo

Re-writing an agenda: similarities over time

This is an interesting concept and has been really confusing, but I think I have it straight in my mind now. Two different things appear to be going on with the health visitors in relation to the **'equality agenda'**, which caused real confusion for me at the beginning. The health visitors know that they work within a society where health inequalities are increasing across socio-economic groups and therefore, they are required to work with some families more than others. This is confusing within health visiting practice, where it has been a universal service. Changes in health visiting practice in the UK seem to be moving it more towards that of social work, where the greatest resources are given to the greatest in need. Hence this confusion of **'universal provision…meeting individual needs'**.

This is then confused with the **'equality agenda'**, where the health visitors understand that to tackle discrimination, everyone must be treated with equal respect. Nonetheless, this is often confused with **'all equal…all the same'** and difference (cultural or ethnic) is negated and ignored. There is also a concern that within communities, there is not positive discrimination shown towards the cultural 'other' and a concern that **'damage is caused by specialist BME teams'** and that **'specialist provision unfairly advantages BME groups'**. All of these discourses are confused by the health visitors but the result appears to be that over time, some of the health visitors negate difference and make the **'all equal…all the same'** agenda the dominant one, thereby **'re-writing the equality agenda'** and negating cultural adaptations to their practice. There is a plethora of literature on 'cultural blindness' which I need to go and read now.

H10 Advanced theoretical memo: asserting an identity over time 26 September 2009

26 September 2009_ Advanced theoretical memo

Asserting an identity: undermined over time

The health visitors used many different strategies to **'assert and identity over time'** (Appendix H13) but here they **'asserted the professional self'**. What does that mean? Asserting the professional self is all about 'being professional' as a means of asserting norms and values. I have asked the health visitors what it means to 'be professional' and many refer to using **'evidence based practice'** and **'fit to practice' agendas.** They see the use of good quality research to inform their practice, although in every day practice, many admitted to using personal experience and intuition as well. This is consistent with the scholarly literature pertaining to practice. These discourses are dominant within health care and I wonder why the concept of being professional is equated to using 'evidence based practice'? Knowledge and skills were also important for the health visitors but the most important discourse was around 'protecting the child'. 'Being there for the child' was currently commented upon.

What does this mean for cultural practice? If things become contentious, especially around infant feeding (often cited by the health visitors as an area of conflict) then some of the health visitors rely on **'research'** and **'evidence based practice'** to support **'norms and values'. 'Being Westernised'** also is a code which comes to mind here, as **'being Westernised'** is associated with holding the same **'norms and values'** and this was perceived as easier practice and the health visitors felt more comfortable on this Westernised terrain.

What has happened over time? Many of the health visitors felt that their role was changing and they were becoming more like social workers and **'social police'**. They were undermined over time, in that their clients often didn't know what they were there for and because they wore ordinary work clothes (as opposed to a uniform) their role was changing, fluid and under threat. The rapidly changing political climate, job cuts and threat to their professional standing were also under threat. Several of the health visitors spoke of the fear that their roles would be given to unqualified staff or lower graded staff in the economic restructuring which is currently happening in the British NHS.

To assert the **'professional'** nature of their job was both a way for the health visitors to justify their role and also possibly a way of **'stabilising uncertain cultural terrain'**. By relying on Westernised research and Westernised 'evidence' to base their practice, the health visitors were closing down cultural dialogue and engagement. This was very different to the health visitors who said that cross cultural working was to **'take the ball and see what you can do with it'.** I love this phrase – it sums up negotiation, being open, listening and taking the issue…not asserting some professional values on top of the issue, to see what can be done. Lots to think about here.

H11 Advanced theoretical memo: hidden work 20 October 2009

20 October 2009_Advanced theoretical Figure

Hidden work

I have started thinking recently about the way the health visitors interviewed negotiate their obvious feelings of fear, anxiety and uncertainty with their professional competence. The discourse in health is all around competence to practice and 'fit for purpose' agendas. How does this fit with the feeling of anxiety and uncertainty in cross cultural working? Going back to the situational maps, I again struck with the context of health visiting which is around professional competence. Are health visitors able to voice their concerns and anxieties? They were largely **'unsupported by management'** and I wonder if they don't feel able to voice their concerns with management, as they are meant to be competent to practice across cultures? How does this fit in with **'evidence based practice'** and **'political correctness'**?

The context of health visiting practice is central to this research and I wonder how much the discussions in the media around nursing competencies are influencing the health visitors? Is health visiting treating culture as a science to be known, understood, put into a box and discovered? Rather than an 'art' – something to be creative about, to change, to make mistakes, to learn from?

Susan really struck me when she said 'I think you need to be creative whatever situation you find yourself in' (Susan: 245). Surely culture should be treated as an 'art' rather than a science. What does the literature say about this? There is a substantial body of scholarly material on mental health as both an 'art' and a science – is that the same for culture? Or is it always an 'art'? Now I think I am really at the heart of this discussion.

25 October 2009_Advanced theoretical memo

Relational journeys

I had originally thought that the health visitors could be divided into two different groups – those who did form a relationship with their clients across cultures, and those who didn't. Now I don't think that is correct. It seems that all of the health visitors set out on their **'relational journey'** with clients, but some are hampered along the way by their 'emotions' or the **'cultural terrain'**. ALL health visitors in this study were on a **'relational journey'** with their clients, but some did manage to engage and others did not achieve a depth of cultural engagement due to several factors.

Firstly, issues of interpretation, the interpreters, communication, language and trust were the most important issues the health visitors discussed when working cross culturally. This is predictable and the scholarly literature is full of research which supports this. Much of my research has been taken up with issues of interpretation, communication, language and trust, all very important element of 'relational journeys' but I am not sure this brings anything new to the research field. This is known already. I need to think about the elements which are behind the communication – what else is going on? 'Cross cultural terrain' is important here.

Secondly, relationships (and especially communication) in much of the scholarly literature is framed as happening within a vacuum – it is as if health visitors and clients are operating in a societal vacuum. This research identifies context as vital to **'relational journeys'**. The health visitors are scared someone will **'play the 'race' card'** and they are **'stumbling over the vocabulary of 'race'.** The context shapes the relational journey – a history of colonisation, 'race' riots, immigration, the Danish cartoons etc. The situational map (discourses of 'race') is really important here to help me to identify the context of 'relational journeys through culture'. These relationships are not occurring through a vacuum, but through a current socio-historic process. This is very important. Is this recognised in the nursing literature on communication? I have not found it, but I will go back again and look at the literature.

Finally, the health visitors who appeared to engage in the most meaningful **'relational journeys'** did not focus on the **'cultural terrain'** but focused on the person. It was all about **'establishing trust'**, **'taking the ball and see what you can do with it'** and a **'fight against injustice'**. How does this shape '**relational journeys through culture'?** What about the health visitors who were hesitant, and were **'moving forward…retreating back'**? This ebb and flow into and away from **'cultural terrain'** is very interesting. It appears to be a 'hesitant journey' through **'cross cultural terrain'.**

H13 Advanced theoretical memo: taking bearings 27 November 2009

27 November 2009_Advanced theoretical memo
Taking bearings: Locating self - 'professional self', '(In)visibility of white self', 'gendered self' and 'protective self'.

It became obvious that how the health visitors presented themselves to the clients was important. Some of the health visitors used the power of the 'professional self' to assert their authority in cross cultural encounters. This is discussed in a different Figure (Appendix H10)

Nonetheless, the health visitors were not only powerful but also felt very powerless. The professional self was both used as a powerful tool and yet the picture is more complex, as the health visitors also expressed a lack of power in the face of cultural difference.

> Ruth: You know the families I find hardest are the foreign doctors or health workers. I don't know why, maybe it is just that they question everything and you know, you just feel a bit, well it is difficult when you have to explain everything and sort of justify every single thing you are doing. I also find the Chinese families quite difficult. You know, you tell them about cot death but they just keep swaddling their children and laying them on their tummies and you just sort of think, well, what can you do? You can just tell them I think, but it is frustrating at times. The Jewish families are also really bad for that too, swaddling their babies, it is part of their tradition and no matter how much you tell them the dangers of it, they just go on doing it anyway (shrugs). You feel depowered really, I think that is what it is anyway' (Ruth:57-64) [sic]

The health visitors also felt powerless within a powerful health system such as the National Health Service.

> Alice: A decision was made a couple of years ago now to make the Bangladeshi team move all of their clientele mainstream as well, so they don't exist at the minute because we were told they need to be integrated.
> Fiona: How has that been for you as a health visitor?
> Alice: It has been really difficult, really it was a case of overnight we were informed that we were going to be given the families back to us and they were just sent back to us.
> Fiona: Were you given any help or training to help you?
> Alice: We were told that the team as it stood, because by that time the specialist nurse for asylum seekers had been merged into the Bengali team to call them the BME team and what they said was that they would have responsibility for the training and teaching of the staff and they came and we were told that the case load responsibility would come back to us but it didn't work like that (Alice:20-30) [sic]

(In)visibility of white self – powerful self

> I think there are some people who are more westernised, are educated ,more on a par with us (Jane:388)

Gendered selves (continued below)

Locating gendered self

Many of the health visitors spoke about the importance of their 'gendered selves' and how this was difficult to reconcile with women of other cultures who they did not perceive as also having this same 'gendered self'.

> Emma: I can remember being very, quite angry as a student midwife when a gentleman came in with this, em lady in, like em, full absolutely full sort of like gown and she was walking behind, which I still don't like to see, em and it was just very sharp words and she sat down and it was almost as if she was talking to a child and he insisted she sort of, em, saw a , he insisted on this that she saw a female doctor and it was awful because in no, at no stage was she given any kind of like , given any input at all and that kind of stuck with me' (Emma: 101-106) [sic]

> Beth: recently there has been a spate of honour killings the police have classed as, or attempted, a woman who basically got thrown down the stairs and another lady who was saying basically if you leave him someone will get murdered in your extended family and often it seems as if the women in their own family are against the woman and the women don't support the woman in that situation (Beth:249-253) [sic]

What is really interesting is that the health visitors 'positioned self' in many different ways. Was this a way to manage uncertainty, among other things? The most important aspect for this research seems to be 'professional self' - what does that mean? How do issues of power come into this?

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