I am the author of the thesis entitled \textit{Lay Headings Practices in the Household} submitted for the degree of \textit{Doctor of Philosophy}.

This thesis may be made available for consultation and loan. Copying of any part of this thesis is prohibited for two years from the date this statement was signed; after that time limited copying is permitted in accordance with the Copyright Act 1968.

Full Name: \textit{Anita Peerson} (Please Print)

Signed \textcolor{red}{\textit{Signature Redacted by Library}}

Date: \textit{3 \textbf{.} 3 \textbf{.} 99}
DEAKIN UNIVERSITY LIBRARY

TO: ALL USERS OF THIS THESIS

Please sign this form to indicate that you have used this thesis in accordance with the disposition signed by the author of this thesis.

Thank you.

SUE MCKNIGHT

Name               Signature               Date

Maureen Ryan       Signature Redacted by Library  10/4/00
Monika Kebainen    10/10/00
Bernie Ward        21/01/01
Urs M. M.           21/12/01
LAY HEALING PRACTICES
IN THE HOUSEHOLD

Anita Peerson
RN, BA(Hons).

This thesis is submitted in total fulfilment of the requirements for
the degree of Doctor of Philosophy

Faculty of Arts
Deakin University
Geelong
Australia

September 1998
I certify that the thesis entitled

Lay Healing Practices in the Household

submitted for the degree of

Doctor of Philosophy

is the result of my own research, except where otherwise acknowledged, and that this thesis in whole or in part has not been submitted for an award, including a higher degree, to any other university or institution.

Full Name: Anita Peerson

Signed: [Signature Redacted by Library]

Date: 5.3.99
# CONTENTS

Acknowledgments .................................................................................................................. v

Abstract....................................................................................................................................vii

Introduction................................................................................................................................. 1

Chapter 1: Women and Men as Lay Healers: Literature Review ........................................... 12
   Historical Overview ..................................................................................................................... 14
   Contemporary Lay Healing Practices in the Household .............................................................. 24
   The Future of Lay Healing Practices for Public Health .............................................................. 28

Chapter 2: Theorising the Power-Knowledge Relationship

Underlying Lay Healing Practices in the Household ................................................................. 37
   Medical Pluralism ......................................................................................................................... 38
   Medical Dominance ....................................................................................................................... 44
   The 'Household Production of Health' ....................................................................................... 50
   Embodied Self, Gender and Risk ............................................................................................... 57
   Power-Knowledge Relationship ............................................................................................... 68

Chapter 3: Methodology .......................................................................................................... 83
   Undertaking Fieldwork in Geelong, Victoria, Australia ............................................................. 83
   Choice of Methods ....................................................................................................................... 85
   Pilot Study .................................................................................................................................. 88
   Larger Project ............................................................................................................................... 89
   Data Analysis ............................................................................................................................ 93
   Reflections on the Research Process ......................................................................................... 94

Chapter 4: Lay Conceptualisations of Health And Illness ...................................................... 102
   Being Healthy: Gender and Age/Generation ......................................................................... 103
   Ill-Health ................................................................................................................................... 115
   Mental Health and Mental Illness ............................................................................................. 123
   Spirituality ................................................................................................................................. 130
   Gender, Health and Illness Behaviour ..................................................................................... 138

Chapter 5: Laypeople's Health Knowledge and Decision-Making ........................................ 151
   Sources of Lay Health Knowledge ............................................................................................ 153
   Flows of Health Knowledge ................................................................................................... 187
Chapter 6: Health Education, Health Promotion and Illness-Injury Prevention by Laypeople........................................194
  Parent-Child Relationship .............................................199
  Ways of Teaching .......................................................207
  Discourses on Risk, Accidents and Safety ..........................213

Chapter 7: Lay Diagnosis and Treatment of Illness and Injury........228
  Lay Health Knowledge ..................................................230
  Lay Diagnosis ............................................................233
  Lay Treatment ...........................................................240
  The Affective Partiality of Lay Healing ...............................250
  Decision-making when Lay Treatment is not Enough ............256

Conclusion ........................................................................268

Appendices
  Appendix A
    Acronyms .................................................................277
  Appendix B
    Discussions with Others ..............................................278
  Appendix C
    Models of Healing .....................................................279
  Appendix D
    Ethical Considerations .................................................282
    Consent Form ............................................................283
    Plain Language Statement .............................................284
  Appendix E
    Pilot Study: interview and focus group discussion schedule ......285
    Pilot Study: questionnaire ..............................................287
    Pilot Study: data analysis ..............................................290
  Appendix F
    Larger Project: interview and focus group discussion schedule ......317
    Larger Project: questionnaire ...........................................319
  Appendix G
    Profile of Participants: geographical location .......................323
    Profile of Participants: biography ......................................325
    Introducing the Participants: socio-demographic data ............332

Bibliography ....................................................................338
Maps

Map A.1: City of Greater Geelong, Geelong Region ........................................ viii

Tables

Table 2.1: Healing Relationships ................................................................. 49
Table 2.2: The Process of Healing ............................................................... 61
Table 4.1: Household Health Status .............................................................. 116
Table 5.1: Sources of Lay Health Knowledge ............................................... 154
Table 6.1: Health Education, Health Promotion and Illness-Injury Prevention .... 198
Table 6.2: Regrouping of Issues ................................................................. 198
Table 6.3: Ways of Teaching ...................................................................... 208
Table 6.4: Being 'Cautious' and Being a 'Risk-taker' .................................... 220
Table 6.5: Different Risks for Different People .............................................. 221
Table 6.6: Factors Affecting Laypeople's Perceptions of Low to High Risk ....... 221
Table 6.7: Parents' Safety Rules .................................................................. 224
Table 7.1: Signs and Symptoms of Ill-health ............................................... 234
Table 7.2: Bodily Signs and Symptoms ....................................................... 235
Table 7.3: Household Labour when Member is Sick ..................................... 245
Table 7.4: Health Care Services Utilisation in Previous 12 Months ............... 256
Table 7.5: Increasing Severity of the Condition ........................................... 258
Table E.1: What Health Care Services are Used by Members of Your Household in Geelong? ................................................................. 291
Table G.1: Age by Gender ........................................................................ 332
Table G.2: Marital Status .......................................................................... 333
Table G.3: Family Structure ...................................................................... 333
Table G.4: Participants 1995 - Family by Number of Children .................... 333
Table G.5: Participants 1995 - Number of Children in Household by Children's Ages .............................................................................. 333
Table G.6: Participants 1995 - Education and Qualifications ..................... 334
Table G.7: Occupation .............................................................................. 334
Table G.8: Household Income .................................................................... 335
Table G.9: Participants 1995 - Number of People Earning an Income in the Household ................................................................. 335
Table G.10: Participants 1995 - Health Care Financing ............................... 335
Table G.11: Birthplace .............................................................................. 336
Table G.12: Participants 1995 - Ancestry .................................................... 336
Table G.13: Participants 1995 - Migrants: Years of Residency in Geelong .... 336
Table G.14: Languages Spoken at Home .................................................... 336
Table G.15: Participants 1995 - Proficiency in English ............................... 336
Table G.16: Religion ........................................................................................................... 337
Table G.17: Religion by Religiosity .................................................................................... 337

Figures

Figure 5.1: Self at the Centre of Multiple Flows of Knowledge .................................. 189
Figure 5.2: The Process of Informed Decision-making ................................................. 191
Figure 6.1: A Continuum of Risk ...................................................................................... 215
ACKNOWLEDGMENTS

Sessions with my co-supervisors, Liz Eckermann and Jenny Hughes were full of laughter, respect and goodwill. I appreciate their mentoring and showing me the way. Their faith in myself and ability to undertake and complete this project is precious and incalculable.

John Deeble provided initial external supervision, and guidance on health economics, health policy and health care services utilisation. I appreciate his comments on the raw data on health economy and private health insurance.

I am grateful to the 98 women and men who participated in the study, and kindly volunteered their time from hectic schedules in everyday life. They narrated, with much laughter and tears, their lay healing practices in the household: drawing upon their individual and collective experiences as laypeople and as parents of young children.

Intersectoral consultatics with laypeople, healers, academics and policymakers of diverse backgrounds provided insights on lay healing from various perspectives.

Duncan Ironmonger, Sally Henderson, Jenny Lewis, Stephen Vaughan, Cath Webber-Martin and Ian Weeks kindly read thesis drafts and provided comments. Neville Millen updated my skills on coding, statistical analysis and reporting of quantitative data. Past and present postgraduate students and academic staff at the Faculty of Arts, Deakin University provided ongoing moral support: Evelyn Bach, Alison Brookes, Anna Brujenes, Chris Cherry, Mary Drum, Richard Gould, Tony Hughes, Chris King, Tania Lienert, Suzanne Nunn, John Perry, Tony Reid, Maureen Ryan, Bob Swinburn Lyn Turney, and Li Veit-Brause. The Inter-Library Loans and Off Campus Services, and other library staff at Deakin University, Geelong deserve a special mention for facilitating my access to overseas publications. I am grateful to Geoff Leeming and the audio-visual staff at Deakin University for their provision of simple technology to tape interviews and focus group discussions. Rhonda Spalding and Judy Barber assisted with transcribing interviews. Susan Feldman kindly loaned me a tape transcriber to facilitate transcription of interviews and focus group discussions, whilst Susie della Monica assisted with presentation of tables and figures, and with Dorthe Rusz, enabled printing of the thesis.

Funding for the project came from a Deakin University Postgraduate Research Award (scholarship) (1995-97), postgraduate assistance (1994-98) and conference support (1994-97), with many thanks to Bill Logan, Adriaan Adolph and other staff from the Research Office. The welfare state’s generosity, part-time teaching at La Trobe University, Bundoora, and nursing at various Melbourne metropolitan hospitals provided the economic resources for lay healing in everyday life.

The following special friends gave me inestimable social and emotional support: Tamara Aspwoode, Chris Ballantyne, Christie and Don Brown, Jo and Michael
Butcher, Eva Fisch and Brian Malone, Terrie Hall and Ian Fox, Sally and Geoff Henderson, Debra Jackson, Jenny Lewis, Patricia McKendrick, Ceri Rodrigues, Ana and Paul Vrantsis. Their friendship sustained me during the times everyday life competed with my project for attention. Cath Webber-Martin, Gillian Stanley, Heather Hicks and Kok Chong Moey were spiritual mentors and extended my lay knowledge of alternative therapies and folk healing. Nel Willekens and Heather MacDonald were the initial inspiration for the project: as international role models, actively linking the macro with micro in pragmatic ways.

Finally, a big hug to my darling daughter, Jessica, for her infinite patience with having a mother who is always talking, reading and writing about health.
ABSTRACT

This thesis explores the power-knowledge relationship underlying lay healing practices in the household; a non-traditional area of study in public health. Lay knowledge continues to be discounted as illegitimate and 'non-expert' by policymakers, health professionals and academics. Given the absence of theory on lay knowledge and decision-making, an eclectic theoretical approach was undertaken in this study. Theory is drawn from medical anthropology, sociology of the body, health economics, gender studies, social theory, psychology, nursing, ethics, philosophy and history of medicine in order to contribute to and advance debate.

Operating within the genre of a 'multi-sited ethnography' (working across different sites), methods for data collection included 'anthropology at home' by undertaking fieldwork in Geelong, Victoria, Australia. I conducted interviews and focus group discussions with, and administered a questionnaire to, 98 participants who are parents of young children. They were recruited via primary schools and snowball sampling. The quantitative data presents a socio-demographic 'picture' of 78 women and 20 men (representing 98 households) from urban, rural and coastal areas of the region. The qualitative data contains case studies as well as narratives, analysed for their content and discourses. Additional methods included maintenance of a 'reflexive journal', inter-sectoral consultations and public health policy analysis.

Research findings indicate laypeople’s conceptualisations of the body, self, health and illness rest upon a notion of the embodied self and health that is physical, mental and spiritual. Laypeople have a substantial knowledge base on health and ill-health that derives from many sources, is both generalised and specialised, and is set within the context of everyday life. Laypeople make diagnoses and treat illness and injury within the household. They also exercise substantial agency in determining their choice of healer(s) for therapeutic intervention and management of ill-health outside the household.

This study has substantial implications for public health in terms of healers' clinical practices, research and policy.
Map A.1: City of Greater Geelong, Geelong Region
INTRODUCTION

Provenance of Lay Healing

Health care studies in anthropology, sociology, economics, history, philosophy, and policy tend to concentrate on health professionals and the use of health care services in western society. Abundant critical literature questions that biomedical health professionals have all the answers to what ails society in general, and individuals in particular. Little legitimacy is given in the research to other forms of health care, which are as diverse as the historical and cultural context from which they emanate. There has been little interest outside medical anthropology in examining the role of alternative therapists and their healing practices. There is also scant anthropological and sociological research on folk healers and their practices emanating from and operating within western cultures. Migrant communities, where folk healers continue to practise their traditional healing in the 'host' country, have been overlooked in the health care literature. Most studies on folk healers have centred upon their magico-healing practices in Third World countries and small scale societies. There is also an absence of documentation on health care provided by ordinary people as lay healers, and it is this 'alternative' source of health care provision which is the focus of the current thesis.

Lay healers are ordinary women and men providing healing in their homes, neighbourhoods, social networks and communities. Lay healing concerns the healing practices we undertake for ourselves in the popular sector of the health care system (Kleinman 1980, Dean 1990). Lay healing encompasses a variety of implicit aims, objectives, resources, tasks, relationships and settings. These aims may include: promoting health, preventing illness and injury, and improving health status in terms of morbidity, mortality, quality of life and well-being. The resources necessary to provide lay health care include: knowledge, other people to assist with healing, money, time and energy, and motivation and commitment to improve health status. Tasks undertaken to provide lay healing within the family are: health education; health promotion. illness-injury prevention; diagnosis and treatment of illness and injury; and, managing the household economy. Individuals' intimate relationships with 'significant others' (their children, partners, relatives, friends) influence the type of

4 See Kickbusch (1989), Peerson (1990). Illness-injury will be used throughout the thesis as shorthand to indicate how people's endeavour to prevent both illness and injury in everyday life.
health care that is provided by lay persons and the consequent health outcomes (Kleinman 1980, Calnan 1987, Dean 1990).

Lay healing was not 'invented' by this generation in this country. Lay healing is a universal experience of laypeople throughout history and in different cultural settings (Kleinman 1980, Dean 1990, Conrad et al 1995). It is an often taken-for-granted activity of everyday life. And yet, there are large gaps in published literature on lay healing within families. It has not been seen as a formal object of study until recently. There is no substantive body of research addressing: i) gender and age dimensions of lay healing; ii) lay healing practices in the household; and iii) the power-knowledge relationship underlying these practices, in terms of the sources and types of lay health knowledge and the decision-making process. My study provides some insights by applying theory and appropriate methodology to collect empirical data on all the above three areas.\(^4\)

This thesis explores the power-knowledge relationship underlying lay healing practices within the household; a non-traditional area of study in public health. How laypeople provide healing within the household has implications for their use and purchase of health care services outside the household. I am interested in parents' health knowledge and decision-making on behalf of their children, and for themselves and their partners, as a special case of the 'household production of health' (Berman et al 1994).\(^9\) This field study takes a multi-disciplinary approach to health. The emphasis is upon multiple activities, mechanisms and resources employed by households to promote and maintain health, and prevent illness and injury, rather than on investigating poor health in terms of single diseases. Furthermore, intra-household behaviour is linked with health outcomes in relation to the macro social and economic environment, the health care system overall, and health-producing and health-hazarding behaviours.

By asking ontological and epistemological questions related to the power-knowledge relationship, insights into lay knowledge and its importance for public health will be expanded.\(^{10}\) My research will concentrate upon the provision and delivery of health care for children that is undertaken by ordinary women and men - as parents and lay healers - in the domestic sphere. The setting is Geelong, a regional city in Victoria, Australia in 1995. My immediate aim is to:

\(^4\) See Chapter 2 for further discussion.
\(^9\) See Dean and Hunter (1996), Popay and Williams (1996).
To examine the nature of lay healing by parents on behalf of their children, and for themselves and their partners, in my sample of households.

The more general aims of the thesis involve:

1. Providing a 'voice' for the popular sector of the health care system.
2. Informing public health policy of lay discourses of health and ill-health, and lay healing practices in the household.

Why is a 'voice' necessary? Lay knowledge is important for its epistemological and political challenges to the knowledge of medical or scientific experts (Williams and Popay 1994a), who set themselves up as 'geniuses of dissemination' (Saul 1997:41). Laypeople are not a tabula rasa upon which experts can project knowledge in the hope of changing individual behaviour, and reducing morbidity and mortality (Syne 1997). Rather, laypeople have a substantial knowledge base on health and ill-health that derives from many sources, is both generalised and specialised, and is set in the context of everyday life. Laypeople actively use their knowledge to make decisions about healers and healing both within and outside the household. It is timely for experts to listen to and heed laypeople's knowledge, experience and perspective of health and illness-injury. I agree with Williams and Popay (1994a:123) that:

in so far as such knowledge about illness remains private, expressed only in the clinic, the home, or in casual encounters with others, it offers no direct political challenge to the power of [bio]medicine.

My research objectives are therefore as follows:

1. To identify lay healing practices occurring in the household.
   i) To develop an understanding of what actually happens at the household level in the popular sector of the health care system.
2. To establish whether these practices are used differentially according to gender, age/generation and health status.
   i) To explore the various dimensions of health, healers and healing that occur within the household.
   ii) To determine why people use lay healing rather than another form of healing at the household level.
3. To examine the power-knowledge relationship underlying lay healing at the household level.
   i) To establish the sources of laypeople's health knowledge.
   ii) To identify the type of health knowledge laypeople have.
   iii) To investigate how laypeople use their health knowledge to make decisions about lay healing within the household.
Research questions investigated in this project are:

1. *How is health produced and protected in the household?*

2. *What is the power-knowledge relationship underlying lay healing in the household?*

A diverse collection of experiences and activities form the backdrop to this inquiry. These included the researcher: being the eldest of a large family; a child of Dutch and German immigrant parents with a matrilineal tradition of healers; being the parent of a 14 year old daughter; having a career in nursing and teaching; undertaking policy and research work in health, gender, family and migration issues; and, consumer lobbying and advocacy. I have been approached by relatives, friends, colleagues and even strangers to provide 'lay' advice about issues from diagnosis to health promotion to health insurance. Given my autobiography, I pondered whether the anecdotal information truly represented the issue of lay healing practices in the household and deemed it worthy of more rigorous and systematic investigation.

**Setting the Scene: Geelong: A Regional City in Victoria, Australia (1994-98)**

In this study I use my 'sociological imagination' (Mills 1959) and 'anthropological imagination' (Cornwall and Lindisfarne 1994) to reveal how private health perceptions and attitudes are becoming a public issue, thus creating changes in the perceptions and boundaries surrounding health and ill-health. The 'voice' of laypeople, as expressed through lay activism and representation, tends to communicate the caring and nurturing aspects of the domestic sphere, whilst at the same time, this voice is becoming professionalised, politicised and bureaucratised through consumer organisations such as the Consumers' Health Forum (located in the national capital city, Canberra). Similarly, laypeople as 'community representatives' on health research, ethics and policy committees represent a politicization of lay perspectives on health. In

---

1. During the conduct of research (1994-1998), there was a change of government (and political parties in power) at both the Federal (Australia) and State (Victoria) spheres. In early 1996, after 13 years of a Federal Labor government, the Liberal/National (Coalition) Party was swept into power. Similarly, at a State level, the present Liberal government entered Parliament in late 1992 following a lengthy term in opposition. Consequently, there has been a change in policy direction at both conservative government spheres. In late August 1998, the Federal government announced national elections are to be held 3rd October, 1998.

The Liberal and National political parties are conservative in their policies, supporting economic rationalism and private enterprise. The Australian Labor party (ALP) upholds socialist democracy, supports the welfare state's provision of assistance to disadvantaged people, fosters debate and implementation of Australia becoming a republic, and encourages reconciliation of indigenous peoples with other Australians.

1. 'Sociological imagination' refers to the 'quality of mind that will help them [i.e. people] to use information and to develop reason in order to achieve lucid summations of what is going on in the world and of what may be happening within themselves' (Mills 1959:5).

1. 'Anthropological imagination' means 'to see the world as others see it' (Cornwall and Lindisfarne 1994).

addition, the public domain is increasingly intruding upon the private realm, in that policies and programs determined by governments (Federal, State, regional and local) have implications for how laypeople respond to additional impositions and constraints upon their everyday lives (Rayner 1997). For instance, the increasing demise of public services in rural and remote areas of Australia means people have to travel further to access banks, hospitals, post offices, supermarkets and libraries, as well as health facilities.

Beck (1992) suggests that the distinction between public and private spheres has collapsed, resulting in chaos and confusion in many areas of late modern society. Firstly, there is increased state surveillance of private individuals' affairs, loss of democratic processes, minimal checks and balances to government activities, and the erosion of funding and resources for public services such as education, health and welfare due to the privileging of 'economic rationalism'15 Secondly, there is a blurring of the two spheres as the work and leisure boundaries of laypeople have become narrowed. These simultaneous occurrences have led to an 'atomisation' of society, and greater fragmentation and disintegration of the social fabric that binds people (Cox 1995, Fukuyama 1995). Instead of a unified society based on values of trust, reciprocity, honesty, community (what Putnam [1993] and Cox [1995] call 'social capital'),16 distrust, disintegration, loss, insecurity, fearfulness and anxiety appear to prevail in social relations (Krygier 1997). The health of 'civil society' has eroded (Putnam 1993, Cox 1997b) and amidst uncertainty, the individual must re-invent her/his own biography through reflexivity (Beck et al 1994). Saul (1997) argues that this condition has come about in western society, as a result of increasing neo-corporatism,7 whereby groups are acting in their own self-interests. Individual citizens, who constitute a democracy, are thus less able to implement social justice and altruism in the interests of the public good (cf. Korten 1997).

In Australia, many laypeople have expressed their concern about the widening gap between rich and poor (People Together Project 1998). They have become disenchanted with the purchaser-provider approach with the incumbent 'user-pays' fees, when it is privileged over taxpayer-funded public services meeting the needs of society (Rayner 1997). The political discourses on the welfare state separate taxpaying citizens from 'client/customers' of services (Muetzelfeldt 1997). In addition, there are tensions between 'majority rule and minority rights' (Rayner 1997), and ongoing debates on

---


17 The aims of neo-corporatism are characterised by: (1) shift power directly to economic and social interest groups; (2) push entrepreneurial initiative in areas normally reserved for public bodies; (3) obliterate the boundaries between public and private interest - that is, challenge the idea of public interest (Saul 1997:91).
republican versus monarchist rule. Aboriginal efforts to achieve reconciliation and self-determination amidst acculturation, poor health status and low life expectancy continue. Migrants endeavour to retain their cultural identities within a mainstream Anglo-culture (Horne 1997, Krygier 1997). It is also the case that a variety of lay perspectives remain unheard by policymakers, health professionals and researchers (Peerson 1996a). The important questions to ask about these trends are: i) what means are available for laypeople as citizens to exercise their rights and responsibilities?; ii) how is it possible for laypeople to 'voice' their concerns about government policy which duly impact upon their everyday lives?; and, iii) what are the implications of these trends for laypeople as healers providing health care in the household setting, and their use of formal health care services?  

The current Federal government presents the family as a social institution to be treasured and valued. However, its policies and practices concerning the powers of the Industrial Relations Commission (more rights given to employers than employees, whilst gagging trade unions), the demise of the 'social wage', private health insurance (government supported despite falling membership), and reduced funding for tertiary education, have revealed a government more concerned with mainstreaming and removing resources from families and workers than in supporting them (Castles 1996, Hubbard 1996, Livingstone 1997, Rayner 1997).

In turn, the State government's policies and programs are more akin to 'economic rationalism', whereby the upper middle class are advantaged. The managerial emphasis is upon: 'steering' rather than 'rowing' (proposed by Osborne and Gaebler [1992]); separation of policy advice from service delivery; support for 'contracts', 'competitive tendering' and enterprise bargaining; and adherence to the purchaser-provider model following Britain and New Zealand. The outcomes of these decisions in Victoria, Australia are numerous and have produced major public responses. For example, rushed legislation with little opportunity for parliamentary or public debate; diminution of spending in the health, education and welfare public sectors; approval for a large gambling hall to be built to finance other similar 'public works'; support for an annual car rally in a residential area; closure and sale of primary and secondary schools for redevelopment as private housing; privatisation of public utilities such as gas and electricity; curtailment of the state auditor-general's independence; and demise of the Equal Opportunity Board and Law Reform Commission (Rayner 1997). Laypeople as citizens have expressed their collective dismay at these intrusions into democratic processes, social capital and curtailing of public services through collective activism and protest (Rayner 1997, People Together Project 1998). This situation has enormous

---

18 Providing answers to these questions is beyond the scope of this thesis.
19 That is, there is greater focus on setting the agenda, rather than on maintaining infrastructure.
implications for the provision of formal health care services, because of a reduction of resources and funding as a public service for laypeople.

Within the health care system in Victoria, there have been a number of structural changes which have implications for how laypeople provide healing in the household and their degree of confidence in health care services outside the household. For instance, casemix funding was introduced in state public hospitals in July 1993, amidst regressive funding cuts.\textsuperscript{21} As a result, early discharge policies were imposed and the hospital-in-the-home program was piloted in November 1994 and later expanded (KPMG 1995, 1996), creating substantial profits for public hospitals. Three rural hospitals became privatised when confronted with potential closure and loss of services to large catchment areas. Nursing personnel, who occupy the largest proportion of the health care workforce, sustained heavy losses (N=3500) as a result of the budget cuts or left hospitals due to heavy workloads, 'burn-out', job dissatisfaction and poor morale, imposing further stresses upon the system. A series of work bans were implemented by nurses as collective action to improve their working conditions in mid 1997; which was immediately followed by similar industrial action by other health professionals (medical scientists, pharmacists, social workers). In addition, the privatisation of the communications system for the state's ambulance services led to recent calls (mid 1997) for a review of the tendering process and the 'winning company': the communication organisation as well as the former health minister were blamed for the supplier's inability to get ambulances and officers to emergencies in time. Overall, retrenchment through 'voluntary redundancies' and restructuring has created marked changes in the workplace culture of health care services.

The Federal government's policies on family welfare assume that the family is nuclear, with men being seen largely as 'breadwinners' in the paid workforce and women as 'childbearers and rearers' at home.\textsuperscript{22} International and national evidence emanating from the International Year of the Family (IYF) (1994) indicates that the family enjoys diversity in structure and functions, and is rapidly changing (UN 1993, 1996). Marital breakdown, with divorce occurring in one in three Australian marriages, has led to remarriages, step families, blended families and extended families.

Of the 597,500 families who had a child with a natural parent living elsewhere, 41% received no child support, 42% received cash child support and a further 16% received only in-kind child support, such as assistance with clothing, pocket money, school fees, health insurance or mortgage payments (ABS 1998a:8).

\textsuperscript{21} This occurred whilst the Commonwealth health department was still developing indicators from the American model to suit Australian conditions (Health Issues Centre 1992).
\textsuperscript{22} Less than 40% of all Australian families are couple families with dependent children (ABS 1998a).
Female headed-sole parent families tend to have low incomes, resulting in a substantial number of children under 18 years of age living in poverty and dependent upon the welfare state (MacDonald 1995, ABS 1998a). The Federal government has imposed funding cuts to child care places and fee subsidies; making it uneconomical for women to undertake paid work or to further their qualifications. Laypeople, especially women, are thus forced into a lay healing role and strive to efficiently manage their household budgets because of reduced access to public resources. (See data in Chapters 4-7).

The Burdekin report on de-institutionalisation (Human Rights and Equal Opportunity Commission 1993) reveals the extent to which caring services previously provided by the public sector now shadow a burden upon families and communities. Women especially are expected to provide care (physical, emotional and spiritual) for persons with mental illness, intellectual and physical disabilities, and chronic illness. Whilst this social change incurred substantial financial savings to governments, there was little or no support for community infrastructure to absorb the transfer of costs. Families, in particular, have had to draw upon their own resources (time, energy, social, material, financial) to provide for people who would otherwise go without (Edgar 1997, cf. Young 1996).

The family-work relationship is also changing. Since the 1960s in Australia, more women are working in the paid labour force, albeit mostly in short-term, part-time and casual employment. They still face a lower income compared with men for the same position, skills and experience, and encounter a 'glass ceiling' despite Equal Opportunity, Anti-discrimination and Affirmative Action legislation (House of Representatives Standing Committee on Legal Constitutional Affairs 1992). Many men have experienced retrenchment or unemployment as a result of changing workplace practices and industrial relations. From April 1997 to June 1998, the national unemployment rate varied from 8.9-8.3% (ABS 1998b:16). Unemployment is consistent officially around 8.7% nationally, and above 40% for youth (aged 15-19 years) in some rural areas (Dusevic 1997). Further stresses are short-term contracts, high job insecurity, absenteeism, and heavy use of sick leave, poor remaining staff

---

23 In 1997, the total number of families in Australia was 2,414,300. Of these, 20.8% were sole parent families, of which the majority were lone mothers (18.1%) (ABS 1998a:29).

24 There are significant gender differences in Australian workforce participation. In June 1998, men's workforce participation was 72.9%, in comparison to 'married women' (55.1%) and 'all women' (53.9%). 1,202,400 married women worked full-time compared to 2,104,700 'all women' and 4,267,700 men. 1,618,800 'all women', 1,041,000 married women and 588,900 men worked part-time (ABS 1998b:16).

25 Also known as the 'Lavarch Report'. See also Summers (1994), Scutt (1997).

26 In the (rural) Barwon-Western district statistical region, which covers Hamilton, Geelong, Colac, Warrnambool and Portland, 46.5% of youth were unemployed in July 1998. This compares to (metropolitan) north-west Melbourne (58.8%) and inner Melbourne (50.2%), and (rural) Gippsland (45.8%) (Mitchell 1998a:1).
morale and declining productivity (Dusevic 1997). These structural changes have meant an alteration in traditional female and male roles, adding stress to marital and family life with challenges to men’s notion of masculinity and being the ‘good provider’. In some cases, women are asserting their independence, being able to economically provide for themselves and seek male partners as partners/lovers rather than as providers; whilst some men are unsure about their roles and have become confused about developing relationships with women.27 These changes have implications for which gender (or both) takes responsibility for health and well-being, and how roles and responsibilities within the household are negotiated so that personal independence is not undermined.

In other instances, many men who are working in middle management and on the shop/factory floor are working for older bosses with non-working wives who act as ‘adjunct’, ‘help-mate’ or ‘Girl Friday’ to support their husbands’ careers.28 The older men find it difficult to understand the younger men’s rejection of promotion and desire for additional time at home with their partners and children, and their need for adequate parental leave to care for a sick family member or ageing relative.29 Further, ‘downsizing’ has been reported as a social trend of middle class women and men. People previously in high income earning brackets and stressful jobs, working more than 40 hours/week, are tending to opt out and re-evaluate their lifestyle and working conditions (Dusevic 1997). Ironically, flexibility of working hours has caused an erosion of boundaries between work and leisure. Some women and men are seeking an environment more in tune with their inner needs and desires for a simple life that fulfils their personal interests and supports their self-esteem; even if this involves moving house, changing careers, living on less money, and having more time for themselves and their families (McKenna 1997).

At face value, this picture of Australian society and culture is a rather gloomy one. Although changes external to the family have placed a greater burden of care on the family, people everywhere are going about their business, looking after themselves and each other, despite these structural changes. My fieldwork for this study suggests many people still uphold and aspire to the values of empathy, trust and honesty, rapport, sharing and caring. Women and men - participants in the study - reflected upon and narrated their lay healing practices in the household, their experiences of being human, of coping with macro conditions which impinged upon their lives, and their relationships with one another. Their narratives contain much humour, sorrow, courage and honesty.

Thesis Outline

My principal interest in women and men as lay healers lies in the under-researched area of the popular sector of the health care system. This sector is poorly understood and recognised, literally 'silenced' in the public health policies, programs and statistics of western societies, including Australia.

Chapter 1 entails a literature review to establish the use of the term 'lay', to provide an historical overview of women and men as lay healers, contemporary lay healing practices in the household, and, to ascertain the future implications of lay healing practices for public health.

The theoretical approach of Chapter 2 both marks a position and advances current debates on health and ill-health, and enables engagement with the empirical data. Theoretical input derives from medical anthropology, sociology of the body, health economics, gender studies, social theory, psychology, nursing, ethics, philosophy and history of medicine. Issues discussed include: the power-knowledge relationship, medical pluralism, medical dominance, the household production of health, the body as embodied self, gendered theories of health and illness, and household and public health construction of risk.

Chapter 3 details the pluralistic approach to research methodology undertaken for this study. Working in the genre of a 'multi-sited ethnography' (Marcus 1995), the sources of information for this project have been diverse. Multi-sited ethnography refers to 'multiple sites of observation and participation that cross-cut dichotomies such as the "local" and the "global", the "lifeworld" and the "system". Resulting ethnographies are therefore both in and out of the world systems' (Marcus 1995:95), thus making links between macro and micro conditions. Firstly, 'anthropology at home' (Jackson 1987)30 entailed undertaking fieldwork in my home town: Geelong, Victoria, Australia. Collection of empirical data specific to this project included conducting focus groups discussions and individual research interviews with parents of young children (up to the age of 12).31 All participants completed a questionnaire. Secondly, case studies and narratives from the qualitative data were analysed for their content and discourses. Thirdly, I maintained a 'reflexive journal' to annotate ideas and issues encountered in the research process. Fourthly, health policy was analysed. Fifthly, I undertook intersectoral consultation with laypeople, researchers, policymakers and professionals from multi-disciplines.32

30 'Anthropology at home' refers to the conduct of anthropological research examining local knowledge and everyday life in our own communities and countries, rather than 'exotic' locations overseas (Jackson 1987).
31 See Appendix G for a 'biography' of participants. Pseudonyms are used throughout the text to preserve their anonymity and maintain confidentiality.
32 See Appendix: B: discussions with others for details.
Chapter 4 discusses lay conceptualisations of health and ill-health; noting the context in which laypeople themselves frame health and ill-health. It examines conceptualisations which incorporate mental and spiritual factors, not just the physical body. Gender, age and base-line health status are shown to be important dimensions of difference in health experiences.

Chapter 5 examines laypeople's plural sources of health knowledge as well as their health decision-making process which have implications for lay healing practices in the household.

Chapter 6 critiques current discourses and practices of health education, health promotion and illness-injury prevention by health professionals, revealing and recognising the nebulous demarcation between these categories for laypeople, as well as the primacy of the parent-child relationship for these activities. In addition, I discuss lay 'ways of teaching' about health and ill-health, and lay assessment of risk.

Chapter 7 analyses the lay healing practices of 'lay diagnosis and treatment' within the household, again in terms of laypeople using their health knowledge to make decisions about health care. The emotional labour of the parent-child (and partnering) relationship is paramount in lay healing.

The outcome of this project has a strong public health policy focus, thus linking research (theory and empiricism) with action (policies and programs). The findings have the potential to inform policymakers, healers and community groups of the health promotion and illness-injury prevention practices, and lay diagnosis and treatment, undertaken by lay women and men within the household setting, their implications for health care services utilisation outside the household, and could potentially assist such groups with developing new public health policies and programs in Victoria and Australia.
CHAPTER 1
WOMEN AND MEN AS LAY HEALERS:
LITERATURE REVIEW

'Lay': a definition

'Lay' as an adjective and 'laity' as a noun refers to people who are not of the clergy or are non-professionals. That is, they are amateurs and do not have a specific occupation. The etymology of 'lay' derives from the fourteenth century 'Old French word lai, from Late Latin laicus, [and] ultimately from Greek laos' meaning people' (Collins 1981:823). A layman or laywoman is 'a person who does not have specialised or professional knowledge of a subject', and a lay brother or sister is an individual 'who has taken the vows of a religious order but is not ordained or bound to divine office' (Collins 1981:834). It is in this 'non-professional' sense that I use the term 'lay' throughout the thesis.

Spector (1985), Hufford (1988) and Bakx (1991) use the term 'folk', and Velten-Schuberth (1993) the term 'traditional', to describe all persons who provide health care, who are not health professionals.33 These above researchers also collectively categorise a range of health care activities that are non-biomedically and non-professionally oriented as 'folk medicine'. Included in this classification are: specialist folk healers such as curanderos, spiritists, herbalist; 'sophisticated medical traditions as Ayurveda and acupuncture' (Hufford 1988:229); alternative therapists (or complementary healers) such as masseurs, naturopaths, osteopaths; and lay healers. This classification is problematic. These other forms of healing are viewed as mere alternatives to the dominant biomedicine, both in western and non-western societies, rather than being acknowledged as components of medical pluralism (Kleinman 1980). Folk medicine has also been used to describe home and/or herbal remedies and 'old wives' tales' used by lay persons in their treatment of illnesses and injuries at home (Chamberlain 1981, Spector 1985, Peerson 1990, Hayes 1996, Allardice 1997).

The term 'health care consumer' dominates the literature on health care services and professionals, and self-help groups. I contend that people do not make decisions about them selves solely on economic factors (as frequently reported in the literature) but also consider the social, cultural, political, religious, environmental aspects of their everyday lives that may be pertinent to their situation. For example, decisions about the use or non-use of health care (and other) goods and services either inside or outside the household are often based on a variety of factors rather than on economic reasons alone.

Laypeople's criteria for health care decision-making include an assessment of the age, gender and health status of household members as individuals and as a unit. These decisions are further circumscribed by family size, availability of and access to health care services, and their own level of confidence in managing episodes of illness and injury within the household (Peerson 1996a, 1996b). Consumers as a collective body are often more powerful in their actions for improvement of conditions to enhance health than when acting as individuals. Organisations of the health consumer movement in Australia, such as the Consumers' Health Forum (Canberra), Health Issues Centre, Community Development and Innovation in Health (Melbourne), promote lay knowledge, practices and experiences in their discussions with government policymakers and health care providers - in their dual capacities of lobbying and advocacy. This is also an example of citizens exercising their democratic right to be represented and heard by government.

'Self-help' is 'the act or state of providing the means to help oneself without relying on the assistance of others' (Collins 1981:1323). 'Self-care' refers to '[c]are for oneself; self-interested behaviour; frequently used attribute to denote an institution in which patients and convalescents attend to many of their own needs' (Simpson and Weiner 1989, Vol.XIV:915). Self-medication is one form of lay treatment, whereby laypeople prescribe and administer their own medication based on their own or another's diagnosis of their ailment (Dean 1981, Hardon 1991). Dean (1990) argues that self-care is certainly not new, but rather the oldest and most widespread form of behaviour that affects the health of individuals. However, the use of the term in the health field is recent. It is a response to developments and attitudes regarding the role of individuals that occurred over the past hundred years. Dean explains that during the era dominated by the germ theory of disease from the mid-nineteenth century to mid-twentieth century, individual behaviour and social environments were not considered important in health and health care. Health was preserved or restored by professional care either preventing specific diseases with immunisation or treating diseases with chemical agents and/or removal of diseased parts of the body (Tchsh 1989). However, the aetiology of disease and macro and structural responses, have since advanced to include not only the physical and social environment, but also self-care.

Kickbusch (1986, 1989) has long been concerned with aspects of self-care and health promotion by laypeople, the family and self-help groups on a cross-cultural basis. Kickbusch (1989) traces the 'development' of the self-care movement as

---


evidenced in the literature to the 1970s, when self-help groups began to form, and the victim-blaming approach of medical practitioners proved inadequate for explaining and treating illness and disease. A new program by the WHO Regional Office for Europe, Copenhagen - "Lay, community and alternative health care" - was introduced [in the early 1980s] as part of an overall attempt to develop an approach to lifestyle and health' (Kickbusch 1989:126). A social model of health addressing lay healing, self-care and self-help enabled 'a linkage between the lifestyles debate and a more general debate on prerequisites for health' (Kickbusch 1989:126). This approach became the basis for WHO health promotion policies and programs, such as the Alma Ata (1978), Ottawa Charter (1986), Sundsvall Statement (1991), and the Jakarta Declaration (1997) for implementation on a global scale involving public participation within a viable regional and local context. For example, 'Healthy Cities' and 'Health for All' are based on such principles (WHO 1985, Ashton et al 1986, Baum 1993, 1995a, Baum and Cooke 1992).

Women and men in their capacity as laypeople - have been healing themselves and others throughout cultures and before records on healing have been kept. It is not a new phenomenon. This chapter reviews historical and public health literature about women and men as lay healers. I discuss how lay healers have been performing their role throughout western history and in the contemporary period. Gender, age, social class and geographical location are some of the key influences upon their healing tasks. In this thesis I concentrate on the dimensions of gender and generation. In the final section I hypothesise about the future of lay healing practices for public health amidst current concerns of a resurgence of infectious diseases and environmental toxicology.

**HISTORICAL OVERVIEW**

**Women and Men as Lay Healers**

Porter (1985b, 1992a, 1998) asserts that the major focus of historians of medicine has been upon scientific medicine and institutions, and new techniques for scrutinising the human body. This has meant a 'silence' about the sick person's existence (cf. Armstrong 1984). The sick person's perspective of their clinical encounter with a doctor; the 'complex social rituals involving family and community as well as sufferers and physicians'; and the marginality of doctors in 'community care' are excluded from history (Porter 1985:175).

Moreover, in important ways, the sick have not just been 'patients', but 'agents' as well, both looking after their own health, and playing active roles in managing their dealings with medical professionals and the institutions of regular medicine (1992b:91).

---

36 See Hatch and Kickbusch (1983) for definitions of self-care and further details on WHO’s approach to incorporating self-care in health policies.
Lay healing is a temporal and cultural phenomenon. Historical documents - epigrams, dramas, speeches, orations, inscriptions and archaeological records dating from antiquity, diaries and personal journals, parish records and bills of mortality, medical textbooks and case notes - provide historians with clues about medicine (Porter 1998). The written evidence reveals the diversity of 'medicines' as practised by laypeople, learned men, midwives, herbalists, alternative therapists, quacks and fringe specialists through the ages. During Georgian England (1660-1800) for example,

Letters passing between friends and family reveal endless inquiries after and information about health, and judgements upon various doctors. Moreover, they are crammed with detailed recommendations about particular cures and recipes, and advice about how to preserve or restore one's health (Porter 1992b:102).

In some instances, owing to the fragmentary nature of existing historical evidence, it has been difficult to interpret the lay person's perspective and experience of health and illness, and their encounter(s) with diverse medical practitioners amidst widespread contagion (Conrad et al 1995). Given this historical scenario, we can ask some questions about the lay perspective of the body, health and illness, and endeavour to augment our understanding by locating 'lay medicine' in a social, political, economic and religious context. In this section, I discuss lay healing in antiquity, laypeople as patients and lay healers, the role of women as healers, and the competitive nature of quackery and alternative therapies vis-à-vis biomedicine.

Healing in Antiquity

During ancient Greek and Roman times, men could call themselves 'doctors', whilst having limited training and experience in medicine. Their legal legitimacy rested upon their oratory skills and ability to perform cures in public. Doctors competed with other therapists, for example, druggists, midwives, diviners, exorcists to provide similar services. Furthermore, 'the remedies of humble peasants and craftsmen were taken and recorded by physicians' (Nutton 1985:32-33, cf. Chamberlain 1981).

During antiquity, limited use of scientific and medical terminology between lay persons and doctors enhanced the accessibility of medical knowledge. Ideas about the body's anatomy and physiology changed in time from Hippocrates (c.420 BC), to incorporate the four humors (yellow bile, phlegm, black bile and blood), the four elements (earth, air, fire and water), the four primary qualities (hot, cold, wet and dry), and later an understanding of atoms and molecules (Nutton 1992:23, cf. 1995). There were great overlaps in specialist medical and lay knowledge (Conrad et al 1995). Galen (AD.129-c.210) set rigorous standards for the selection of men as respectable doctors

---


by laypeople, and regularly reviewed by councillors, linking competent practice with 'moral virtues' (Nutton 1985:34). 'The civic physician was a man of piety, philanthropy and consummate skill; he poured out his energy and compassion on all who sought his help; and he united within himself learning (episteme) and experience (peira)' (Nutton 1985:35).  

Women were not admitted to the 'medical profession' during antiquity. However, they maintained a healing tradition: as midwives and priestesses in ancient Egypt; as mothers and wives in their care of sick family members and as nurses tending to the wounded in ancient Greece; and, as healers 'skilled at curing a wide range of diseases using traditional remedies' during the Roman Empire (Bourdillon 1988:9). In ancient Sumer, women's divinity, fertility and healing powers were celebrated as essential aspects of the culture. Around 500 BC to 800 AD, women in ancient Denmark occupied an elite healing position as shamans who underwent trances, enacted fertility rites and performed sacrifices in honour of female deities, including Nerthus (Earth Mother) (Chamberlain 1981, Achterberg 1990). During the Middle Ages, the 'noble lady became the manor's doctor and pharmacist. Bundles of herbs hung from the rafters of her larder. Domestic healing included some knowledge of antiseptics ... and basic first aid' (Achterberg 1990:47).

**Laypeople as Patients and Lay Healers**

Porter (1985a, 1985b, 1992a, 1992b, 1998)\(^9\) has done much to 'popularise' the place of lay healing in the history of medicine.\(^10\) He argues that 'popular medicine' was complementary rather than competitive with professional medicine, despite the increasing medicalisation of western society during the late eighteenth century to mid nineteenth century with the establishment of hospitals and public health agencies (cf. Foucault 1973).

In the absence of revolutionary changes in medical knowledge, pharmacology and medical technology (and in the absence of a radical transformation in the healing power of doctors) practitioners needed to make their services marketable, palatable and indispensable (Porter and Porter 1989:208-9).

During the eighteenth century, a three-tier hierarchy of formally trained medical practitioners existed in Britain: physician, surgeon and apothecary (precursor to contemporary pharmacists and general practitioners). Registered midwives, alternative therapists, folk healers and quacks treated patients of various socio-economic status in urban and rural areas. Given a philosophy of self-care, medical pluralism, and patient

---

\(^9\) The introduction of the Hippocratic Oath provided an ethical basis for the practice of medicine, which still holds today in the mid 1990s (Little 1995).

\(^10\) See also Porter and Porter (1989).

\(^11\) See also Rissee et al (1977).
purchase power 'in an emergent consumer society' (Porter and Porter 1989:209),
'doctor-shopping' was commonly practised.

'Far more people ... practised healing without any view to reward, but rather out of
neighbourliness, paternalism, good house-keeping, religion or simple self-help' (Porter
1992b:94). Laypersons themselves provided primary health care since they initiated
their own treatment. Their choice of therapy, beyond their personal expertise or that of
other laypeople, meant decision-making about the efficacy and availability of healers.
The sick person, 'as a sufferer or a self-treater' (Porter and Porter 1989:29, authors'
emphasis) only became a patient when receiving medical care.

Risse et al (1977), Cassidy (1977) and Porter (1985a) give several reasons for the
extent of lay healing in American and British history. Firstly, people were fairly
autonomous and self-reliant in going about their daily lives. These values spilled over
into lay healing in the household and community. Secondly, some individuals viewed
their lives as being increasingly controlled by social institutions, and for others, being
ill meant being vulnerable. Thirdly, there were few practising doctors available in urban
ghettos and rural areas (particularly in the United States), so laypeople had no choice
but to rely upon their own health knowledge and healing abilities. Fourthly, poverty
was an additional factor. Few patients of low socio-economic status could afford the
expensive fees of city doctors. Members of the medical profession were frequently
called upon by charitable organisations to extend their practices towards the poor.
Fifthly, medical information was made public through the media and many families
owned a copy of a 'home medical manual or encyclopaedia' (Risse et al 1977:3), as a
means of enlightening laypeople and protecting them from quacks (Blake 1977).42
Finally, owing to their previous experiences, some individuals distrusted and lacked
faith in the competence of doctors and their recommended treatments which did not
relieve or cure ailments.

The dominant conception of sickness until the mid-twentieth century was that it
was a personal and internal state of affairs. This view persisted despite material living
conditions being far from conducive to good health, for example, overcrowding,
poverty, malnutrition and beliefs in maleficium and the sinful condition of mankind
(Porter 1992b:95-96).43 People took measures into their own hands to promote their
health and prevent illness-injury on a daily basis, for example, exercise, diet, prayer,
rituals. When ill-health occurred, they diagnosed and administered first aid, ensured
bedrest, medicated themselves and cooked nutritious meals for the invalid. 'Medical
self-help includes non-professional nursing and the domestic application of hygienic
principles. This may involve ... disinfection of rooms, insect control, and air filtration'

42 CD-Rom and Internet 'doctoring' has become a fashionable past-time during the 1990s. World Wide
Web sites and CD-Roms on 'home doctoring' are on sale at computer fairs.
43 See also Porter and Porter (1989).
(Risse et al 1977:3). Laypeople relied upon the practical experience of others (friends, neighbours, relatives) in times of sickness, to assist with advice and healing.

Whilst women may have been more prominent in lay healing within the household, given their knowledge of 'kitchen ingredients' (Chamberlain 1981, Hayes 1996), it cannot be assumed that men were excluded. From their extensive historical analysis of 'popular medicine', Porter and Porter (1989:177) conclude:

From the mid-seventeenth century right through to the mid-nineteenth, men and women, husbands and wives, fathers and mothers were both more or less equally involved in the practice of 'medicine without doctors'. There is no discernible trend to the feminisation of the domestic healing role.

Furthermore, 'children's ailments posed parents agonising problems of responsibility; they had to deal with doctors, yet also retain overriding control' (Porter and Porter 1989:40). Lay healing occurred beyond the household to include the community. In Britain, 'the master or mistress of the household - men and women were equally active in this role - commonly took responsibility for physicking servants and employees, and indeed the wider village circle' (Porter and Porter 1989:41). Landed gentry and clergy were often called upon to administer remedies to parishioners and workers on their estates.

The knowledge and skills possessed by laypeople who practised healing were only exceptionally seen as unique, personal gifts or callings; typically they were regarded as applications of a body of lore that was in essence public, handed down orally, sometimes preserved in family manuscript recipe books, or culled out of printed volumes (Porter 1992b:97).

Porter and Porter (1989) assert that laypeople drew upon various sources and types of health knowledge to make their decisions about health care. 'Individual, personal "knowledge" ... was the indispensable prerequisite for devising strategies and making choices. But people reached their knowledge of matters medical through many media' (Porter and Porter 1989:190). Knowledge was not necessarily uni-directional: from doctor to layperson. Rather, the flow of knowledge was multiple. Laypeople and doctors and other healers alike all learned from and informed one another - drawing upon 'personal and familial healing experiences' (Risse et al 1977:4), and medical scientific knowledge. The increased use of the printing press from the 1500s onwards, in Europe, meant that books more so than manuscripts, became more accessible to the populace (Conrad et al 1995). As literacy increased, books, newsletters and journals were means by which people of all classes, laypersons and professionals alike, shared information. '[J]ournals such as the Gentleman's Magazine acted as exchanges - from laymen to laymen, from doctors to laymen - of medical information: diagnostic, therapeutic, pharmaceutical' (Porter 1992b:106, author's emphasis). 'Household health books' contained information in plain English on diseases, health promotion, self-help
and treatment of minor illnesses and injuries. They were often the first point of inquiry when a household member was ailing. If the expertise of university trained doctors was sort after, it was usually when a life-threatening condition or injury occurred, or self-medication had failed. Pragmatism, the severity of the condition, the cost of medicine and the distance from the nearest doctor were factors laypeople considered when treating themselves for ailments. Many kept their own 'medicine chests' of home remedies and commercial nostrums, and took precautions when travelling around the countryside (Blake 1977, Cassidy 1977, Chamberlain 1981, Porter and Porter 1989).

Women as Healers

The history of medicine reveals the gender and class divide in healing, with implications for who could and could not legitimately aid the sick, and in what capacity. Feminist scholars have documented the role of women in healing and the range of their practices in western society (Weedon 1992). They have paid attention to the breadth of women’s knowledge and healing practices - midwifery, herbalism, spiritualism, conception, contraception, abortion. They have also indicated the extent to which women as healers have had a recognised specialist role as female medical practitioner (Green 1989), as autonomous ‘wise woman’ or folk healer in their local communities, how women’s ‘caring’ abilities became the basis for nursing as a female occupation (McCoppin and Gardner 1995), and as lay women in their capacities as wife and mother responsible for their families’ health (Reiger 1985, 1986, 1987, Apple 1995).

Women have always provided health care. Their knowledge and successful practice are often based upon empiricism: trial and error. By treating many patients for various ailments within their families, neighbourhoods, social networks and communities, women gained experiential knowledge, and subsequently modified and extended their healing practices over time. Sharp (1986) asserts that women as folk healers, for example, midwives, herbalists and spiritual/faith healers, are ‘keepers and carriers of knowledge’. Their knowledge has been transmitted inter-generationally, from teacher to apprentice or pupil. Women’s indepth knowledge of herbs - their medicinal, poisonous and culinary properties and their preparation, storage and dosage - has been the earliest form of pharmacopoeia and development of modern drugs for example, belladonna and digitalis (Parvati 1978).

Green (1989) reviews prosopographical data and previous studies of women as healers in Medieval Europe. She argues that women were medical practitioners as well


\[24\] Sharp (1986) makes a strong case for intensive study of women as folk healers, especially in their roles as herbalists and spiritual/faith healers, on the basis that this is a poorly recognised area of women’s health knowledge, beliefs and practices, and these health practitioners tend to be poor, illiterate and/or rural residents.
as midwives at this time.\textsuperscript{47} Whilst they attended to women's health matters, their practices were not limited to obstetrics and gynaecology but they also treated, for example, eye diseases, fevers, kidney disorders, wounds. Furthermore,

Women's health was women's and men's business, the latter being interested if for no other reason than their concern as husbands and fathers for the production of healthy (and legitimate) heirs or, as medical practitioners, for the potential profit to be made in treating the wives and daughters of their wealthier clients (Green 1989:472-73, author's emphasis).

In Western Europe during the 12th to 16th centuries, there were increased restrictions on the licensing of medical practitioners, of both genders, by secular and religious authorities, which in turn limited women's healing activities. Regulation of midwives 'either by municipal or ecclesiastical authorities' did not occur until the mid-fifteenth century. 'Most of these regulations were meant to control not the midwives' medical skills but, rather, their moral character' (Green 1989:450). Obstetric and gynaecological literature written by men at this time drew upon the tradition of midwives' oral history, 'experience and informal apprenticeship' (Oakley 1992a)\textsuperscript{48}. There were social taboos about men examining women's bodies; male medical practitioners often had a female assistant with them who did the 'touching' whilst they made the diagnosis.\textsuperscript{49} Female modesty was a strong argument used by female healers to retain a practice whereby they could meet women's health needs, and by female patients 'who may well have preferred to be treated by attendants of their own sex' (Green 1989:469)\textsuperscript{50}.

In Europe and the United States, during the 'witch-craze', many women with a reputation for healing were under suspicion by secular, religious and medical professional bodies alike for their association with the devil, evil and magic. Superstition abounded about women's sexuality and their 'potential' for causing male impotence. Fear of the feminine, coupled with dependency on her expertise and 'powers' to cure disease and save lives (Khecl 1989, Achterberg 1990), meant for many laywomen, a premature death through torture and/or burning at the stake. This was

\textsuperscript{47} Green (1989:451) is critical of Ehrenreich and English's (1973) 'failure to distinguish between midwives and female medical practitioners in general or to recognise that midwives seem to have constituted no more than a minority of women convicted of witchcraft' (cf. Oakley 1992a).
\textsuperscript{48} Medieval society was largely illiterate. Only people of the upper classes, who attended universities or were residing in religious orders learnt to read and write, and had access to teachers and books.
\textsuperscript{49} See Foucault (1973), and Bynum and Porter (1993), for their analyses of medical examination of the body, and the changing use of the five senses and development of instruments such as the stethoscope, to assist diagnosis of the patients' condition. Porter (1993:184) notes the distinction between the 'thinking' physician who practised internal medicine, and the surgeon 'whose terrain comprised the externals of the body, and whose skills lay at his fingertips not in his mind'. Furthermore, the doctor's bedside manner was crucial to conserving his relationship with patients without the charge of impropriety. The only way to avoid this was to uphold 'the integrity and standing of the [medical] profession and the imperatives of science' (Porter 1993:194).
\textsuperscript{50} Porter and Porter (1989:177) indicate that during the Georgian period in England, they have found no evidence that sick women wished to be treated exclusively by women.
particularly the case at the height of the Inquisition and 'witch-hunt trials' by Catholic and Protestant reformers alike (Ehrenreich and English 1973:19). Oakley (1992a:37) suggests that:

The existence of the woman-midwife-witch-healer challenged and undermined the supremacy of the Church, men and the landed classes. She represented a lay peasant subculture and she symbolised the actual or potential power that a minority group possesses: it is a threat to the established order.51

The establishment of the medical profession as a legal and 'expert' practice heralded a diminution of women's legitimacy as healers during the late Middle Ages. Universities drew medical students from the ruling class and provided systematic learning. Limited medical 'science' was based more on Christian theology, Galenic medical theory, humoral pathology, heroism, and less on observation, for example, bloodletting and using leeches.52 Women (regardless of class or literacy) were excluded from this arena of knowledge and practice (cf. Minkowski 1994). Obstetrics and gynaecology were deemed by the male dominated medical profession (initially by barber-surgeons) as a specialty worthy of its attention, whilst midwifery and family planning remained in the hands of women. In this realm, outside of the biomedical model of health care, women had much autonomy and extensive knowledge to manage pregnancy and birth.53

During the nineteenth century, under the idealism of Florence Nightingale, women made the transition from healing as laywomen to being nurses: 'handmaidens of the doctor'. In this capacity, the nurse as Woman - feminine, spiritual, nurturing - became an extension of the housekeeper, wife and servant in the home, and thereby able to support the rising professional elitism of male doctors. Nurses were also passive and dependent upon the doctor's orders to deliver appropriate health care to patients.54 Curing and caring, previously viewed as being integral to healing by women, became separated. Doctors were seen as curing, nurses as caring (Wicks 1995). Medicine increasingly became male dominated.

Many women are also parents. Throughout history (partly to maintain productive labour for industry), as wives or the partners of men, women have attended to men's health and well-being. They have also been seen as maintainers of household safety (keeping clean, tidy houses), of children's well-being (to reproduce labour) and as 'gatekeepers' for hygiene in producing 'homo hygienicus' (Labisch 1985, Tong 1994, Ruth 1995). Women not fulfilling these activities have often been perceived as

51 See also Puckiss (1996).
abrogating their duties. The 'ideology of motherhood' is pervasive, regardless of class and culture (Chodorow 1978, Kitzinger 1978, Wearing 1984, Collier and Rosaldo 1985).

In the late nineteenth and early twentieth centuries, in Australia, at a time of increasing industrialisation and technological advances, mass immigration, suburban expansion and a declining fertility rate following two World Wars (1912-18 and 1938-45) and a Depression (1930s), capitalism was being re-shaped. The ideology of motherhood became 'scientifically' constructed (Apple 1995:175). The domestic science and the infant welfare movements in Australia, New Zealand, the United States and Europe, signified the intrusion of medical, psychiatric, nursing, education and social welfare professionals - 'experts' - into the privacy and informality of the family home. Interventions in family life, in particular upon women's roles as childbearers and childcarers, became what Donzelot (1979) calls the "psy" complex (Hodges and Hussain 1979) and Lasch (1979) views as 'encouraging the culture of narcissism'. With political, educational and aristocratic approval, the professionals set up organisations such as kindergartens, pre-schools, infant welfare centres, paediatric hospitals; expanded their realm of surveillance of the family through contraception, pregnancy, and childbirth; published and lectured extensively on the value of science for everyday life; and attempted to impose middle class values upon working class homes (Lasch 1997). They also determined whether women were performing their domestic duties; providing a haven of refuge and affection for men from the harsh, competitive industrial world of work; rearing 'normal' and 'healthy' children according to newly devised scientific standards; and ensuring physical and mental hygiene was maintained. During the 1940s to 1960s, books on parenting and baby care by paediatricians John Bowlby (1953, 1958) and Benjamin Spock (1946, 1962) were bestsellers largely bought by 'the literate middle class'. Non-conforming women, 'regardless of circumstances and abilities' (Nicolson 1993:205) were labelled 'bad mothers', resistant to the rationality of science and the expertise of others outside the home, and subjected to the normalising gaze of the staff in mother and baby clinics (Reiger 1985, Carter 1995).

---

47 It is interesting to note the lack of historical literature examining the ideology of fatherhood except in the context of the family (cf. Burgess 1997). Men's input into child-rearing appears to have received little academic attention. The men's movement of the late 1980s and 1990s is placing fathers, sons and parenting at the top of their agenda (cf. Lamb 1987, Biddulph 1995, 1997b, Blankenhorn 1995, Osherson 1996, Peire 1998).
49 See also Kedgley (1996).
Quackery and Alternative Therapies

[S]hared and negotiated therapeutic frameworks - historically and culturally specific - are the very basis of 'effective' patient-healer encounters. Quite simply, what works in one time and place could be quackery in another (Brandt 1991:205).

The frontiers between orthodox and unorthodox medicine have been flexible' and socially constructed (Bynum and Porter 1987:1). In the early nineteenth century, quackery and the rise of alternative therapies that relied on 'Nature', for example, naturopathy, hydropathy, spiritualism, mesmerism, phrenology, gave lay persons of all social classes, access to other modalities of healing from which to choose, especially if they were disgruntled with medical science. The increasing scrutiny and vilification of quackery by the medical profession led to publicised calls to stamp it out by introducing legislation, in the interests of safeguarding the public's health and maintaining professional standards (Porter 1989). Medical reform in Britain began with the Apothecaries Act (1815) and compulsory medical registration (1858), and led to a divide between practitioners of 'regular' and 'irregular' medicine (Loudon 1987).

Similar moves against 'quackery' developed in the United States from 1820. After the rise of medical sectarianism or 'alternative therapies' in the 1820s, such as Thomsonianism, homoeopathy and botanicals revealed a public dissatisfaction with 'orthodox' medicine, especially bloodletting, purgatives and calomel (a laxative containing mercury) (Warner 1987). The medical profession closed ranks by setting up their own medical schools and journals, and developing a code of ethics for clinical practice. Ehrenreich and English (1973) argue laypeople retaliated against this action by initiating the 'Popular Health Movement' (1830s and 1840s), with slogans like 'Every man [and woman] is his [her] own doctor' (1973:25). Self-help was the basis for health reform. It was also at this point that women's rights and women's health coincided as major political and social issues, and were used as arguments for allowing women's entry to study and practice 'regular' medicine. Women were publicly active in the health reforms as lecturers and publishing papers, yet also the targets of such campaigns as wives of men and mothers of children. 'Numerous articles on cookery, bathing, teething, care of infants, childhood sexuality, cleanliness, and domestic economy carefully taught women how to manage their households properly' (Morantz

---


40 It was primarily middle class women at the forefront of the Popular Health Movement, 'who viewed good health as a priority as well as a necessity for living the kind of active life required of them. Paradoxically, the women of the upper classes of the Victorian era viewed themselves as sicker than ever before'. often conducting their domestic affairs from their beds (Achterberg 1990:138). In contrast, 'women of the lower classes who supported themselves by working twelve to fourteen hours daily at factory work, coal mining, and other gruelling occupations ... were genuinely ill much of the time, and had few resources to sustain or regain health' (Achterberg 1990:130).
1977:86). Maintenance of a clean body and a healthy spirit were considered essential for a pure and moral society. Gender relations, sexual practices and the rigidity of marriage were also being questioned by women.

Having discussed women and men as lay healers historically, in the following section I examine their contemporary role. My question is: how do the structural factors of gender, social class, age and geographical location affect their contemporary lay healing role?

CONTEMPORARY LAY HEALING PRACTICES IN THE HOUSEHOLD

Gender

Within the feminist literature, there is greater emphasis on women than men as lay healers (cf. Graham 1984, 1985, Oakley 1993). Indeed there is a marked absence of documented research about men in this capacity.

Contrary to the conventional understanding of health care, more than 90% of the world’s health care is done by women. Women’s work is part of the gender division of labour. This work performed by women is absent from most surveys of health care (Oakley 1993:330).

Women’s work continues to be ’invisible’ or ’counts for nothing’ (Waring 1988). Finerman (1989:25) argues that women perform the role of healing as part of their role of ’nurturing’ the family, and in particular, ’as an extension of child-care duties’. Citing examples from non-western cross-cultural studies, she views lay healing as complex and effective, rather than the popularly perceived view of lay healing as the lowest level of health care and ineffective. In providing health care, women are not only concerned with aspects of their own physical and mental health, and reproductivity, but also the well-being (physical, emotional, spiritual), health maintenance and illness-injury prevention of others. Women diagnose and treat illness with home and/or herbal remedies, and available resources, skills, tools, knowledge, the assistance of others (that is, friends, relatives, neighbours, folk healers, alternative therapists or biomedical health professionals).

Graham (1985:29) states:

We still know very little about the ways in which women have provided, negotiated and mediated health throughout history; we can only guess at the division of resources and responsibilities within the community on which this health work rested.

I argue that the same scenario applies to men. Our knowledge of men as lay healers and their contribution to the health and welfare of themselves and others, remains limited.

Stacey (1994) echoes these sentiments. She recognises 'the responsibility of women for putting bread on to the table goes to the heart of women's [health] politics' and gives credit to the 'increasing, but still too small, number of men who share with women the health promoting activities of the home' (1994:89). For instance, many men have assumed the traditional role of 'breadwinner' by working in the paid workforce, thus providing the financial resources for lay healing in the household.

The men's movement and men's health movement in the western world, including Australia, is gaining popular media and public health attention (Arndt 1996, Margo 1996), and academic interest. The men's movement during the late 1980s to the present has concerned itself with examining masculinity and self-identity. In his critique of patriarchy, masculinity and gender relations, Connell (1987) has coined the term: 'hegemonic masculinity' to refer to hegemony occurring not only by men over women, but also by men over men. Between the two genders and within masculinity itself, Connell (1987, 1995) argues there are unequal power relationships of domination, subordination, complicity and marginalization. More recently, Connell (1995) discusses 'masculinity' not in the singular, but as plural: there are 'masculinities'. Whilst men claim to be masculine, how they claim their masculinity differs in terms of violence, work, gender relations, sexuality, emotions, sport, education, politics and the environment. Gilmore (1990), and Cornwall and Lindisfarne (1994), have examined cross-cultural perspectives of masculinity, noting similarities and differences between men around the world, and the diversity of cultural representation, ideology and experience of masculinity. In Australia, some male researchers and public health 'experts' have drawn a significant relationship between masculinity and men's health status (Commonwealth Department of Human Services and Health 1996a).

Other issues of concern to the men's movement include: spirituality, their bodies, men's relationships with their children, family and work responsibilities. Many of these issues have implications for men's health, and men's contribution as lay healers to

---

62 McKay (1997) argues that the men's movement is not a social movement. Rather, men 'are learning to adapt to the demands of women in their lives, case by case... they are not organised; there are no slogans; there are no signs of a counter-revolution' (1997:103). My observation of the men's movement in Australia, is that (some) men are gathering together into informal groups and grassroots organisations, lobbying government policymakers and public health organisations. These men are actively discussing their masculinity, and developing strategies to cope with changing gender relations, family structures and the family-work relationship, in terms of how these issues affect their health and well-being (cf. Clatterbaugh 1990, Commonwealth Department of Human Services and Health 1996a, Pease 1997).


the health, well-being and quality of life of their significant others. The focus of previous studies on lay healers tends to look only at women. The Men as parents of young children and as providers of health care within the household constitute a 'hidden population' (Fitzgerald 1996). Men’s views on health and ill-health, have been of limited concern to researchers, apart from studies by Mullen (1992, 1993) and Pinnock et al (1998).

Social Class, Age and Geographical Location

Previous research analysing health inequalities have drawn a strong relationship between socio-economic status and health, and discussed the influence of social class upon health. Those few studies addressing laypeople’s healing, have tended to address one social class only - either the middle class or the working class - or have made limited comparison of social classes. In Australia, it has often been argued that people on low incomes (despite universal health insurance) are less able, than middle class individuals and families, to access and afford health care and other services, owing to ‘out-of-pocket expenses’ (McClelland 1991). Sax (1990:54) writes:

[Provided that everybody has access to an adequate level of care, no ethical principle is offended by those who use their own resources to buy extra care. It is not enough [for governments] to make available adequate levels of care. The burdens suffered [by people] in order to obtain care must take into consideration such as prices to be met, waiting and travelling times, and the cost of transport.

These are the 'hidden' costs of health care and might also include interpreting and translating, childcare and time off work. In addition, many doctors charge consumers above the Medicare Benefits Schedule (and sometimes the AMA recommended fees). This medical co-payment is not covered by private health insurance, and laypeople often refer to it as 'the gap'. It is therefore, more likely that they must rely upon their own household resources, health knowledge and lay healing abilities to promote health and prevent illness-injury.

---

68 ‘Hidden populations’ are those population groups hidden from service delivery and social control, and which are not readily distinguished or enumerated (Weibel 1990, Fitzgerald 1996). Fitzgerald makes a distinction between 'visibility' and 'hiddenness'. He argues that visibility is firstly, both a product of discourse i.e. personal and population characteristics, and how one - the researcher, in this instance - views the world. And secondly, 'hiddenness' refers to the secondary characteristics of the population in question. The quantitative characteristics provide estimates of the unknown based on what is known, whilst the qualitative enhances knowledge of who, why, where and what they do (that is, as individuals and their activities in a particular setting).
71 See also Trehewey (1989), Taylor (1994).
Age as a factor influencing lay healing practices in the household can be addressed from two perspectives. In this thesis I concentrate on the generational dimension of age. Firstly, the inter-generational transfer of a resource, that is health knowledge, provides each generation with information about their bodies and life itself. Older women and men as parents and grandparents have a role in transmitting and passing on their knowledge and skills acquired through life experience to the next generation. In small scale societies, and in Aboriginal and migrant groups in Australia, older people are acknowledged as having 'wisdom of the elders' (Knudtson and Suzuki 1992), and as being experienced in life matters and knowledgeable about health. They make a valuable contribution to society as role models for younger people and children. A three-generational study by Blaxter and Paterson (1982) indicates that some grandparents - women more so than men - are sources of social support to their families, and give advice to their adult children on child-rearing, managing episodes of illness and consulting a doctor. Others avoid 'interfering' in their lives and would not recommend any remedies, recognising their daughters' independence and capabilities.

Secondly, the age of each family member and their stage of the life course affects their life chances, health status and capacity to implement lay healing practices of health promotion and illness-injury prevention. Adults and children constitute different generations and may have varied physical, emotional and spiritual needs within households. An additional factor is the division of health care labour between different generations in the same household (Mayall 1986, 1990b). Studies of women's education and household labour, and maternal time use - not paternal - have been found to be important factors influencing children's survival, particularly in developing countries. Despite their 'youth' and limited lived experience, children also contribute to lay healing and look after their own and others' health status. Zelizer (1985), James and Prout (1990), and Morrow (1996), have examined historical and contemporary values of children's labour inside and outside the household, and questioned their dependency upon and independence from adults.

An additional structural factor affecting lay healing practices in the household is geographical location. A person's residency has implications for their capacity to access local community infrastructure, and the time and distance to travel to and from available health care services (Mullins and Short 1992). In Australia, the 'tyranny of distance' (Blainey 1968) has meant the majority of the population are densely concentrated on the eastern coastal margins - especially in metropolitan cities of

---

73 The health knowledge and lay healing practices of adult 'sons' were not examined in this study by Blaxter and Paterson (1982), see Bell (1988), Bulbeck (1997) and Mackay (1997) for Australian studies on inter-generational relationships and transmission of knowledge.
Melbourne and Sydney - and less so in the western, northern, rural and remote areas. Distinctions have been made by researchers between urban and rural areas, inner and outer urban areas, metropolitan and urban areas, rural and remote areas as ways of defining population density. Less attention has been paid to coastal areas as an indicator of urbanicity or as a residential area, although it has captured the cultural imagination of Australian writers such as Drewe (1983, 1996) and Winton (1997). Similar to many outer urban, rural and remote areas, coastal populations are sometimes isolated in terms of limited community infrastructure, public services (health, education and welfare), and access to commercial enterprise. They also have difficulty in attracting and retaining health and other professionals to provide services, and to participate in local community activities - who tend to reside and work in metropolitan areas. Laypeople in more remote areas are therefore reliant on their own resources, health knowledge and abilities to provide lay healing in the household.

THE FUTURE OF LAY HEALING PRACTICES FOR PUBLIC HEALTH
Implications for the Household Production of Health

Two major emerging concerns for public health entering the 21st century are: the re-surgence of infectious diseases and environmental toxicology. Both phenomena have consequences for: how laypeople provide healing in the household; how risk is perceived and assessed by laypeople and health professionals; and, how health-hazarding risks are avoided. They also present challenges to the 'new' public health. Thus, there is a move towards the physical environment rather than the social or emotional environments as the source of health risks (Beaglehole and Bonita 1997). This may mean a resurgence of the 'old' public health with its emphasis on 'homo hygenicus' (Labisch 1985, cf. Latour 1988). Cox (1997a, 1997b) argues against this state. Following Putnam (1993), she highlights the importance of 'social capital' and trust as essential ingredients for a 'healthy society' consisting of healthy citizens. She agrees with Daly (1997) and Syme (1997) that public health 'experts' must give credence to social cohesion, relationships and well-being as positive indicators of public health policies and programs achieving their goal: improvement in individual and population health status (cf. Korten 1997), rather than merely improvements in physical environment.

78 'Urbanicity' is a term used by policymakers and researchers 'to indicate the extent to which a place is urban or rural'. It is also an 'ecological variable' related to health (Verheij 1996:923), such as 'Healthy Cities' (Baum 1993, Baum and Cooke 1992).
80 Given the unique geographical and topographical contours of the Geelong Region, I have included urban, rural and coastal areas in this study. Each area is internally differentiated in terms of family structure, social class, age, gender and ethnicity (City of Greater Geelong 1998).
Examining Public Health in the Past in Order to Move Forward

For an individual to be healthy in body, mind and spirit, and live to a ripe old age was an idealistic but rare state of being, before the nineteenth century in Europe. Diseases in epidemic proportions were: typhus, tuberculosis, plague, cholera and yellow fever. Living and working conditions exacerbated by the Industrial Revolution for urban slum dwellers - overcrowding due to an expanding population, food shortages, poverty, epidemics of contagious diseases, poor hygiene and inadequate sanitation measures - were socio-economic and environmental factors that impeded people's ability to resist disease and prevent death. Infection was spread from one individual to another, through air-, vector-, water- and food-borne micro-organisms or through personal contact.\(^2\)

Public health efforts in Europe, through the lobbying and advocacy of campaigners such as Edwin Chatwin, Friedrich Engels and Rudolf Virchow, saw an improvement in water collection, sewerage disposal, and medical attention for the poor living and working in crowded conditions during the Industrial Revolution (Engels 1987 [1845], Waitzkin 1981, Lupton 1995).

McKeown (1979) examines the historical evidence for the medical profession's claim for eliminating disease and improving public health.\(^3\) Drawing upon British (and to a lesser extent, other European) medical records and demographic data on mortality from the eighteenth and nineteenth centuries, he makes comparisons with medical practices in the 1970s. McKeown restricts his analysis to developed countries, and to the medical profession with limited attention to other therapies including lay healing, which might also have had an impact on public health.\(^4\) Before 1700, high mortality rates resulted from starvation, infectious diseases and homicide. McKeown disputes the claim that morbidity and mortality declines from the eighteenth to twentieth centuries were primarily due to medical intervention, despite an expanding knowledge of the body at a molecular and cellular level. Instead, he asserts that mortality rates were decreasing dramatically prior to the nineteenth century, due to individual behaviour and public health measures, which did not rely on personal medical care. Firstly, population growth slowed through changes in people's reproductive behaviour such as use of contraceptives. Secondly, personal hygiene improved with frequent handwashing and bodily cleanliness. Thirdly, improved nutrition resulted from increased food supplies and advances in agricultural technology and transport. Fourthly, an overhaul of sanitation facilities by local government authorities responsible for the immediate physical environment, enabled water purification and sewage disposal (Garrett 1995).

---

\(^3\) See McKinlay and McKinlay (1977) for comparison of McKeown's arguments with US. data. In the United States, marked decreases in mortality for both women and men since 1900 to 1970 were due 'to the virtual disappearance' of typhoid, smallpox, scarlet fever, measles, whooping cough, diphtheria, influenza, tuberculosis, pneumonia, diseases of the digestive system and poliomyelitis' (1977:414).
The sum of these changes led to better standards of living, taking place independently of medical care, and before the introduction of vaccines and antibiotics to quell the incidence of people dying from communicable diseases, for example, smallpox, tuberculosis, diphtheria, pneumonia.

McKeown's (1979) thesis about the decline in mortality in the western world over the last two centuries, rests upon the following critiques of biomedicine. Firstly, he questions the value of scientific medicine in reducing the incidence of morbidity and mortality, and the efficacy of its treatment(s) of disease. Secondly, biomedicine's lack of attention to care will continue whilst the focus on cure remains. Thirdly, biomedicine is unable to deal adequately with ageing, mental disorders, chronic illness and disability, for which there are no finite solutions or heroic cures. Fourthly, the medical profession disregarded the impact of 'external influences and personal behaviours' upon health status. McKeown argues, a healthier population was produced through better nutrition and an improved standard of living.

Using a Marxist perspective, Blane (1987) re-examines McKeown's assertions in light of capitalism (social class, people's employment and wages) and age-specific mortality patterns. The 'labour-power' of propertyless people was an important factor for ensuring their daily subsistence, reproduction of a generation of workers, and supporting their education and training. Early health education strategies were aimed at the working class' behaviour, reproduction and child-rearing, and drug consumption, whilst overlooking unemployment, poverty and material conditions which affected their lives. Blane (1989:27) concludes that 'preventive medicine was most successful when it sharpened the perceptions of already felt needs and organised collective solutions to them'.

Thomas (1995) agrees with McKeown's thesis and Blane's review. However, she asserts that both writers overlook the role of laypeople's 'domestic labour' in relation to health. That is, laypeople themselves effectively reduced the incidence of disease, through their efforts to promote health in various ways in their homes.80 Significantly, women's unpaid undertaking of housework and child care involved 'emotion work',81 replaced the costs of labour-power, and transformed the means of subsistence (clothing, food) into means of consumption (Thomas 1995:337). In addition, women substantially contributed to "rising standards of living", to qualitative advances in the reproduction of

80 Drawing upon the work of Graham (1985, 1993c) and Stacey (1988) in their definitions and exposés of 'health work' provided by women, Thomas (1995) asserts that the relationship between domestic labour and health has been overlooked by sociologists, and to this I would add, by anthropologists and feminist economists. There has been no link made between aspects of the household economy, i.e. budgets, resources and labour, and its contribution to the production, investment and protection of health in the domestic sphere. Nor has this relationship been examined in terms of how laypeople's decisive management of the household economy influences the purchase and consumption of external health care services.

embodied individuals, to falling mortality rates' (1995:336) and the household production of health.

Mokyr (1996a, 1996b) presents a technological argument in his critique of McKeown's evidence (1979). Drawing upon economic history, Mokyr examines household behaviour in the nineteenth century, when laypeople depended on 'recipes' (household knowledge) and 'household technologies' or 'techniques' (technologies purchased by the household) (1996a:1) to promote health, prevent illness-injury, and implement lay treatment. These techniques included:

- domestic sanitation as well as baby care, food quality and composition, proper home heating and ventilation, isolating patients with contagious afflictions, and care for those with minor sickness such as colds, small wounds, and diarrhoea to prevent complications (1996b:2).

These lay healing practices occurred at a time when there were competing discourses about the human body, health and disease, and medical scientific knowledge was limited. Public health specialists' ability - especially that of the sanitarians - to alter household behaviour rested upon 'persuasion' based on the 'power of words' (such as 'Cleanliness is next to Godliness'), probability theory, statistics, 'best practice techniques' and the 'diffusion' of knowledge through popular literature. Following Pasteur's and other scientists' 'discovery' of the link between micro-organisms and disease (Latour 1988), and Malthus on family planning, public health attention focussed upon food, infants and childcare, water and energy, washing and hygiene, insects, medical practices and public policy as means to reducing morbidity and mortality rates (Mokyr 1996b).

Tesh (1982, 1989) analyses how disease causation theories became the underlying political ideology for public health action in Europe and the United States. With each theory, she addresses historical arguments for factors extraneous to science, such as: people's living and working conditions, their social class, ethnicity and religious belief, the purported sources of blame, and individual or societal responsibility for infection and maintenance of good health, and self-serving political and economic beliefs. The uptake of a theory and putting it into practice through 'disease prevention policy' depended (and continues to depend) upon the differential power of various interest groups - supporters and detractors - who have a stake in the status quo. Scientific, political and economic intransigency has often impeded the implementation of effective public health measures to safeguard the health and wellbeing of individuals and population groups (Brown 1995, Garrett 1995).

Garrett's (1995) evidence for diseases in epidemic and pandemic proportions in the late twentieth century gives strong support for multicausal theories of diseases and the need for multi-solutions (Tesh 1989). She suggests local, regional, national and international efforts to contain and eliminate disease - through lay healing practices,
medical care and public health measures - have often been hampered by scientific rivalry, political intransigency, successive bureaucratic cost-cutting measures, and patient non-compliance with recommended treatment and prevention measures (for example, tuberculosis medication, measles vaccination, safe sex practices). These factors, in addition to a migratory global population, changing human ecology, physical environments, and flora and fauna diversity, have created a paradise for microbes to replicate, swap genes and mutate in human beings with poor immunity (de Silva 1995). Furthermore, they have implications for the extent laypeople are already taking precautions to reduce their exposure to disease, given the time lag in medical/scientific information on disease identification and causation, and receiving public health messages to take specific precautions in the privacy of their homes (Latour 1987). They also have implications for laypeople becoming activists when they perceive their health and well-being are severely compromised.

Lay Activism

When infectious disease outbreaks and environmental toxins are brought to the attention of the lay populace, it requires immediate modification to their physical household environment in terms of safety and hygiene, and where possible, avoidance of health hazarding behaviour, rather than the macro response of 'removal of the hazard'. It also presupposes a trust in public health officials and their ability to protect people's health on a larger scale, so that what happens outside the household does not intrude into the household.\(^7\) In a sense, laypeople are on guard, monitoring and surveilling their own health as a preventive measure. However, what do all these trends mean in real terms for lay knowledge and lay decision-making about health? What do these trends signify for lay healing practices in the household?

The public health net has marginally widened to provide room for lay health knowledge and practices, albeit still under-recognised (Peerson 1996a). This is particularly the situation of 'non-elite' and marginal groups in society. 'Community representatives' are most likely to be 'people of higher income, education level and occupational group than average' (Jewkes and Murcott 1998:855). This situation clearly 'demonstrates a mismatch between ideologies of public participation and practice' of public health policies, and a curtailment of democratic processes (1998:856).

Evidence to date reveals that lay activism is undertaken with a view to improving the status quo, voicing concerns about damage to human bodies and the deep ecology (Mathews 1991, Suzuki 1997), and about being heard and represented. Lay activism is more likely to occur when laypeople perceive threats to cherished values (health,

\(^7\) In August 1998, the people of Sydney experienced two public health alerts for several days owing to water contamination by giardia and cryptosporidium micro-organisms. Prompted by official and lay anger, the reasons for this situation are being 'investigated' (Leech 1998).
education, welfare, housing, employment, physical environment, justice, clean air) or they are markedly dissatisfied with the status quo and 'official' explanations. They are using sociological imagination (Mills 1959) in converting private fears into public issues. It is at this point that laypeople are most likely to both singularly and collectively take action and seek redress (Korten 1997, Krygier 1997, Rayner 1997). Three examples of lay activism in relation to health and well-being in everyday life are: i) self help groups; ii) 'popular epidemiology'; and iii) social movements. 

Firstly, self-care is not only an individual activity; it also refers to collective agency. Self-help groups comprise lay members relying on mutual support and informed decision-making, and present health care alternatives and complements to orthodox medical care (Kearney 1991, Wood 1996). They consist of persons 'with a common problem, stigma or life condition that involves no professional involvement of a consultative kind, and in which there is no financial profit' (Kearney 1991:29). As a collective agency, self-help groups act as a locus of education, resources and support to their members, provide information, advocate for them to government and other organisations, and establishing links with health professionals and alternative therapists who in turn make referrals to the group. On the one hand, self-help groups serve as a source of support, by providing knowledge of mechanisms which laypeople can use to access the health care system more widely. They are also a reserve of power in that they lobby and advocate extensively. In this sense, they present an alternative option for laypeople, to medical and other health professionalised knowledge and care. On the other hand, self-help groups may be viewed as 'professionalised' and 'formalised' groups of lay persons. They generally adhere to formal infrastructure of a management committee, have office facilities, hold regular meetings with agendas, require membership (paid subscriptions necessitate a bank account and budget management), produce and send out newsletters to their members, and provide a venue for members' meetings and conferences.

Secondly, laypeople in their local communities are often making connections themselves between knowledge and practice, and with what they see in everyday life, often long before medical, scientific and political bodies publicise the facts. Brown (1990, 1992, 1995) refers to this as 'popular epidemiology'. It is 'the process whereby lay persons gather scientific data and other information, and direct and marshal the

---

88 I contend, that laypeople are not powerless, but rather are active agents drawing upon their local and experiential knowledge. They are 'agentic selves', able to work collectively as interest groups, and sometimes in liaison with government policymakers, researchers and public health professionals (Stacey 1994, Brown 1995, Dean and Hunter 1996).

89 Also known as 'lay epidemiology' (Davison et al 1991, Frankel et al 1991, Watterson 1994), and is similar to the 'shoe leather' origins of epidemiology as a discipline (Brown 1995).

90 Activist groups were not studied in this project.


resources of experts to understand the epidemiology of disease' (Brown 1992:269). This is the 'paradox of experts' when multi-disciplinary scientific and/or medical experts may be pitted against one another, when in other instances they may be on the same side. In addition, the polarity of lay vis-a-vis professional knowledge reveals divergent interests and perspectives, and the contestation of knowledge itself (Latour 1987) and the definition of risk.\footnote{See Douglas (1986), Frankel et al (1991), Beck (1992).} Popular epidemiology 'emphasises basic social structural factors as part of the causal chain' (Brown 1992:269), 'involves social movements, and challenges certain assumptions of traditional epidemiology' (Brown 1990:78), including its values and the 'standard of proof', and the 'expert' assessment and communication of risk (Brown 1995, Williams et al 1995).

In Australia, the CSIRO and other health and medical research institutions (including universities) are at the forefront of scientific and technological advancements, including investigation of contagion and toxins. The medical profession has a secondary position to these bodies, as it relies upon the latest information to treat disease on a practical and individual level. Meanwhile, politicians are mandated to keep the public informed of risks to individual and population health. Public servants in their capacity as public health officers have a role in monitoring, reducing, and controlling risks of disease outbreaks, as a preventive measure. Government inquiries and commissions (presided by 'independent' experts) are often held when laypeople's concerns and fears are expressed and reported by the media on a wide scale. It has been known for their findings and recommendations to be suppressed or politically delayed, subsequently affecting people's morale, belief in, and ability to trust, leaders and others in powerful positions in society about decisions that affect their lives on a daily basis (cf. Brown 1990, 1992, Tesh 1993, Garrett 1995).

Thirdly, by making links between 'health, lifestyle and environment' (Berger et al 1991) laypeople form the crux of 'grassroots groups'. In time, local activities evolve to become social movements; gathering momentum and broadening their focus to become more political in their outlook and seeking societal change.\footnote{See Tesh (1993), Tiourina (1994), Williams et al (1995), Korten (1997).} Feminists, for instance, have longed argued that 'the personal is political' as the motive for their activism.\footnote{See Summers (1994), Kaplan (1996), Bullbeck (1997).} Lay activists often expand their local networks and galvanise a collective consciousness on a global level. For example, 'green politics' has lead to changing paradigms from 'pre-environmentalism' (Nature is at the disposal of human beings) to 'environmentalism' ('meddling with Nature is detrimental' to human beings), and subsequently led to scientific investigations to take seriously laypeople's claims of disease caused by environmental factors (Tesh 1993, cf. Lewis 1995). Firstly, media lobbying and advocacy may be resorted to by social movements as strategies to expand local and

CONCLUSION

The term 'lay' has been largely absent in the literature owing to several factors. Firstly, there is a tendency of policymakers, health professionals and academics to focus on health professionals and institutions, rather than laypeople's healing practices. Secondly, these personnel prefer to describe laypeople as consumers but not producers, providers (that is, healers) or investors in health.

There is a need to take a bottom-up approach to uncover the historical evidence on laypeople as healers and as patients (sick persons) within the context of their families, neighbourhoods and communities. The persistent focus within the recent history of medicine is upon scientific biomedicine, health care services and personnel. There is also little historical attention to alternative therapists and folk healers, and their role in providing additional sources of healing when laypeople decide lay healing is not enough and require other options.

The major focus on contemporary lay healing practices in the household has been more so on women rather than men. Three areas of study on gender and lay healing has been in terms of change: i) the family; ii) gender relations; and iii) the family-work relationship. Nearly three decades of second wave feminism and the more recent men's movement have made inroads into social relationships, by deconstructing and reconstructing stereotypes of femininity and masculinity, and redefining roles and responsibilities. However, the gender imbalance of research to date reveals: i) women are perceived as present in the household, as mothers and lay healers; and ii) men are perceived as absent from the household. From the mid 1990s, research indicates that men are much more aware of their father role than in the past. However, the literature neglects the role of men as lay healers providing health care in the household. Social class, age and geographical location as structural factors influencing lay healing practices in the household have not yet been examined in great detail to date.

In the late twentieth century, there continues to be a tension between the political pre-eminence of rational science and medicine, and the prevailing economic rationalist arguments for individual responsibility for ensuring people's health and well-being. McKeown's work (1979) signifies firstly, a conceptual shift about the value of biomedicine to cure disease and save lives. Secondly, his work was a precursor for the shift from the 'old' public health and its emphasis on hygiene to the 'new' public health.
New public health concentrates on the environmental, historical, political, economic and social influences upon health, taking a population focus, as well as taking account of individual lifestyle factors. However, the new public health can also be criticised for its professionalisation of public health expertise (Baum 1990). Lay activism has provided laypeople with formal and 'legitimate' avenues for exercising their 'voice', changing the status quo, and providing social support to the sick. I contend that additional issues are missing from debates about the value of medicine's contribution to society; that is, the role that laypeople play in health and healing. Do they make decisions within the domestic sphere, even before or instead of seeking medical attention or other therapies outside the household? We do not really know what happens in the household apart from fragmentary historical evidence.

To suggest a future for lay healing practices in public health, entails not only 'refocussing upstream' (McKinlay 1979) to identify and redress the causes of ill-health, but also investigating how laypeople initiate healing in the domestic sphere, their health knowledge and decision-making processes. Current public health concerns tend to focus on infectious diseases and environmental toxicology that retain an emphasis on the physical body. There is also an imperative to examine emotional and spiritual well-being and impairment from individual and population perspectives, and the importance of developing indicators of 'social capital' to 'measure' a healthy society (Cox 1997b, Korten 1997). Furthermore, voicing laypeople's perspectives on health and ill-health, acknowledging the extent of their lay healing practices in the household, and promoting their active participation in formal health care decision-making alongside policymakers, health professionals and academics will lead to greater cooperation, alliance, trust and mutual respect in addressing health and ill-health.
CHAPTER 2
THEORISING THE POWER-KNOWLEDGE RELATIONSHIP
UNDERLYING LAY HEALING PRACTICES IN THE HOUSEHOLD

A Multi-theoretical Approach to Lay Healing

In order to understand the illness experience of the individual, we require a
general analysis of the social system in terms of inequalities of power. However,
we also require a cultural study of disease categories which are variable over time
and space. The linkage between the macro-analysis of social systems and the
phenomenology of individual sickness is provided by the concept of the social
role, and in particular by the idea of the sick role (Turner 1987:4-5).

Turner's (1987) model provides a schema for using the 'sociological imagination' (Mills
1959), to explore the power-knowledge relationship underlying lay healing practices in
the household. The three levels of analysis, used in this thesis, address the 'individual'
experience of health and ill-health, the 'social' and 'cultural' construction of health and
illness, and the 'societal' effects of inequality between people and between health care
sectors. The different orders of theory complement each other, and enable examination
of the tensions between individuals and society, agency and structure, micro and macro,
rights and responsibilities. They also facilitate an explication for laypeople's health
knowledge and decision-making, and their healing practices in the household, before
and instead of using other health care services outside the household.

In this thesis I take a multi-theoretical approach to lay healing practices in the
household for the following reasons. To date there is neither a substantive body of
research nor a comprehensive social theory examining the power-knowledge
relationship underlying lay healing practices in the household. For instance, Foucault
(1973) spans all three levels of analysis; he privileges the body and social structure as
'anatomo-politics' (individuals) and 'biopolitics' (populations). Whilst he provides
insights into governmentality occasioned by institutions of health, his 'archaeology' of
modern medicine does not address lay healing in the household at the micro level.
Rather, individuals are seen as duplicating the regimes of medicine at the macro level.
Theories on 'medical dominance' (Willis 1989a) and 'medicalisation' (Zola 1974, Illich
1977) do not acknowledge laypeople's agency, nor the extent of lay healing occurring
in the household before biomedical care (or another healing option) is sought. Dean's
(1980) pioneering work on self-care in Denmark and subsequent work (1981, 1983,
1986b, 1989, 1990, 1993) indicating theoretical and methodological issues have
informed this study. In the international journal Social Science and Medicine (1996)
there are three key papers addressing lay healing practices, the importance of lay
knowledge for public health, and lay perspectives on modern medicine. Dean and
Hunter (1996), Popay and Williams (1996), and Williams and Calnan (1996b), ask
theoretical questions as well as suggest appropriate methodologies for empirical data collection on lay healing.

In this chapter, I use conceptual frameworks from multi-disciplines - medical anthropology, political economy, medical sociology, anthropology and sociology of the body, feminisms and masculinities - to explain lay healing practices in the household. These conceptual frameworks provide salient insights into issues such as lay conceptions of the body, the role of intimacy as a basis for healing, and the epistemological bases of lay knowledge. They also address the political and ideological commitments of laypeople to self-care, involving notions of body ownership and responsibility, and the extent to which laypeople subscribe to economic rationalism, i.e. the affordability of health care when only allopathic professional health care is officially supported (by Medicare in Australia). How laypeople use their health knowledge, make decisions and provide healing within the household has implications for their use of health care services outside the household. In the following sections, I examine medical pluralism, critique medical dominance, review the household production of health, discuss the notion of the human body as the embodied self, as well as explore the power-knowledge relationship in terms of lay knowledge and lay decision-making.

MEDICAL PLURALISM

Individuals in the household setting are the primary decision-makers in maintaining their health. They determine which healing option(s), of which biomedicine is just one, to resort to both within and outside the household. The basis for their decision-making may be philosophical, ideological, emotional, habitual or traditional. It may be perceived in pragmatic terms according to its accessibility and availability (Sharma 1992).

For the purpose of this project, I develop a framework based on Kleinman's model (1980) of the health care system. I use his model as a theoretical basis for locating and examining both lay healing practices and the 'household production of health' within the health care system (ie. the popular sector), and for increasing our understanding of the interaction between the popular, folk and professional sectors. I suggest ways of enhancing our understanding of lay healing (within the household setting) in the popular sector of the health care system. Furthermore, we can view Kleinman's model of the health care system as one of 'medical pluralism'; in that many options of healing are available, not just that provided by the medical profession and

---

98 See Appendix C: models of healing that are allopathic, alternative, folk healing, social and lay, in terms of: epistemological models; practitioners; etiology; education and training; subjectivity and objectivity; public and private settings; units of analysis; and forms of diagnosis, treatment, prevention and research.

Kleinman (1980) argues that health care systems are cultural systems (similar to political and kinship systems, and language), which include people's knowledge and beliefs, and certain patterns of behaviour invested with symbolic meaning and rituals, and which are open to external factors and contain internal structures. External factors that are historical, social, political, economic and ecological in character all impinge upon cultural systems within a particular locality. At the same time, they influence the re-definition and expansion of medical boundaries to meet newly created needs in society. The internal structures are roughly the same across cultural boundaries, while the content varies with the social, cultural and environmental circumstances of each system (Kleinman 1980:45-9). The popular sector is the largest sector of the health care system, and is intersected by the folk and professional sectors at 'points of interaction, entrance and exit' (Kleinman 1980:50). In these sectors a different set of beliefs and values operate, and to which the sick individual or 'patient' must subscribe in order to obtain therapy for her/his illness.

a) Popular sector

The popular sector 'is the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities initiated' (Kleinman 1980:50). It is orientated towards 'health' in the holistic sense and preventive medicine (Shearwood 1979). Within this sector are several levels of knowledge, beliefs and activities pertaining to individuals, families, social networks and the local community. Individuals make decisions (sometimes in consultation with others) about their ill-health, possible causation and appropriate treatment. They also assess lay treatment or therapy received from the professional or folk sectors. All of this takes place within the 'cognitive and value-orientation of the popular culture' (Kleinman 1980:50).

I contend that popular health care, or lay healing, performed by laypeople encompasses a variety of aims, objectives, resources, tasks, relationships and settings. These aims might include: promoting health, preventing illness-injury, and improving health status in terms of morbidity, mortality, quality of life and well-being. Resources necessary to provide lay health care include: knowledge, other people to assist with health care, finance, time and energy. Tasks undertaken to provide lay healing are:

- **health education** which might include: food and nutrition, social relationships, sexual behaviour, first aid, safety, rest, management of illness, personal hygiene, and the provision and use of medicines.

---

97 See Appendix C: models of healing.
98 See Kleinman (1980:50, Figure 3) for a schematic view of the 'local health care system: internal structures'.
• health promotion and illness-injury prevention to maintain physical, mental and spiritual well-being (Kickbusch 1989, Peerson 1990). These activities consist of two types:
  i) those actions we 'take-for-granted', almost subconsciously, including teeth brushing, daily showering, putting a seatbelt on when driving a car and observing the road traffic rules, eating a meal with one's partner or going out to dinner and the theatre, or to the 'pub' or 'footy' with friends; and,
  ii) those activities which require positive, dramatic and 'conscious' adjustments to one's lifestyle, usually upon the onset of symptoms of illness or injury, an alteration in health status (such as diabetes) or paying attention to public health campaigns, which entail making changes to one's diet, exercise, sport, exposure to dust and chemicals, or medication regimes.

• diagnosis and treatment of illness and injury such as recognition of the onset of signs and symptoms, assessing the severity of illness-injury, making a diagnosis, and determining the most appropriate remedy for the condition, such as first aid, surgery, management at home.

• household economy includes laypeople's management of their household resources, labour and budget, and prioritisation of the provision and payment of health care both occurring within and outside of the household, in preference to other concerns such as education, housing, transport.\textsuperscript{99}

Health and ill-health are subjective experiences occurring within a social, cultural, political, economic and environmental context. The public, private or intimate nature of the relationship individuals have with their significant others, and within wider society,\textsuperscript{100} will influence the type of health care that is provided by lay persons and the consequent health outcomes (Kleinman 1980, 1995b, Calnan 1987, Dean 1990). Lay healing needs to be distinguished from the other 'non-medical' sector of healing: the folk sector.

b) Folk Sector

The folk sector is 'non-professional and non-bureaucratic' (Kleinman 1980:59). Its specialists - shaman, witchdoctor, herbalist, curandero, medicine-man, spiritist - are frequently dichotomised (by researchers) into sacred (religious) and secular (empirical) practitioners according to the principal function(s) they perform in their societie.\textsuperscript{101}

These functions include: health care, magico-religious rites, invocation of spirits,

---

\textsuperscript{99} I discuss health education, health promotion and illness-injury prevention in Chapter 6, and, lay diagnosis and treatment of illness and injury in Chapter 7. A full discussion of the household economy (including labour, time, budget, resources), private health insurance and perceived barriers to (formal) health care is beyond the scope of this thesis.


mediation between lay individuals and communities over disputes, or between natural and supernatural worlds. What distinguishes these healers from a lay person or health professional is their initiation, intensive training and privileged access to knowledge as a source of power to be used in the ultimate interests of their society (Peerson 1990).

Knowledge and skills to diagnose and treat illnesses are limited to a select few in any society. Folk healers undergo specialist training under the guidance of old masters. They may be recruited to a specific healing tradition on the basis of their personality, long-standing interest, community need or heredity, father to son, and less often, mother to daughter (Worsley 1982, Frohock 1992). A shaman, for instance, may have had a 'near-death experience', seen visions or undergone altered states of consciousness, recognised by their society as signs of selection to this specialist role (Atkinson 1992, McClenon 1993). Some folk healers work alone or may be part of networks with other folk healers, 'and these provide for the exchange of techniques and information, and monitoring of each other's behaviour' (Helman 1990:62).

Folk healers also 'share ethnic background, language, social class and community of their followers, and have an intimate knowledge of the patient's role in the community' (Henderson and Primeaux 1981:66).

These socio-cultural elements predispose towards a favourable prognosis of the patient's ailment; as the knowledge, beliefs, values and world view of the folk healer and her/his constituent community are the same. 'The curer is most likely to focus on the infraction of the social and cultural norms, infractions that [her or] his patients readily recognise' (Shearwood 1979:297), and thus takes a different approach to healing from healers in the professional sector.

c) Professional Sector

This sector is resorted to when lay healing is adequate. In Kleinman's model (1980) the professional sector comprises the realm of scientific biomedicine and its professionals, supported by legal and bureaucratic structures (Willis 1989a), in which physicians have supreme power over other health and allied personnel, and, marginalised practitioners of alternative medicine or, 'natural therapies'. Also within this sector of Kleinman's model, are the 'professionalised indigenous medical systems: traditional Chinese medicine and Ayurvedic medicine' (1980:54). Western health care practitioners resort to high technology for diagnosis and treatment of illness, much of

102 See also Worsley (1982), Helman (1990). In their respective studies of women and health care in the Latin American and Himong communities in Melbourne, both Peerson (1990) and Rice (1993) have encountered folk healers (herbalists, spiritists). Toloo's study (1996) of Lebanese people in western Sydney reveals they consult 'bonesetters' within their own community, as well as rely on doctors and informal sources of social support when sick.

103 Alternative therapists are included in the professional sector of the health care system (Kleinman 1980), owing to their professional status. However, they do not abide by the scientific biomedical paradigm, but instead their healing practices stem from a different epistemological base(s) (McGuire 1988, Frohock 1992, Saks 1992, Sharmu 1992, Fasthope 1986, 1993, Eisenberg et al 1993, Budd and Sharma 1994, Kleinman 1995b).
which takes place in large institutions and specialised clinics.\textsuperscript{104} However, it must be noted that in the Australian health care system, many allopathically trained doctors also practise healing modalities based on other knowledge foundations, such as traditional Chinese medicine and acupuncture (Willis 1989b, Easthope 1998),\textsuperscript{105} and some nurses are implementing aromatherapy, massage and relaxation in hospitals and hospices.

Practitioners of biomedicine tend to ignore the patient's subjectivity and hence, identity, personality, beliefs and culture. Furthermore, her/his perception of illness, and its diagnosis and treatment may conflict with that of the professional providing health care (Peerson 1995a). It is curative rather than preventive medicine that has pre-eminence. Also within this model, the mind and body are considered separate entities. This is reflected in the treatment of physical and psychological ailments by clinical medicine and psychiatry respectively, with increasing specialisation in each area (Capra 1988, Kleinman 1995b). The health professionals are considered 'experts'. Alternative forms of knowledge are not deemed 'real' or 'legitimate' (Frohock 1992). "The biological aspects of medical problems are the "real ones", while the psycho-social and cultural aspects are seen as second order phenomena and are thus [rendered] less "real" and important" (Kleinman 1980:57), since the 'illness as experience' becomes decoded to 'disease as biological pathology' (Kleinman 1995b:32, author's emphasis), leading to a negation of the sick person's suffering (Cassel 1991). Although, as referred to above, individual practitioners within scientific medicine may adopt a more pluralistic approach to healing.

Expansion of Kleinman's Model

Kleinman's model (1980) enables a cross-cultural understanding of medical systems in 'modern' and 'pre-modern' societies at the local level, in the east and west, and in countries of the First and Third Worlds (1980:27-9). It adopts a holistic view of health and health care; integrating internal and external factors. The practice of medicine, regardless of its origins or traditions, is placed in a cultural context. It is a social and cultural construction of reality, shaped by individuals, families, social groups and bureaucratic states, which dictate which relationships and behaviours are legitimate and which are not. Kleinman (1980:39) acknowledges at the local level,

social factors such as class, education, religious affiliation, ethnicity, occupation and social networks all influence the perception and use of health resources ... and

\textsuperscript{105} In Australia, some GPs have undertaken studies and are offering alternative therapies as part of their health care services to patients. The medical consultations are then refunded under Medicare (Germov 1999b, Easthope 1998). Other doctors refer their patients to alternative therapists, with whom they have a symbiotic professional relationship. In Melbourne, Victoria University of Technology offers courses in osteopathy and Chinese herbal medicine. RMIT provides courses in osteopathy and chiropractic. In 1998, the Swinburne University of Technology (Melbourne) appointed a professor of 'integrative medicine', to provide accredited courses in alternative therapies for doctors (cf. Easthope 1998).
thereby influence the construction of distinctive clinical realities within the same health care system.

Furthermore, medical systems may be homogenous, different but still integrated, or 'multiple and unintegrated in the same locality' (1980:39).^{108} Within Kleinman's model (1980), illness, disease and sickness are considered to be due to a variety of causes, and not just a single biological factor. There are many explanations for causation of health and ill-health. No specific one is right or wrong. Possible explanations for causality and diagnosis of illness and disease by patient and healer may differ, which together with available resources, will influence the choice and outcome of therapy, and the degree of patient compliance in overcoming illness (Eisenberg 1977, Kleinman 1978, 1984, Helman 1990).

Kleinman's model provides an explanatory framework for medical pluralism, in which health care takes place, health and illness are defined and treated within a cultural context. Preventing ill-health in each sector is also given credence. In theory, the sick individual has three choices of sectors (and their accompanying forms of therapies) from which to seek health care, not just biomedicine in the professional sector. This model recognises and pays much attention to the popular and folk sectors of health care, emphasising the activities of healing and caring, and the specialised knowledge incumbent in each sector. This knowledge is valid and efficacious, and is placed at the same level of importance as that held by clinicians in the professional sector. In the latter, biomedical knowledge is deemed superior to both popular and folk knowledge, and knowledge attached to various forms of alternative medicine such as iridology, acupuncture, osteopathy, naturopathy. These other forms of knowledge are often ignored and dismissed by proponents of professional medicine (as well as state authorities), as irrelevant, illegitimate or 'pseudoscience' (Bartholomew and Likely 1998), despite increasing consultation by laypeople.\textsuperscript{109} The medical profession neglects to consider that within these sectors of alternative health care, treatment of the signs and symptoms of illness and disease does occur effectively.\textsuperscript{110} Causation of ill-health is not confined to the physical mind or body, but also refers to the individual's worldview, and personal understanding and explanation of ill-health within a holistic framework which includes spirituality. More recently, Kleinman (1995b:24) asserts that biomedicine is itself not homogeneous, but is also pluralistic; owing to the diversity of health professionals practising various specialties under the rubric of biomedicine (cf. Armstrong 1983, Atkinson 1995), and an increasing tendency for medical and nursing

\textsuperscript{108} As an example of the latter, is the attendance of individuals of diverse ethnic backgrounds (and hence medical systems) at the local community health centre in an inner city suburb in Melbourne.


practitioners to incorporate complementary modalities into their repertoire of services (Willis 1989b, Easthopc 1998).

In the popular sector, the role of the family, social networks and local community are important in caring and providing support to the individual, both in health and ill-health. In the folk sector, the specialist healer has the predominant role in the diagnosis and treatment of illness and disease. The folk healer shares the sick individual’s worldview and community. Their attempts to achieve therapeutic outcomes result from a harmonious and balanced perspective that is culturally based (Eliade 1964, Hultikranz 1985, Frohock 1992, McLenon 1993, Csordas 1996).

Whilst Kleinman acknowledges the existence of external factors that are historical, environmental, political, economic, regional, and their impact upon local health care systems, his model does not develop a detailed analysis of these factors. Thus the social and physical environmental conditions that predispose towards certain illnesses and diseases, but that cannot be wholly explained by cultural elements, remain unexplored. Ethnic differences are explained as cultural. Structural factors along with class, age, and gender, are acknowledged but are not fully explored to explain differences in patient and healer perception of health and ill-health, and outcomes of treatment.\textsuperscript{99} The role of gender is not fully explored in Kleinman’s model of health care systems, which tends to render all individuals - patients and healers - as gender neutral (Stacey 1988). Thus, there is, a need to turn to feminist and masculinist literature\textsuperscript{100} for an understanding of the nexus between gender and health, and the role of women and men in health care in cross-cultural settings.

Kleinman (1995b, 1998a, 1998b) continues to review his model, and maintains that it continues to offer medical anthropologists a locus to theorise the ‘everyday experience’ of health and illness within the household, the nature and ‘efficacy of indigenous religious healing’ (1995b:10), as well as the ‘moral processes' and ‘ethical discourses' of healing. A critique of biomedicine continues to influence his work, although he has moved away from disease categories and somatization to examining the nature of human suffering. He also incorporates a greater emphasis on political economy in his subsequent work, taking into account the bureaucratic and rationalistic practices of governments as they impinge upon diverse healing practices, and the health and well-being of laypeople.

**MEDICAL DOMINANCE**


Biomedicine, rather than 'Western medicine', 'allopathic medicine' or 'cosmopolitan medicine' is the preferred term by Kleinman (1995b:25) to explain its positionality *vis-a-vis* other forms of healing, 'because it emphasises the established institutional structure of the dominant profession of medicine in the West, and today worldwide, while also conjuring the primacy of its epistemological and ontological commitments'. Furthermore,

It has long been a global institution. It is no longer only Western, either in its site of practice or even in its locus of knowledge production and technological innovation (1995b:25, cf. Good 1994).

However, biomedicine remains a minority approach to healing internationally (WHO 1983, George and Davis 1998).

Freidson's sociological examination of the professions (1970b, 1984, 1985b, 1986) and the medical profession (1970b, 1985a), led to the development of 'medical dominance' theory. Freidson argues the professions occupy an elite position as opposed to other occupations owing to their higher education and social status. Medical practitioners within their profession are elitist, stratified and hierarchical. The medical profession has primary control of medicine and heads the occupational hierarchy of health care labour in terms of gender, class and ethnicity. The clinicians are predominantly members of the bourgeoisie who restrict entry of individuals into the profession. Willis (1989a, 1994) extends Freidson's work by examining medical dominance in Australia in relation to midwifery, optometry, chiropractic and radiology, in terms of 'autonomy', 'authority' and 'sovereignty'.

Firstly, the medical profession has complete autonomy over the practices of its members, through professional bodies such as the AMA, the Royal Colleges of physicians and surgeons, and university faculties of medicine. Although their clinical practice and research are subject to critical peer review, doctors are not accountable to any other agency in society (Zola 1974, Willis 1989a). Secondly, the entrenched hegemony of doctors over other biomedical health professionals (nurses, midwives, pharmacists, physiotherapists, social workers) concerns the rights and duties of each occupation or their 'occupational territory' (Petersen 1994). This also extends to the lesser power of alternative therapists (Waiztkin 1983, Russell and Schofield 1986). Bureaucratic and legal structures support physicians' authority in society (Ehrenreich and Ehrenreich 1974, Willis 1989a). Allied health professionals such as pharmacists, medical scientists, occupational therapists, physiotherapists, social workers, speech therapists and dietitians rely on medical requests or referrals to undertake their work. Many of them are female, conservative and middle class. Nurses require doctors' 'treatment orders' to provide holistic care to patients on a 24 hour basis. Thirdly, 'medical sovereignty' or 'imperialism' of doctors (Zola 1974) entails their knowledge on
health issues concerning society, even if these involve questions of law, ethics and morality (Willis 1989a, 1994, Germov 1998b).

In the following section, I discuss critiques of, and challenges to, medical dominance. I also examine the doctor-patient relationship and propose the term 'patient-healer relationship' as a better way of conceptualising healing relationships.

A Critique: Challenges to Biomedicine

Medical dominance is steadily being challenged from many quarters. Taking a political economy approach, several authors dispute medical dominance theory and assert the medical profession is becoming corporatised, proletarianised, and deprofessionalised (Hicks 1984, Germov 1998a). Similarly, nurses and allied health professionals have challenged medical knowledge and questioned doctors' claims of authority for patient well-being and healing. These critiques are inter-related.

Firstly, in capitalist society, biomedicine is a commodity produced and consumed ostensibly for profit, rather than meeting the needs of a society it is designed to serve. It is difficult for biomedicine to balance community expectations of improved health status, with the capitalist desire for capital accumulation and profits. In turn, profits are sought from the sale of drugs, high technology, health insurance and private hospitals in the market place. and are used to fund 'prioritised' areas of medical research. that will ultimately reap further profits (McKinlay 1977, 1979, Navarro 1976, 1978, 1986, Waitzkin 1979a, 1979b, 1981, Russell and Schofield 1986, Germov 1998b).

Secondly, in Navarro's (1986, 1988) view, the hierarchy of medicine in both State and private enterprise, is determined by the owners of production and is a faithful reproduction of class relations. At the uppermost level are the administrators of capital and funding, who give medicine its corporate or entrepreneurial character. Through increasing rationalisation and bureaucratisation (Weber 1968, Marx 1977) of hospitals and other health care institutions, corporatisation enables managerial control of medical practice by setting political and economic boundaries (Collyer and White 1997). In addition, members of the medical profession are increasingly proletarianised as salaried employees with power secondary to the elite group, but still dominant over all other health professionals (McKinlay and Stockle 1988).

Thirdly, Haug and Lavin (1983) contend the medical profession is becoming deprofessionalised as consumer knowledge is increasing through the mass media. Laypeople as health care consumers also display limited trust in the medical profession. Feminists argue for less intervention in normal and natural life processes that are

---

113 Not all of them are self-employed in private practice.
114 See also Haug (1973, 1976).
medicalised as disease (Broom 1991). Rising consumer complaints are due to patient dissatisfaction and the inability of the medical profession to use its traditional 'curing' skills to 'care' for chronic illness. Various studies report laypeople's concerns of doctors not taking patients seriously, short consultations, poor listening and communication skills. Laypeople have also expressed their disenchantment with the elitist position and lifestyle of medical profession (Little 1995, Sitzia and Wood 1997).

Many sociologists of health and illness and medical anthropologists argue that the medical profession is an 'institution of social control' (Zola 1974). Illich (1977) asserts the medical profession, similar to other professions, is 'disabling' since it undermines laypeople's capacity to help themselves, and limits their autonomy. Furthermore, biomedicine causes 'clinical iatrogenesis', i.e. people become sick, disabled or die due to infection, surgery and drugs as a result of medical intervention. Biomedicine's effectiveness in improving health status, or reducing morbidity and mortality remains debateable (cf. McKinlay 1977, McKeown 1979). Zola's and Illich's arguments are still relevant in the late 1990s, as biomedicine determines the legitimacy of health and ill-health, dismisses laypeople's inter-subjective experiences, disregards the saliency of their health knowledge, and continues to medicalise life processes, including impotence. Biomedicine continues to emphasise health negatively as disease, and remains limited in its ability to redress chronic illness, disability and ailments of unknown aetiology. Human interests are of a second order to technological imperialism (Kleinman 1995b, Sharma 1996b).

Recent studies reveal the increasing consultation of complementary therapists and use of alternative medicines by laypeople. Easthope (1998) suggests alternative medicines are popular in usage owing to: people's search for meaning and for control over one's life, the distrust of scientific experts, the patient-healer relationship is 'personal', and the illness may be of a chronic or terminal nature (potentially fostering a long-term relationship between patient and healer). Other reasons given by laypeople in Australia, Canada, Britain and the United States for their use of this healing option, range from lay and GP referrals to the healer's reputation, and from a holistic approach to belief in efficacy of treatment. These factors suggest an undermining of biomedicine and its claims to improve health status and well-being. The extent to which laypeople consult folk healers in their ethnic communities and mainstream society is poorly documented, in Australia, the United States and in other western countries. The WHO (1983) provides evidence that 'traditional medicine' practised by folk healers, is

115 See also Ehrenreich and Ehrenreich (1974).
efficacious and reduces State costs in providing health care to all citizens, particularly in developing countries.

The media reports of litigation cases reveal the public disclosure of medical negligence by one doctor in one instance has implications for the reputation of and people's 'trust' in the profession as a whole (Dingwall 1994, Little 1995). However, the actual number reaching the courts for a hearing is few owing to out-of-court settlements, for example, international class action cases concerning silicone breast implants and the Dalkon shield intrauterine device. Cook and Easthope (1996:95) argue 'litigation is a double-edged sword: it undermines both the patient's trust in the doctor, and the doctor's trust in the patient'. Whilst private health insurance companies underwrite risk for the 'insured' (largely the chronically ill and the elderly), they are increasing their premiums (Productivity Commission 1997), and 'suggest' to doctors that they regulate their servicing in order to minimise costs.

Bioethicists both assist and question the clinical decision-making of doctors, nurses and other health professionals, on life and death matters: abortion, euthanasia, organ transplants and reproductive technology (Singer 1994). Similarly, institutional ethics committees scrutinise the inclusion of 'human subjects' (and their body parts) in research projects (NHMRC 1992, 1996a, 1998, Daly 1996).

Laypeople, both as individuals and collectively (through self-help groups, complaints units and consumers' health care organisations) are politically active in 'voicing' their concerns and discontent with biomedicine - as a source of knowledge and as a practice (Kearney 1991, Nettleton and Harding 1994, Calnan and Williams 1996).

Nonetheless, despite these multiple challenges to its 'dominance', the medical profession continues to retain a political 'voice', credibility as scientists, and autonomy of clinical decision-making about patients' health status, by providing reductionist and technological solutions to people's suffering (Good 1994, Hahn 1995, Kleinman 1995b, Numbers 1997). The implications of medical dominance theory for this study, given the multiple challenges to the medical profession, are laypeople having to either rely on their own healing abilities, or seek non-medical care from alternative therapists and folk healers.

Patient-healer Relationship and Doctor-patient Relationship

The doctor-patient relationship is problematic on many fronts. It is understood to refer to the unequal power-knowledge relationship (Foucault 1979) existing between two persons of dissimilar social class, gender, age, occupational category and education. In keeping with the 'sick role' (Parsons 1975, 1978), the patient has little or no agency, but is passive and dependent on the doctor (usually male) to make decisions on her/his behalf, and initiate diagnostic and therapeutic procedures on the basis of informed consent. The patient is obliged to actively seek assistance for alleviation of
their ailment. They are also absolved from blame for their sickness and relieved from their work obligations (Gerhardt 1987, 1989). The relationship characterises the medical dominance paradigm whereby the health care system consists largely of biomedical health professionals and health care services, rather than medical pluralism. Biomedical knowledge and practice are privileged, valued, regarded as legitimate and, socially and legally sanctioned. Within the medical dominance framework, healing takes place in a formal public setting of the hospital or the clinic.

I contend the term 'doctor-patient relationship' is narrow and outdated. It is far better, to consider the health care system comprising of many healing modalities. All knowledge and practices, their efficacy and power to heal are equal. This does not assert that one is better than the other, but rather that they all have the potential to heal. I propose a new term: patient-healer relationship. Table 2.1 presents an outline of differences between the doctor-patient relationship and the patient-healer relationship.

<table>
<thead>
<tr>
<th>Table 2.1: Healing Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor-Patient</strong></td>
</tr>
<tr>
<td>Biomedical dominance</td>
</tr>
<tr>
<td>• health care system consisting</td>
</tr>
<tr>
<td>solely of health</td>
</tr>
<tr>
<td>professionals and health care</td>
</tr>
<tr>
<td>services</td>
</tr>
<tr>
<td>Biomedical knowledge &amp; practice</td>
</tr>
<tr>
<td>is privileged, valued,</td>
</tr>
<tr>
<td>legitimate</td>
</tr>
<tr>
<td>Unequal power relationship</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Patient with little or no agency</td>
</tr>
<tr>
<td>• dependent on doctor to make</td>
</tr>
<tr>
<td>decisions</td>
</tr>
<tr>
<td>• informed consent</td>
</tr>
<tr>
<td>Healing takes place in a public</td>
</tr>
<tr>
<td>setting</td>
</tr>
<tr>
<td>Doctor and patient are often</td>
</tr>
<tr>
<td>of dissimilar social class,</td>
</tr>
<tr>
<td>gender, age, ethnicity,</td>
</tr>
<tr>
<td>occupational</td>
</tr>
<tr>
<td>category, education</td>
</tr>
</tbody>
</table>

My reasons for preferring to use this term are as follows. Firstly, anybody can be a patient. Illness and injury are inevitable and unpredictable, are features of the human condition, and cross 'marked identities' of gender, ethnicity, social class, sexuality and age (Kleinman 1998b). Secondly, anybody can be a healer and provide healing for

---

118 Budd and Sharma (1994) use the term 'patient-practitioner relationship'. Whilst other writers, following a market model of health care, prefer to describe patients as 'clients', 'consumers', 'customers' or 'service users' (cf. Sitzia and Wood 1997).
119 Many biomedical health professionals and social scientists have written of their experiences of illness,
someone else, according to their knowledge, confidence and abilities. Thirdly, this term extends the generally accepted construction of who is a patient and who is a healer. The patient is the sick person requiring healing, whilst the healer is one who heals another person of their ailment, that may be of a physical, mental or spiritual nature. Fourthly, the term 'patient-healer relationship' also questions the nature of that relationship. Here, decision-making for diagnosis and treatment of illness-injury has a greater chance of being joint - informed or shared - with patients having the potential to exercise agency and being primary decision-makers (Wood 1996, Charles et al 1997). They can be seen as 'agentic selves' determining the healing option best suited to their condition. Healing may occur in two settings: public or private. The patient and healer may be of similar or dissimilar social class, gender, age, ethnicity, occupational category and education.

At a time when the importance of lay knowledge for public health is starting to become acknowledged,\textsuperscript{120} and multiple interest groups are placing pressure upon the beleaguered medical profession, to avoid over-servicing and questionable clinical and research practices,\textsuperscript{121} it is perhaps timely to consider that biomedicine - and its practitioners - remains one form of medicine amongst many. It has a place in healing, but it is no longer the pre-eminent one (George and Davis 1998).\textsuperscript{122} Acknowledging the presence of medical pluralism is a theoretical and methodological step forward within the social sciences.

Having discussed the macro 'picture' of health care provision and the locus of lay healing practices within this picture, in the following section, I debate salient notions of the family and household, and discuss the 'household production of health' at the 'micro' level. The household is both the setting for lay healing practices, and the unit of analysis in this study.

THE 'HOUSEHOLD PRODUCTION OF HEALTH'

Family and Household

The social sciences consider the family and household to be the smallest units of social groups for analysis, beyond the individual level. Sociologically, the family is viewed in terms of socialisation, and the social roles and responsibilities of each family member (Edgar 1997). The Australian Bureau of Statistics (ABS 1998a) defines 'family' as 'two or more people living in the same household who are related to each other by blood, marriage, de facto partnering, fostering or adoption'. Whilst Edgar (1997:322) asserts 'the family links people across time, through blood ties, in a shared

---

\textsuperscript{120} See Dean and Hunter (1996), Popay and Williams (1996).

\textsuperscript{121} This is frequently argued by doctors as a measure to avoid litigation. 'Defensive medicine' is practised rather than 'good medicine' (Little 1995).

\textsuperscript{122} Navarro (1988) argues that biomedicine is neither dominant nor proletarianised.
culture of family meanings, symbols and rituals in ways that no household of unrelated people can do. Age, gender, ethnicity (language, country of birth, ancestry, period of residency), family structure (presence/absence of children, number and ages of children), religiosity, and social class (education, income, occupation) reveal much about the socio-demographic composition of families and their social position. Economic studies of the household address sexual and age division of labour, time use, resource allocation, household income and expenditure. The household is a discrete economic unit of production and consumption of commodities. Households, or domestic groups, are groups of people who live together and form functioning social and economic units; their members are not necessarily related by marriage or blood (Brower 1989:476). The ABS (1991b) defines ‘household’ as ‘either a person living alone or people who usually reside and eat together. A household resides in a private dwelling’. Anthropologists take a broader perspective, and deem kinship and social relations as the basis for all other relationships that are economic, political and religious. Exchange and reciprocity are seen as integral to all relationships. Individuals do not exist alone, separate from others. They have consanguineal, affinal and social relations with members of their families, social networks and local community. Korten (1997) uses the term ‘social economy’ to describe the social relations and activities.

Both women and men are carrying out most of the productive and reproductive activities through which people meet their basic needs for food, shelter, clothing, childcare, health care, care of the elderly, housekeeping, education, physical security, and entertainment. Social economies are by nature local, unwaged, nonmonetized, and nonmarket. They are energised more by love than by money (Korten 1997:44-45).

The United Nations (UN) (1993, 1996) in the lead up to the International Year of the Family (IYF) in 1994, examined family structure and function from a global perspective. It identified the following ‘basic functions of families’:

(a) Establishment of emotional, social and economic bonds between the spouses;
(b) Procreation and sexual relations between the spouses;
(c) Giving name and status, especially to the children;
(d) Basic care of children and, in many cultures, of the elderly and relatives with disabilities;
(e) Socialisation and education of the children, and even of the parents;
(f) Protection of the family members;
(g) Emotional care and recreation of the family members;
(h) Exchange of goods and services (1993: 4).

The UN (1993) recognises various family arrangements: nuclear (biological, social, one-parent, adoptive and in vitro), extended (three generations, kinship, tribal and

---

polygamy) and reorganised (remarriage, community living and same gender). The National Council for the International Year of the Family (Australia) (1994a:7) takes a broad view of the family - recognising its diversity in time and place, responsibilities, locus of caring and nurturing and the need for greater support to the family, to reduce the incidence of stress (violence, abuse, marital and family breakdown, dislocation, poverty) experienced by families.

The terms 'family' and 'household' are problematic for their fluidity of settings in time and place (in western society, Third World countries and small scale societies), life styles, patterns of social relations (nuclear family, sole parents, homosexual marriages, single adults), mobility and age of members (generational, stage of the life-cycle), income, migration (travelling for work to provide for and/or contribute to the household) and development of fictive kinship and social bonds with others (neighbours' children, adopted aunts and uncles, who become like one of the family) (Brown 1989, Berman et al 1994, Hartley 1995, McDonald 1995).

There are three major assumptions in our society and within the health care system concerning the 'family' and its role in health care. Firstly, it is assumed that the average ('intact') family exists and consists of a woman and man (either married or in a de facto relationship) with approximately 1.9 children (ABS 1998a:29). A second assumption decrees that the family is a support system. That is, the family is a single and integrated unit capable of providing essentials for living such as food, shelter, clothing, etc. as well as meeting the social, emotional and spiritual needs of all its members. Thirdly, it is expected that there is somebody at home to provide voluntary and unpaid care for the sick, children, older persons and the disabled (Peerson 1992, Summers 1994). These are assumptions. Numerous studies and statistics attest that the family for many people does not exist: it is not a support system with somebody at home, available on a continual basis, and nor is the family always 'a haven in a heartless world' (Lasch 1976, cf. Hartmann 1987). For example, domestic violence fails to ensure the health and well-being of household members.

Health professionals and services continue to make these assumptions and rely heavily on the family to fill in the gaps of service providers. For instance, it is assumed that when a person is discharged from hospital, there is somebody (usually a woman) at home to provide convalescent care which may include wound dressings, insulin injections, medical checkups or adherence to a special diet. In the current social and

---

124 The ABS (1998a:49) defines the 'intact family' as: 'A couple family containing at least one child who is the natural or foster child of both members of the couple, and no child who is the stepchild of either member of the couple. Intact families were only identified if they contained at least one child aged 0-17 years'. Intact families are commonly called 'nuclear families'.


127 Australian casemix measures for funding public hospitals and ambulatory care, using diagnostic-related groups (DRGs), has various implications for women and men as lay healers in the home. This was
economic circumstances in Australia, this concept is a myth. Despite a recent recession (1992-93), women's greater participation in the workforce suggests that they will be less available, as many work part-time and also undertake voluntary community work (Bittman 1991, ABS 1994a, 1994b, 1998b). It cannot be assumed that women will have the time and energy - personal resources - to undertake further tasks. Clinton (1996), Kilmartin (1996), Raphael and Sprague (1996), and Edgar (1997) agree upon the importance of governments at all spheres - Commonwealth, state, local - ensure that families, and women and men in their roles as parents and as lay healers, have access to support services.

A growing trend in Victoria is the 'hospital-in-the-home' (KPMG 1995, 1996). Laypeople are being taught by health professionals how to use health technology to improve or maintain health status of a family member. Individuals are expected to employ high technology equipment responsibly, know what to do in an emergency, and have an understanding of the principles of asepsis, sterility and cleanliness. The theoretical component of their hospital-in-the-home practice is essential for the maintenance and use of this equipment and related therapies to prevent infection and exacerbate illness or injury. Examples of these activities are management of diabetes, haemo- and peritoneal dialysis, ECG and blood pressure monitoring, giving analgesia, and wound care. Laypeople perform this 'labour' on an unpaid, informal basis in the privacy of their homes.

'Household Production of Health'

Health itself is not a commodity, since it cannot be exchanged, bought or sold, despite its value in use. Health care, however, is a commodity, consisting of various goods and services produced and consumed according to the nature of the demand and supply relationship (Evans and Stoddart 1990). Inputs such as capital (buildings, technology, institutions) and labour (health workforce) produce health care. The expected output is improvement in the health status of individuals and populations as measured by several indicators (AIHW 1998). All resources involved in the production and consumption of health care are ascribed an economic value. Economists frequently argue that resources are finite, and that the value placed upon them should reflect their

already forecast by Mary Draper (Health Issues Centre 1992) prior to the actual introduction of this policy for Victorian public hospitals, on top of substantial funding cuts, in July 1993. Draper argued that whilst early hospital discharge practices are a means to increasing patient throughput and hence revenue, they also place enormous pressure on families to provide lay healing sans adequate resources (social, physical, psychological and financial). Unnecessary readmissions, under a different DRG at an alternative health care agency, are likely to occur, as families are unable to cope with the additional demands placed upon them. (Informal discussions with my nursing colleagues reveal this is happening in Victoria. Patients are re-presenting at doctors' surgeries and at hospital accident and emergency departments with post-surgical infections, haemorrhages and wound break-downs requiring urgent treatment).

126 See Peerson (1991), McKenna (1997).
market value. These finite resources are budgets, time and energy. That is, an equilibrium exists between demand and supply (Sax 1990, McGuire et al 1992).

From a health economist's point of view, how laypeople provide health care within the household has implications for their use and purchase of health care services outside the household. Within the household, laypeople are both producers and consumers of health care.\textsuperscript{129} Health inputs from outside the household vary according to the individual and the household, for example, nursing care and home remedies. Therefore, pertinent to this study are questions about: household inputs (socialisation, culture, values, knowledge and socioeconomic status); the type, distribution and substitution of health care services provided within the household; and, the resulting health outputs (morbidity, mortality, quality of life and well-being) (Thomas 1995, Mokyr 1996a, 1996b).

Harris (1993) asserts greater attention to 'household and residential organisation' or HRO (developed by Mullins and Short [1992]) will 'provide a focus on household economy and residential area and the social relations which exist within and between each' (Harris 1993:23). Of importance are: 'the ways people organise their households and residential areas'; the distribution of material resources within households to meet their needs; how they consume goods and services (including those relating to health and well-being); and, their 'patterns of physical space' (Harris 1993:24). Mullins (1995) further explores the inter-relationship between households, consumerism and residential mobility/development. He notes researchers and policymakers have overlooked the importance of the household as a locus for economic, social and political activities, with greater emphasis being placed upon the public sector and formal economy. Waring's (1988) feminist critique of national accounting systems of New Zealand and elsewhere reveals an exclusion of the informal (household) economy - which includes women's unpaid labour - black markets and the environment (cf. Ward 1993). Ironmonger (1994a, 1994b, 1995, 1997a, 1997b)\textsuperscript{130} has undertaken substantial economic modelling and compiled statistical evidence on the household economy of Australian and other industrialised countries. Both Waring and Ironmonger consistently argue for the imperative of paying greater attention to unpaid labour, time use and resources - such as energy, leisure, childcare - with the household as a unit of analysis. To date, this still largely 'counts for nothing' (Waring 1988, 1996). P. Short (1996) has more recently examined data from the 1990 survey of HRO in Brisbane, in terms of kinship and social relations, and how these impact upon the inter-household transfer of resources between household members, and consumption of goods and services. P. Short concludes that 'informal economic relations' (or the 'interhousehold economy') are based on reciprocity and kinship obligations. These in turn may be constrained or

\textsuperscript{129} See Broom's (1998a, 1998b) critique of 'women as consumers, men as providers in health care'.

\textsuperscript{130} See also Ironmonger et al (1995).
disrupted by 'forced transitions' such as 'invalidity', 'changing employment', 'residential or occupational relocation or household breakup' (1996:142-44).

Following earlier work in micro-economics (Da Vanzo and Gertler 1990), and as a means of reducing the gaps between health care and the social sciences, and between policies, programs and research, Berman et al (1994:206) 'propose the possibility of developing a program of applied studies to understand the process by which inputs to households become outcomes in terms of health improvements'. The 'household production of health' (HHPH) would be 'an integrating concept for motivating and organising the thinking of a variety of disciplines which seek to shed light on the determinants of health and health change' (1994:206). They define the household production of health as:

A dynamic behavioural process through which households combine their (internal) knowledge, resources, and behavioural norms and patterns with available (external) technologies, services, information, and skills to restore, maintain and promote the health of their members (1994:206).

The emphasis is upon the multiple activities, mechanisms and resources employed by households to promote and maintain health, and prevent illness, rather than poor health in terms of single diseases. Health knowledge plays an important role in household members' decision-making about their well-being as individuals and as a household unit. Furthermore, intra-household behaviour is linked with health outcomes, in terms of the macro social and economic environment, the health care system overall (ie. the availability of public health facilities), and health producing behaviours, such as hygiene, food preparation, self-care. Collectively, these factors will contribute to the household health outcomes as measured by morbidity and mortality, quality of life and well-being indicators.

This concept is markedly different from previous studies in micro-economics which tended to separate household consumption and business production as two distinct settings accompanied by specific activities. Households do not only produce; they only consume goods and services (commodities). The 'new household economics' (NHE) has sought to overcome this hiatus by pointing out 'that households do not purchase or procure commodities like they do "goods"'.

Rather they produce commodities by combining procured goods and their own time and capacities. In other words, households demand goods and services in order to use them, within some type of household 'production' process, to produce the final products desired by them, the actual sources of their satisfaction (Berman et al 1994:209, authors' emphasis).

Having healthy children, for instance, is for most families/households a source of satisfaction.
The inputs to producing healthy children include food and feeding behaviour, willingness to seek health care for both prevention and treatment, clean water, an uncontaminated household environment, care and attention, etc. All of these inputs require household application of time, skills, and sometimes purchased goods applied through household patterns of behaviour. Different combinations of these inputs might produce equally healthy children (Berman et al 1994:209).

There are constraints on households to produce healthy members regardless of their age, gender and health status. The decisions household members make to produce health on a daily basis, amidst constraints of available labour, income and resources, also produce opportunity costs of doing something else - buying a new car, going on a holiday overseas - which may also be important for the household production of health.

Despite its immediate appeal, this recent view of micro-economics has encountered a few problems. Berman et al (1994:210) remark upon:

The appropriateness of a model of household choice being applied to poverty households, where choices are likely to be highly constrained ... little attention to cultural determinants and individual preferences which affect choice ... [and] assumptions that households make choices or decisions (emphasis in original).

Berman and his colleagues assert that these assumptions can be overcome by using, instead, the HHPH model.

Understanding cultural factors influencing behaviour as well as macro economic and structural factors influencing and constraining the household economy are important to development [ie. public health] efforts at the national and international level, and essential for overall improvement of child health (Schumann and Mosley 1994:201).

Research that is multi-disciplinary, quantitative and qualitative would shed light on: i) household definition, structure, and function and its implications for health; ii) illness perception, definition, labelling, and meaning; iii) inventory and description of the range of household health-producing and maintaining behaviours and analysis of their health effects; and, iv) the determinants of health-producing behaviour within the household economy including time use, allocation of work and household expenditure on health (Berman et al 1994:213-4).\(^{131}\)

These four areas are the subjects of this research project which examines women and men as lay healers promoting health and preventing illness-injury for themselves in the household setting, of the popular sector of the health care system. In exploring the household production of health, I wish to expand Berman et al's model (1994) to include questions of how health is protected.\(^{132}\) This entailed asking participants in the

---


\(^{132}\) Health economists would ask: how is health invested? The World Bank (1993) takes a macro-level examination of international and national efforts to improve child health, and argues that greater government investment in low-cost measures (immunisation, women's education and employment,
study, parents of young children, questions about health education, health promotion, illness-injury prevention, diagnosis and treatment of illness-injury, and household economy. The resulting data elucidate lay health knowledge and decision-making inside the household. In the following section I discuss theoretical positions on the human body, gendered embodiment and constructions of risks to embodiment by households and public health.

EMBODIED SELF, RISK AND GENDER

Embodiment

The body has gained increasing prominence in social science literature in the last two decades, in recognition of the shifting boundaries between Nature and technology (for example, developments in organ transplants, IVF, genetic engineering, and the impact of bionic body parts on the ageing process).

The body and self were described as reflexive aspects of one wholeness, one 'being'; neither complete without the other (Saltonstall 1993:9).

Everyday existence consists of a series of 'attentions' to the body (Turner 1984, 1992, Shilling 1993). Using our lay knowledge, we make decisions to promote our health and prevent an illness or injury. Those individuals who have recently experienced a chronic illness, a disability or life-threatening condition are in the throes of reconstructing their embodied selves. I include also those persons who have experienced a major life crisis such as divorce, migration, poverty, death of a spouse or child, torture and unemployment. We constantly assess and negotiate innumerable risks to our bodies, for example, a potential cold, gastro-intestinal infection, a broken leg, and endeavour to minimise those risks. As individuals and as a population, improving our health in terms of morbidity, mortality, well-being and quality of life requires vigilance and regulation (Turner 1992, Petersen 1997). Not only are we all taking care of our bodies, diagnosing and treating illness-injury, thereby practising lay healing, we are also lay healers. We are doing what people around the world have been undertaking for centuries in a variety of settings.

This self-healing and health promotion in the lay sphere raises important historical, anthropological, sociological, economic and philosophical questions about improved maternal health) will lead to a marked decrease in child morbidity and mortality. To support its arguments, the World Bank uses DALYs indicators as measures of ill-health (not QALYs). For an Australian perspective on health promotion, the NHMRC (1995:i) states: 'a healthy population is a basic requirement for national economic development. The investment in healthy people and a healthy society, therefore, has wider implications for a nation's future'. The Jakarta Declaration (WHO 1997) calls for an investment in health rather than in health, as recognition of other sectors and their impact upon health. These views of health as an investment are economically oriented. Health as a personal and social investment is not considered important. Similarly, the everyday life context of providing health care in the household by laypeople is absent, as well as lay discourses on health promotion and illness-injury prevention as an investment.
lay responses to altered bodily states in general, and about the power-knowledge relationship underlying lay healing in particular. Academic interest in the nexus between the human body as a biological entity of anatomy and physiology, and portrayed or represented in a socio-cultural context is increasingly evident.

Bodies in their own right, as bodies, do matter. They age, get sick, enjoy, engender, give birth. There is an irreducible bodily dimension in experience and practice; the sweat cannot be excluded (Connell 1995:51).

The physical, material, and visceral reality of the human body - its blood and sinew, flesh and bones - is undeniable (Sharma 1996a).

Both medical anthropologists and sociologists of the body have laid claim to this interest, placing the body at the centre of discourse. A human being has a body, does a body and is a body. The body is active not static, within and outside of medicine, grounded in society and culture, in time and place. It is also a 'text' that is read, gazed upon and touched by others. The body has come to be talked about in a variety of ways. The body is 'corporeal' and 'mindful', 'gendered' and 'ageing'. It is 'flexible', 'volatile' and 'perfectible'. The body is the means and medium of life: it lives and dies. It is enabling and/or limiting. That is, the body may be 'physically able or disabled', 'normal, pathological and deviant', 'sacred and profane'. At times, the body is invisible, silent and docile (Foucault 1973, 1979, Murphy 1987), whilst conversely it is also a visible, voiced and autonomous self (Foucault 1981). Furthermore, the 'individual body', 'social body' and the 'body politic' also 'embodies rights', is 'property', and constitutes a 'nation state'. Particularly aspects of the body's anatomy and physiology, such as the hand, teeth, respiration, nervous system, sexuality and reproduction, immunity and genes, as well as beauty, the senses, imagination and emotions experienced by the embodied self have also been documented.

These descriptions and theoretical musings about the body cross the boundaries between biomedicine and the social sciences. Douglas (1966, 1970) calls for an inclusion of embodiment into social theory, asserting that social behaviour could otherwise not be accounted for. Early studies of the body by Mauss (1973) and Blacking (1977) focused upon 'techniques of the body' (its capabilities and constraints).

---

and 'communication'. However, the classical and modern traditions in sociology have been largely disembodied. Turner (1992, 1994a) claims that a sociology of the body provides a much needed theoretical basis for sociology in general, and medical sociology in particular. He asserts:

the sociology of the body enables us more clearly to understand the relationship between illness as a loss of identity, the psychological transformation of personhood which often results from major illness, and the importance of body image to well-being (1992:167).

Furthermore, Turner (1994a:14) argues:

we cannot separate the idea of the self as a project from the body as a project since the authenticity of the self is necessarily bound up with the production of the body as a reflexive subject ... it is the surface of the body which is the mirror of the self. These very general questions about identity and the self lie at the theoretical core of the contemporary debate about the sociology of the body in advanced societies. These debates are inextricably bound up with the question of modernity and postmodernity (cf. Giddens 1991, Slater 1997).

Within sociology, the social constructionist argument predominates (even by those who claim to be sociologists of the body) so that the corporeality of the body remains elusive (Giddens 1991, Turner 1992). However, Shilling (1993) argues that the body has had an 'absent presence' within social theory.

Medical anthropology has been more willing to put the body at centre stage of discussion on health and ill-health. In particular, Kleinman (1995b, 1998a), Lock and Scheper-Hughes (1990), Singer (1990c), Csordas (1990, 1994), and Strathern (1994, 1996), focus on the cultural meanings of embodiment. Becker (1995), Lambek and Strathern (1998), provide examples of embodiment from Fiji, Melanesia and Africa. Whilst Scheper-Hughes and Lock (1987:7) assume the 'body as simultaneously a physical and symbolic artefact, as both naturally and culturally produced, and as securely anchored in a particular historical moment'.

Insofar as emotions entail both feelings and cognitive orientations, public morality, and cultural ideology, we suggest that they provide an important 'missing link' capable of bridging mind and body, individual, society, and body politic (1987:28-9).

The study of emotions, medical anthropologists argue, would address pain, suffering, disability, disembodiment, depression, rituals, language, social relations, placebo and nocebo effects. Sharma (1996a) calls for the development of anthropologists' 'cultural imagination' in their study of the human body. Lock (1993a) reviews the published work on the body in anthropology, particularly of scholars who seek 'to situate the body

142 Sharma (1996a) argues that anthropologists ground their theory and empirical research on the body within cultural specificity; by paying attention to the importance of imagination in healing.
as a product of specific social, cultural, and historical contexts; who have engaged the nature/culture or mind/body debates in a substantial way' or who have 'grappled with the poetics and politics of the production and reproduction of bodies' (1993a:134, cf. Strathern 1996). Lock (1993a:134) is wary of 'universal truths, entrenched power bases, and intransigent relativisms' which make difficult a cross-cultural understanding of human beings, their bodies and their selves (cf. Singer and Baer 1995).

My own inquiry sites the body as a trinity of the body, mind and spirit (Deliman and Smolowe 1982) at the centre of lay healing. Furthermore, the body is the locus of life and death, of being and personhood, of representation of the self to others, of sacredness and profanity, and of lived experience (Goffman 1959, Douglas 1966, Toombs 1987, Seymour 1989, Turner 1992, Saltonstall 1993, Illich 1994).

**Embodied Healing**

To heal someone, is 'to perform or effect a cure', 'to make whole or sound in bodily condition', 'to restore to health' and 'to recover from sickness or a wound' (Simpson and Weiner 1989: Vol.VII:52). When we are ill or injured, the aim of healers is to heal the body from a damaged state to one of integrity. Achterberg (1990:194) asserts:

> Neither healing nor curing is something that one person does to another. Instead, both terms refer to internal processes reflecting a more basic definition of health which implies harmony and wholeness (cf. Deliman and Smolowe 1982).

In this section I discuss the process of healing: involving time and social relations whilst reconstructing the embodied self that has become altered or damaged in some way.

Healing as a process or 'making whole' encompasses a series of events or 'acts' (Sacks 1984:181). Healing involves three stages: repair, recovery and re-entry, and the individual moves from a state of passivity to increasing activity. Recovery has two sub-stages of passive convalescence and active rehabilitation (Sacks 1984). The anthropologists, Arnold van Gennep (1965) and Victor Turner (1967, 1974), might regard these stages as 'rites of passage', whereby there is a set of rituals performed and movement from one state of being to another. The stage of recovery could be considered a 'liminal' state (with 'transitional' rites), for it is 'betwixt and between' the stages of repair ('preliminal' with 'separation' rites) and re-entry ('post-liminal' with 'incorporation' rites) (Morris 1987:247, cf. Murphy 1987). Recovery occurs once healing is initiated and before the sick person takes up her/his place in the world. Table 2.2 presents a schematic view of the process of healing.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Repair</th>
<th>Recovery</th>
<th>Re-entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>Passive</td>
<td>Increasingly active</td>
<td>Fully active</td>
</tr>
<tr>
<td>Aim</td>
<td>Restoration of function</td>
<td>Regain function and mobility, and a sense of self, in readiness to rejoin the world</td>
<td>Importance of spontaneity and re-learning how to perform tasks</td>
</tr>
<tr>
<td>Examples</td>
<td>First aid, surgery, medication, pastoral care, counselling</td>
<td>Rest, respite, immobility, non-activity, thinking</td>
<td>Learning to walk, dress and feed oneself with or without aids</td>
</tr>
</tbody>
</table>

Repair enables restoration of function, joining of tissues and replacement of organs and body parts through first aid, surgery and medication. Recovery involves regaining function and mobility, and sense of self, in readiness to rejoin the world. Spontaneity and re-learning are essential to performing basic tasks. The passive non-active state of rest, respite, immobility and thinking, is crucial to the increasingly active state of learning to walk, dress and feed oneself, with or without aids. Re-entry refers to the resumption of previous concerns or taking up new activities. The individual is more enlightened about her/his embodied self with insight gained from the ontological experience (Sacks 1984, Murphy 1987).

Sacks speaks of the period of repair as being in a state of 'moral infancy'. 'One had to regress' (1984:165, emphasis in original). Convalescence can mean being in a liminal state. One feels in limbo, dependent upon others, their kindness and assistance. The need for a safe place to convalesce is both social and physical; a necessary a priori to the resumption of tasks, activities and responsibilities of the world. The process of recovery involves the challenge of reclaiming damaged capacities, the acceptance of those which have been lost and the joy of exploring new ones (Tony Moore 1992:xiii). Sacks claims that whilst improving the function of his own injured left leg with rehabilitation he encountered 'the need for growing up' (1984:166) before being able to reassume 'adulthood' in his re-entry into the medical profession. Achterberg (1990:194) contends 'through the healing process, a person may be more whole, more harmonious, or more "well" than before, having gained strength and insight. Disease or suffering, in fact, may be regarded as critical events in the path

---


The current exploratory view of the healing process does not take into account the period of illness or injury, its severity (i.e. life-threatening, acute, chronic, disabling, rapid recovery) or co-morbidities (i.e. co-existing conditions such as diabetes, cardiovascular disease, emphysema), and it requires greater inclusion of mental health and spiritual well-being. Therefore, the model I propose requires further development to include these factors.

Reconstruction of the Embodied Self

Lay responses to altered bodily states, are not only occurring to the physical body, but also to the body as a whole entity that is physical, mental and spiritual. Subjectivity means coping with the loss of embodied self that existed pre-illness or injury, and endeavouring to reconstruct oneself. Recovery from physical illness or trauma and life crises may bring to the surface a sense of disembodiment, accompanied by feelings of dislocation, fragmentation and disintegration. It is like having a body but not being that body; as if the body does not belong to the self. The self and body are discontinuous; separated from one another; foreign, extraneous (Sacks 1985). Melancholy, sorrow, grief and mourning for the remembered previous whole self are part of the reconstruction,\textsuperscript{144} as well as pain and suffering.\textsuperscript{145} The process of healing, accompanied by the individual’s embodied knowledge, becomes important for the repair, renewal and re-shaping of the embodied self, to overcome fear, despair and powerlessness, to face the world on renewed terms with dignity, courage and faith (Kelly 1992, Thomas Moore 1992, Duff 1993).

The exterior of the body is the medium by which the individual is represented in public. The self is continuously constituted in face-to-face interaction. Most people have a large repertoire of techniques to change their appearance to an image they wish to present to others (Seymour 1989:98).

Changes to one’s physical being may result from radical surgery involving removal or alteration to major organs, amputation, plastic surgery or prosthesis. Improving one’s physiological processes with a mitral valve replacement, liver transplant, or haemo- and peritoneal dialysis may be vital life-saving measures, whilst others with cancer may suffer hair loss, anorexia, nausea, diarrhoea, skin rashes as side-effects of chemo- and radio-therapy. As a result of these ‘bodily alterations’ (Seymour 1989), the external physical self may manifest visible anatomical changes (scars, weight gain, lumps) as well as changes in appetite, lifestyle, mobility. These in turn


may effect the internal body's physiology and the self that is invisible to the naked eye. The individual is nonetheless, acutely aware of these changes, and their effects upon their relationships with significant others and within wider society. Goffman (1963) discusses in detail the stigma of having a 'spoiled identity' and the 'degradation ceremonies' which occur within the hospital and the home.

Visible changes to the embodied self may impact upon significant others, and these effects may vary by gender and age. Their love, care, attention and 'emotional labour' will assist the reconstruction of self. They are also affected by the changes they perceive in oneself, whilst healing. Additional resources for healing may be prayer, 'magic words', symbolism through myth, archetype and metaphor, imagery and ritual, and order. Embodied healing is a gendered experience. Women's and men's perspectives on health and ill-health also convey notions of femininity and masculinity when 'healthy' and 'unhealthy'.

Gendered Embodiment

Feminist critiques abound of masculinist perspectives of the body, health and ill-health. Firstly, women's bodies were historically and popularly represented as deviations from the norm: male bodies. The influence of the women's movement (particularly the radical feminists) proclaimed a consciousness that women's bodies are inherently different to that of men's in structure and function. The majority of studies on ill-health predominantly used men's bodies, health or ill-health status as the 'golden standard' - with which women were unfavourably compared - for health care decision-making; ie. biomedical diagnosis and treatment (Broom 1992, 1998b).

Secondly, biomedical sciences treatment of women's bodies by a predominantly 'male' profession meant that women's concerns about their bodies and health often went unheard, and were disregarded as 'authoritative' (Sargent and Bascope 1996, Jordan 1997). This had particular implications for the medicalisation of normal and natural life processes of fertility, pregnancy, childbirth, menstruation and menopause. In other instances, feminists have critiqued biomedical treatment of breast, cervical, uterine and ovarian cancers, and the development, use and 'success' of reproductive technologies such as in vitro fertilisation and genetic engineering. The portrayal of women's

sexuality within the specialties of obstetrics and gynaecology has also been scrutinised (Emerson 1973, Scully and Bart 1978, Findlay 1993, Koutroulis 1990).

Thirdly, where gender was perceived as a key factor in health and ill-health, it was largely measured in terms of morbidity and mortality rates, and differential use of health care services. More men die sooner than women, who live longer and experience more sickness, and are more likely to consult a healer, and be consumers of health care services. Doyal (1994), Eckermann (1994b), Macintyre et al (1996) and Broom (1998a, 1998b) question this generalisation. They argue it is imperative to disaggregate the data in terms of the individual's gender, age (or stage in the life course), ethnicity, and time and place. The most commonly cited explanations for observed gender differences in health include: biological risks, acquired risks, reporting biases, and differential use of health care services (Macintyre et al 1996). 'Women are the consumers of health care owing to their 'greater tendency to consult, and to take medication ... [and to] sex differences in illness behaviour' (Broom 1989:123, cf. 1992, 1998a). As a result of these critiques and women's collective lobbying and advocacy, women's health services were government funded in Australia, and a national women's health policy and program were implemented.152

Theoretical analysis of men's health, and statistical and data collection of specific men's health issues remains limited (cf. Fletcher 1994, 1995, Mullen 1993, Pinnock et al 1998). Men, as part of the men's health movement and the men's movement - a nascent history - are asking themselves questions why so many men commit suicide, pursue risk-taking behaviour, and delay seeing a healer for diagnosis and treatment of ailments until it is too late (Fletcher 1994, 1996, Edgar 1997). The evidence on men's health to date indicates that 'when men do present at health services, they are usually in a crisis situation' (Pease 1997:37), due to: i) the association of masculinity with strong physical bodies; ii) the physical and social experience of ageing;153 iii) limited knowledge of their bodies' anatomy and physiology; iv) difficulty in making a distinction between what is normal and abnormal bodily states; and, v) being unable to 'read the all-is-not-well signals' of their bodies (Pease 1997:37-39).154 Furthermore, men's mental health and exposure of their feelings towards others remains a public health problem, having implications for their relationships with significant others (NHMRC 1995b).

Fletcher (1995:11) argues that 'embedded within the call for attention to men's health is the call for attention to the male aspects of the construction of gender.' Broom (1994:404) contends: 'when pursued constructively, attention to men's health will help

154 See also Commonwealth Department of Human Services and Health (1996a), Margo (1996).
us to understand that gender is potentially relevant to everyone's health, not just women'. Broom (1998b) asserts gender and health should be understood in terms of 'multiplicity not duality' and, historical and cultural 'specificity not singularity'. Eckermann (1994b) proposes all health status indicators should be 'gender sensitive' and 'gender specific'. Doyal (1994) and Broom (1998a, 1998b) argue against a universalistic notion of women and men as being all the same: there is a need to recognise the diversity of women and men in terms of their socio-economic status, age, race and ethnicity, sexuality, exposure to hazards, and the gendered division of labour, which will have an impact upon their health status.155

Defining and Negotiating Risks to Embodiment

What is risk? How is it defined? Who defines it: public health experts, laypeople, scientists, doctors or government policymakers? The sciences monopolise definitions of risk. Scientists tend to assume an empirical accuracy in defining risk through rationality, and yet knowledge of risk is imperfect and continuously contested.156 Assessing risk becomes difficult for laypeople, as 'much of the information we receive in the public media about safety and threat is contradictory, sporadic, incomplete, or slanted to protect vested political and economic interests' (M. Clark 1993:238). Consequently, the withholding of information has proved to be a great risk to the individual concerned, particularly when they are faced with life-threatening conditions (cf. Coney 1987, Garrett 1995, Kennen 1996).

Beck (1992) argues that contemporary society is a 'risk society', whereby individual agents and institutional structures everywhere, examine and assess risks within law, medicine, ecology, work, etc., and weigh them up, making decisions about their own risk-taking behaviour. He defines risk as: 'a systematic way of dealing with hazards and insecurities induced and introduced by modernisation itself' (1992:21). The risks may be actual or potential, visible or invisible, irreversible and long-term. Owing to their multiplicity and proliferation accompanying industrialisation, globalisation and technological advancement, it has become more difficult to calculate what constitutes a risk and what does not, and pre-determine the outcomes of exposure to 'known' risk factors. There are differences between lay and 'expert' perceptions of risk, for instance, about lifestyle, food and environmental hazards.157 The human body has become a site of risk and 'unhealthiness': constituting 'embodied risk' (that is, risks which are located

155 Specific questions on measuring women's health status are included in the National Health Survey 1989-90 (ABS 1991a, Maddern 1994) and in 1995 (ABS 1996b, 1997), and a longitudinal study of Australian's women's health is currently underway by multi-disciplinary researchers, following Federal government funding in 1995 (Research Institute for Gender and Health 1996).


within individual bodies and populations) (Kavanagh and Broom 1998). Zola (1974:92) states:

from sex to food, from aspirins to clothes, from driving your car to riding the surf, it seems that under certain conditions, or in combination with certain other substances or activities, or if done too much or too little, virtually anything can lead to certain medical problems.

Furthermore, 'every aspect of our daily life has in it elements of risk to health' (Zola 1974:92), including the hidden, secret and invisible phenomena lurking within the depths of your body waiting to be 'discovered' by an awareness that something's just not right. Embodied risk may be confirmed by a visit to the doctor (case history and physical examination) and a pathology test, x-ray procedure or exploratory surgery (Atkinson 1995). Epidemiology establishes and identifies the risk factors of health within a given population group; constructing risk profiles. The public health profession and some clinical medical specialities have generated a new medical entity: the 'at-risk health status' (Kennen 1996:1545) and an 'epidemic' of papers on risk in medical journals (Skolbekken 1995). At the same time mass screening programs detect asymptomatic disease in healthy populations, creating a 'borderland between disease and technology' (Daly and MacDonald 1997) and difficulties in establishing a medical diagnosis and appropriate therapy. Individuals deemed most at-risk are told by clinicians to self-regulate their lifestyle, even where there may be genetic reasons for the condition, for example, persistently high cholesterol levels. The household becomes the setting for mirroring public health concerns with risk through identification, prevention and surveillance. This scenario raises important questions concerning the construction and language of risk (Calman and Geoffrey 1997).

Firstly, who is at risk?: the individual, social group, national or global population? Population groups that have become labelled a 'risk group' are also a 'target group' at whom risk reduction (and elimination) measures outlined in health policy documents are directed (Nutbeam et al 1994, NHMRC 1995a). Although women constitute 51% of the Australian population, some women more so than others are considered 'at-risk' of ill-health: low socio-economic status, adolescent women, non-English speaking background migrant women, Aboriginal women, older women (Subcommittee on Women and Health 1993).

Secondly, what and who gets left out of the definitions of risk, and why? What are the underlying agendas surrounding the definitions and discourses of risk? Douglas (1986) adopts a cultural relativist position and argues that the social acceptability of risk is related to ethics and social justice. Lay and public health decision-making about

---

158 A high technological revolution in medicine since the late 1960s has enabled doctors to 'gaze' at the internal workings of the body and diagnose maladies by 'looking' at computer printouts (Atkinson 1995).

risk requires making a choice; which in turn requires selection, and selection demands judgement not only about what is but what ought to be in the future' (Douglas and Wildavsky 1982:84). Therefore, definitions of risk have a temporal quality. Tesh (1989) discusses the changes in discourse on what constitutes risk to public health: from contagion, supernatural forces, personal behaviour and miasma theory to germs, lifestyle and the environment theories. With each change, the monitoring of risk also required alterations in public health policy programs, 'guaranteed' to reduce and eliminate risk. Support for one theory over another, depends on the powerful rhetoric of the prevailing interest group(s) at the time. Defining a phenomenon as risky or an individual as being at-risk, has becomes a means of mobilising support for implementing social and political changes.\footnote{\textsuperscript{160} See Brown (1990, 1995), Whittaker (1995).} For instance, funding, resources and political will have been extensively mobilised to establish breast cancer screening policy and treatment for menopausal and post-menopausal women in Australia (Short 1995).\footnote{\textsuperscript{161} See Short (1995) for women's experiences of breast cancer screening, assessment and treatment in Australia, which do not conform to the expected continuum of risk management.} However, it leaves the problem that what is left out from the definition of risk is often not taken seriously.

Thirdly, is everything a risk? If so, how do we manage to maintain our bodies, promote health and prevent illness-injury, and still continue living? Is dying a risk? In Australia in the 1990s, lay individuals are exhorted to live a 'healthy lifestyle' and minimise 'risks' in everyday life.\footnote{\textsuperscript{162} See NCEPH (1991, 1992), Commonwealth Department of Health, Housing and Community Services (1993b), National Health Strategy (1993b), Nutbeam et al (1994), Commonwealth Department of Human Services and Health (1994a)).} Overprotective, ever vigilant parents are regarded as pathological and individuals who are extremely cautious about maintaining their health are considered hypochondriacal. By promoting health and preventing illness-injury, individuals can improve their health status in terms of morbidity, mortality, well-being and quality of life. Health promotion campaigns abound with messages about diet ('eat more fibre', 'eat less fat'), disease ('get sunsmart, save your skin'), exercise ('sport for all'), smoking ('no puffing') and drink-driving ('win or lose: 00 is the way to go') (Victorian Health Promotion Foundation 1994). These campaigns are funded by federal and state health departments, and various foundations with a philanthropic interest in health promotion (Peerson 1995a). They also portray deep-seated conflict between lay and 'expert' perceptions of risk. Illness then, signifies not taking care of oneself, of one's body, nor paying attention to these explicit health messages. The lay individual may have some control over her/his health through lifestyle, ie. diet, exercise. Is this a case of 'victim-blaming'?\footnote{\textsuperscript{163} See Ryan (1971), Crawford (1977), Douglas (1992).} What about the wider structural factors over which the individual may have very little direct control, which are risky to one's health? Exposure to dust, chemicals, water, unsafe work practices and home environments may be risky to one's

In the event of illness, it is a moral imperative for individuals to seek a return to 'health'. Inability to do so results in deviance, disease and/or death (Herzlich and Pierret 1987). 'Death is something that should only happen to poor, unlucky, malnourished people' (Grant 1994: 193). We would rather not think about it as it is too distressing, and instead prefer to uphold the values of beauty, youth and fitness, idealised in the pictorial imagery of advertising and mass media. Hence, death is seen as a moral failure. Nationally, death as a numerical figure indicates a country's mortality rate that can be scrutinised and compared with other industrialised and developing countries, and high death rates indicate national failure. For biomedicine in general, and for doctors in particular, the Hippocratic oath cannot be fulfilled and high technology proves inadequate to immortalise human life. Parents, families and friends of the diseased, grieving the loss of a loved one, apportion much blame and guilt for 'not having done enough' to prevent death (Peerson 1995a, Kubler-Ross 1995, 1997). When we die, we want to die 'healthy' or have a 'good death' by dying of heart failure, old age or during an ecstatic moment, with dignity and with all our human faculties intact (McNamara et al 1994, McNamara 1998).

In the previous four sections, I examined the multiple healing options medical pluralism offers laypeople when seeking treatment for ill-health, analysed the problematic position of medical dominance from a political economy viewpoint, explored the household production of health where much of lay healing takes place, and reviewed discourses on individual embodiment from anthropological and sociological perspectives with attention to gender and risk. In the following section, I discuss the importance of the power-knowledge relationship for laypeople and their lay healing practices in the household, and the implications at the micro and macro levels.

POWER-KNOWLEDGE RELATIONSHIP

Foucault's (1979) concept of power and its relationship to knowledge will be the framework for answering the research question: how do laypeople use knowledge and exercise power to provide lay healing for themselves and others? Foucault's notion of power is one of pluralism. Many institutions, agents and mechanisms have power over the body at different levels. This form of power has a number of distinct features.

---

Power exercised on the body is conceived not as property, but as a strategy ... [it] is exercised rather than possessed; it is not the 'privilege', acquired or preserved, of the dominant class, but the overall effect of its strategic positions - an effect that is manifested and sometimes extended by the position of those who are dominated ... this power is not exercised simply as an obligation or a prohibition on those who 'do not have it', it invests them and is transmitted by them and through them; it exerts pressure on them, just as they themselves in their struggle against it, resist the grip it has on them ... Lastly, they are not univocal; they define innumerable points of confrontation ... (Foucault 1979:26-7, cf. Hoy 1986).

For where there is power, there is also resistance. Foucault (1973, 1979, 1981) argues against conceiving power relations in society in terms of the sovereign and the subject. Rather, he suggests it is preferable to examine the multiple points of power that are local and regional (not just central), and the 'effective practices' of power (such as policies and programs). In addition, he asserts that power circulates and is not homogenous or exclusively retained by one individual or a group. It is essential to take an 'ascending rather than [a] descending analysis of power' - by taking a bottom-up approach, and an examination of the technologies which produce truth or knowledge (like a conference or research project), which encapsulate the 'truths' of presenters and participants in terms of their experiences and practices (McHoul and Grace 1993:87-90).

Here in Foucault's terms, power is a primary 'given' in society; exercised by certain institutional and individual agents acting as conduits of power (Hoy 1986). This notion contrasts markedly with a Marxist analysis of power ie. a top-down view of power relations between two social classes. According to Marxist analysis, a superstructure of social relations, politics, law and religion - derived from an economic base - legitimates the power of the ruling class to oppress and exploit the working class. In The Birth of the Clinic, Foucault (1973) identifies the principal agents of power in eighteenth century France, as the State, physicians and surgeons, and to a lesser degree, the family. All collectively and separately aimed to preserve the political anatomy of the body for their own interests, as well as exercise control over the individual in society (Hodges and Hussain 1979, Rabinow 1984).

Foucault extends the boundaries of power held by agents to include knowledge. He makes an equation between power and knowledge, and assumes they are synonymous not distinct entities (Hoy 1986). One begets and infers the other.

---

[The] 'power relations' are to be analysed ... not on the basis of a subject of knowledge who is or is not free in relation to the power system, but, on the contrary, the subject who knows, the objects to be known and the modalities of knowledge must be regarded as so many effects of these fundamental implications of power-knowledge and their historical transformations. In short, it is not the activity of the subject of knowledge that produces a corpus of knowledge, useful or resistant to power but power-knowledge, the processes and struggles that traverse it and of which it is made up, that determines the forms and possible domains of knowledge (Foucault 1979:27-28).

Within this framework, in the following sections, I discuss current discourses of power in everyday life as well as in the medical and social science literature (as empowerment, agency, authority, partnership), differentiate between the indiscriminate use of belief and knowledge, consider various types of knowledge (ie. lay, biomedical and other), and explore lay decision-making at the micro and macro levels.

The Discourse of Power

How can we conceive of power when it is considered a given possession by some (who are said to have or hold power), whilst others feel disempowered, powerless, empty of power? These are both honorific and pejorative connotations towards the word 'power'. Hillman (1995) explores the discourses of and the etymology of the word 'power'. He claims there are many ideas and manifestations of power: control, office, prestige, exhibitionism, ambition, reputation, influence, resistance, leadership, concentration, authority, persuasion, charisma, rising, decision, fearsomeness, tyranny, veto, purism, and subtle power. Each of these kinds of power rests upon a relationship between oneself and 'others' (individuals, organisations, political structures), and a consciousness. Furthermore, power requires a balance of efficiency, growth, service and maintenance for its upkeep and expression (Hillman 1995: 30). Social capital coupled with trust encourages the positive use of power in society, and allows for dissent and debate, without fear of reprisal (Putnam 1993, Cox 1995, Fukuyama 1995, Rayner 1997).

My intention here is to examine the discourse of power within the power-knowledge relationship, used by individuals of different backgrounds when discussing health and ill-health, with the ultimate view of examining how laypeople use power (in relation to knowledge) to make decisions in everyday life. The health, medical, social science and popular literature are replete with images, metaphors and rhetoric of power. We often talk about personal 'empowerment' (Grace 1991, Anderson 1996), having 'agency' (Giddens 1991), 'control' of somebody else within social relationships (Weber 1958), and being in 'partnership' with another party (Labonté 1997). These forms of power are clearly distinct from Foucault's (1979) notion of power as being a strategy, exercised by many individuals and organisations, located at different points and to which there is also resistance. Foucault's later works, from The History of Sexuality
(1981) onwards, contain a constitutive as well as an oppressive interpretation of 'power'. Writers inspired by Foucault have commented on 'governmentality', 'the gaze', 'panopticism', 'regulation', 'surveillance', 'discourse' and 'ethics' as indicators of power over the body.\textsuperscript{166} However, what do these taken-for-granted notions of power mean? How are they used in everyday language? What is their relationship to knowledge, its importance for decision-making, and implementation through action, with subsequent evaluation? How reflexive are laypeople about their use of power?

Firstly, \textit{empowerment} means personal power or 'bestowing power on others' (in Labonté 1990:64). 'Empowerment comes from widening your understanding of the kinds of power going on around you and from uncovering a wider spectrum of possibilities for embracing power' (Hillman 1995:11). The individual who has high self-esteem and resilience,\textsuperscript{167} is able to cope with the trials and tribulations of daily life, and has confidence to move from knowledge to action. Both Lerner (1986) and Freire (1992) have established ways in which laypeople may empower themselves through personal and collective action. Empowerment is one of the central tenets of feminism. It implies sovereignty and emancipation from the stereotypes of femininity and womanliness.\textsuperscript{168} Labonté (1990, 1997), Grace (1991) and Anderson (1996), note 'empowering’ patients, consumers and communities underlies public health discourse. Paradoxically, there is also a tendency to minimise ‘both structural inequities as well as vulnerabilities that might be concomitant with the illness [or injury] experience’ (Anderson 1996:699), to take a top-down approach to policies and programs, and to exclude lay input into decision-making at the local level. Syme (1997) asserts many health promotion campaigns have failed because they did not involve communities in their design, implementation and evaluation. Consequently, laypeople have little choice but to be self-reliant and pursue a healthy lifestyle as an individual preventive measure against illness and injury.

Secondly, Turner (1992:247) defines \textit{agency} as the 'practices or actions that have an effect and bring about change.' 'Human agents' in Turner's terms are both embodied and reflexive. 'Agency' is related to other terms such as autonomy, self-determination, liberty, freewill, 'dignity, integrity, individuality, independence, responsibility, and self-knowledge' (Dworkin 1988:6). 'Autonomy functions as a moral, political and social ideal' (1988:10), for individuals live in a society which places constraints upon their agency through laws, rules, policies, norms, values and mores. Other constraints are structural factors: Gender, age, ethnicity, sexuality, religious beliefs, parental and career


status, marital status, and socioeconomic status may be circumscribed by legislation. People exercise agency by being active not passive, by making a choice between two or more options. The outcome may be utilitarian: weighing up the benefits and costs of each decision (Sen and Williams 1982), but it may involve other 'values'. Whilst public health professes equity as a principle of social justice - operating as its underlying aim of the 'common good' - paradoxically individuals continue to be 'selectively targeted' in health policy. This amounts to a 'disguised paternalism'; whereby individual autonomy has little ethical value, and following Marx and Bourdieu, the ruling ideas of the ruling class dominate in an official context (Lindblach et al 1998).

Thirdly, control implies authority, responsibility, and inequality of two (or more) parties. One party has power over others, constituting an unequal power relationship. For example, patriarchy is a relationship of unequal power. It refers to the dominance of men over women characteristic of the household group or clan organised on kinship or economic terms (Millett 1972). Male authority includes power over other men, over children, and exclusive rights to a woman's fertility, sexuality and labour. Patriarchy serves as a model for gender relations and as hegemonic ideology.

Finally, partnership signifies collaboration, cooperation, negotiation of different perspectives and reaching a compromise. Partnership is both participative and inclusive (rather than exclusive), resting on the humanistic, democratic and moral premise that all parties are equal. 'Community participation' and 'community representation' within the new public health has been viewed by WHO and cross-nationally as a democratic measure of including laypeople in policy making and program implementation, and as conducive to improving population health status. The rhetoric of the new public health is intersectoral collaboration; whereby laypeople and individuals from multidisciplines work together to achieve reforms in clinical practice, workforce education, research and policy. It is vital to have a full picture of lay healing practices in order to evaluate the efficacy of current public health policies (Syme 1997).

In this study I consider the potential for laypeople to feel empowered, exercise agency, implement control and the extent of their partnership with others in their everyday lives. These forms of power have implications for: i) laypeople's affective relationships with their partners and children; ii) the patient-healer relationship in clinical settings; and, iii) their use of health knowledge to make decisions about health both within and outside the household.

---

Knowledge and Belief

Since knowledge rather than belief is central to this study, I wish to discuss the etymology of each term, unpack their meanings and critically analyse their use. There is a persistent tendency within the medical and social science literature to privilege the word 'knowledge' over the concept 'belief'. This springs from the Newtonian and Cartesian traditions that knowledge is rational, objective, measurable, quantifiable, and derives from the laboratory as a 'pristine fact'. Secondly, belief and knowledge are concepts taken as givens, not clearly defined by writers and sometimes used as interchangeable synonyms. Thirdly, biomedical health professionals are presumed to have only knowledge but not beliefs; as if they stand outside the society and culture in which they live and practise. However, it is often the ethnocentric 'belief' (in conjunction with knowledge) of a nurse or doctor which prompts her/him to choose one form of patient management over another, and which informs hypothesis development in biomedical research. Fourthly, in the social science and biomedical literature, the term 'lay belief' continues to be 'popular' rather than 'lay knowledge'. The basis for this uncritical use of the term is that laypeople (regardless of their occupational backgrounds), who are not scientists or biomedical practitioners, are presumed to hold beliefs but not knowledge. Therefore, they are assumed to not 'know' anything, but they 'believe' in something. They are presumed ignorant and naive, and not specialists (Mullen 1993, Dines 1994, Nettleton 1995, Pitts et al 1996, Sensky 1996).

The construction and usage of the words 'belief' and 'knowledge' have historically shifted position from their earliest 'folk logics'.

By the nineteenth century ... 'to believe' had come to connote doubt, and today it suggests outright error or falsehood. Knowledge requires both certitude and correctness; belief implies uncertainty, error or both (Good 1994:17).

Lay belief has been variously constructed as a 'model', a 'theory', an 'understanding', a 'concept', a 'prototype', an 'attitude' or a 'perception', rendering it readily dismissed as irrelevant and unimportant. Rational, 'value-free', positivist, scientific knowledge - not belief - is given pre-eminence in most societies and is used as the benchmark from which all other forms of 'knowledge' are deemed to originate. I agree with Dean and Hunter (1996:747) that '[r]ather than contrasting subjective and objective data, the relevant point is that ... all knowledge is relational rather than universal.'

The Oxford dictionary (Simpson and Weiner 1989) uncovers the etymologies of knowledge and belief, and makes clear the distinction between them. 'Knowledge' stems from Old English geccnāwan, Old Norse knā (I can) and Latin noscere (to come

---

to know), from the verb 'to know' and 'knowing'. Knowledge is synonymous with: information, wisdom, culture, science, intellect, erudition, foresight. In this context, knowledge derives from many sources. It is learned and experienced. It connotes a relationship between what is known and the unknown. It requires the use of human faculties and abilities. In contrast, 'belief' originates from the Old English verb beliefan or 'to believe'. It is also 'a principle, idea, etc. accepted as true or real, especially without positive proof' (Collins 1981:133), congruent with probability and judgement (Roget's 1981). Belief is closer to religious faith, truth and trust, personal opinions or a philosophy than it is to facts, information, reliable evidence or proof (cf. Good 1994:15-17).

Within the domains of theory and praxis of medicine, anthropology and medical anthropology, Good (1994) concludes the empiricist, rational paradigm of medical knowledge predominates, whilst at the same time, 'belief emerged as a central category for the analysis of culture' (1994:21), and has served 'as an unexamined proxy for "culture"' (1994:39). In health care, biomedical practitioners and policymakers, following the Health Belief Model (Janz and Becker 1984), tend to 'believe' that if laypeople are 'educated' to do things differently or given information, they will rationally alter their irrational beliefs and behaviour, and thus they 'will produce a new life and ultimate salvation' (Good 1994:7). Good (1994:8) asks:

Why is there this deep attachment to analysing others' understandings of illness and its treatment as medical 'beliefs' and practices, and why is there such urgency expressed about correcting beliefs when mistaken?

Similarly, the KAP research model (knowledge, attitudes and practices) continues to be popular among social scientists and biomedical practitioners, particularly those working in the field in Third World countries (cf. Pelto and Pelto 1997). However, this model ignores structural conditions (cultural, social, political, economic) which affect laypeople's capacity to implement lifestyle changes. Secondly, evaluation as a component of the model is absent. Furthermore, I agree with Good (1994:24) that 'all discourse is pragmatically located in social relationships, that all assertions about illness experience are located in linguistic practices and most typically embedded in narratives about life and suffering'. Both belief and knowledge are applicable for all epistemologies and ontological representations of healing, regardless of their origins.

For the purpose of this dissertation, I follow in Good's footsteps and remain reflexive in the use of 'belief' in medical anthropology, other social sciences, medicine and health policy. I give pre-eminence to the term 'knowledge' when discussing the power-knowledge relationship underlying lay healing practices in the household. Laypeople do have knowledge - much knowledge, from multiple sources - and they use that knowledge to make decisions about their embodied selves in everyday life.
Lay Knowledge

Laypeople have 'knowledge' as well as beliefs, attitudes, worldviews and values. Stacey (1994) uses the term 'people' rather than 'lay' when speaking about lay knowledge. 'People knowledge' is experiential knowledge, and 'is not that sort of knowledge that is codified in books or taught in university lecture theatres or in schools; it is not systematised and generalised as professional knowledge is' (1994:90). She asserts that 'in health care matters, people knowledge includes a good deal of medical knowledge which has been acquired as part of experience' (1994:90, cf. Williams and Popay 1994b). Whilst I do not deny laypeople's experience as a source of knowledge, i.e. experiential knowledge, I contend that ontological experience and hence the epistemological base of that knowledge is much broader. Other writers use other terms for lay knowledge such as: 'local'; 'everyday'; 'authoritative'; 'situated'; 'discounted'; 'situational'; 'expert'; 'embodied'; 'theoretical, empirical, rationalised, intersubjective and negotiated'; and, as 'silence, received, subjective, procedural and constructed'.

Backett (1992b) indicates that laypeople draw upon many sources of knowledge, for example, genetic information, personal and family histories, observations of other people's health and illness behaviour, media, and 'biomedical advice directly from medical personnel'. 'Lay bodies of knowledge could readily accommodate contradictory information and behaviour' (1992b:501), but it had to be valid, make 'commonsense' and be socially legitimated. I suggest sources of lay knowledge may encompass: the inter-generational transfer of knowledge: role-modelling by example; personal (health) professional training, education and practices; consumer advocacy and lobbying; health promotion campaigns; mass media; and lay referrals (friends, colleagues, social networks). The basis for these sources of lay knowledge is not always rational science; that is, factual and empirical. Several forms of knowledge lie outside the 'rational science' mould, for example, 'intuitive knowledge', 'self-knowledge', 'commonsense knowledge' and 'experiential knowledge'.

Intuitive knowledge is often referred to as a 'sixth sense', a 'gut feeling' or even an instinct. Other synonyms are: perception, awareness, discernment, a 'deep down feeling', 'in the bones' or an 'inner voice'. Osfield (1997:59) describes intuition as:

---


When you sense that someone is staring at you, lying to you or even attracted to you, you have received information directly from your sixth sense. Alternatively, intuition may arrive in powerful flashes: as a visual image passing rapidly through the mind; as an inner voice or a strong sensation about a person or a situation; or as a physical, gut feeling, accompanied by body tingling, a cold sweat or a rush of warmth.

Women are popularly said to have intuition whilst men do not (Chamberlain 1981, Osfield 1997). Intuition is a form of embodied knowledge, rather than being socially constructed. Laypeople often point to their body parts to describe the origins of this knowledge. Intuition is sometimes referred to as coming from 'deep within' the heart or chest region. 'Gut feeling' refers anatomically to the belly, below the diaphragm, the solar plexus or upper mid abdominal region.

Closely associated with intuitive knowledge is self-knowledge, which relates to a person's sense of 'self' and what constitutes their selfhood, their feelings about their bodies and themselves that is full of 'elemental human wisdom' (Sacks 1984:171). Self-knowledge is about how individuals define themselves at any particular chronological age or stage of the lifecourse (Featherstone and Hepworth 1991). It is concerned with 'knowing oneself' in a 'biographical and cultural context' (Radley 1993). It is 'embodied knowledge' that does not come from anatomy and physiology textbooks, written by other people's knowledge of the material body, or defined by an international nosology of mental health. Rather, as Seymour (1989:97) suggests,

A person develops an awareness of his or her body by the experience of living in that body. However, because the body in which the person lives is visible to others, it is the object of social attention and public appraisal. Social interactions provide the person with critical knowledge of his or her body.

Commonsense knowledge is taken-for-granted knowledge which is also seen as lying outside the rational realm. It is a self-evident truth, 'vernacular wisdom'; 'the mere matter-of-fact apprehension of reality' (Geertz 1983:75). Commonsense is subjective knowledge that derives from everyday life in a real world (that can be chaotic), not a laboratory with fixed and controllable variables. It is also culturally and historically relativist (Geertz 1983).

Another source of lay knowledge is experiential knowledge. It is accumulatively grounded in everyday life and specific experiences (Dean and Hunter 1996). This knowledge may be personal (pertaining to an individual or a household) or collective (referring to a body of people that are locally or regionally situated). For instance, a person lives overseas or enters another country as a refugee, endures poverty or job retrenchment, suffers diabetes or chronic backpain, marries and discovers s/he is infertile. S/he acquires knowledge from these multiple experiences (Murphy 1987). The

---

176 See also Chamberlain (1981).
personal experience of being sick, the disruptions to daily life, consulting one or more healers, and the exchange of knowledge that occurs during a clinical consultation - taking a history, physical examination, reading the signs and symptoms, interpreting diagnostic tests, giving advice on remedies - increases the store of knowledge. Systematically processing the experiences of daily life, laypeople build up experience that while different from that of professionals, must be recognised as parallel expertise' (Dean and Hunter 1996:746, cf. Mayall and Foster 1980). Furthermore, drawing upon their knowledge, people are making decisions in their everyday lives at the micro and macro levels.

Lay Decision-making: micro and macro

It is comfortably believed that decisions result from a full briefing. Once all the angles are considered, all eventualities foreseen, decision follows. It is as if decision were a matter of weighing pros and cons in the balancing scales of judgement. This view of decision making gives too much credit to reason. Decisions come as much from the gut, from a chance bit of data or gossip, from intuitive hunches, from the still voice of ... 'the angel', as they come from long pondering a well-written digest of the facts (Hillman 1995:180, cf. Bernstein 1996).

Choice often involves both decision-making and non-decision-making. Making a decision entails exercising agency, and suggests movement, action, doing something, and implementing it (Giddens 1984). It also involves inclusion and exclusion, opportunities gained and opportunities lost, going one way and not another. It is like being at the juncture of a crossroads with a signpost pointing in two or more directions at once, and the question is: which way, now? Having self-esteem and confidence is important for putting knowledge into action (Steinem 1994). A person may have knowledge of something but lack the confidence to make a decision and to implement it. Sometimes we hesitate to trust our own judgements, fear making a mistake, and worry about a poor outcome or that the situation may worsen, and this may result in non-decision making.

Within health economics, the 'individual consumer is [seen as] sovereign and [as capable to] assess the utility [ie. satisfaction] associated with all the relevant sets of final consequences' (McGuire et al 1992:37), and thus make a choice. Utility theory makes two assumptions. Firstly, people are presumed to be rational all the time - in the past, now and in the future. Secondly, rationality is linked with maximum utility. If we presuppose that utility equals satisfaction, then maximum satisfaction follows rationality. Thus, since people are rational, they want to maximise their satisfaction, therefore there is greater utility. This concept implies that the consumer is always rational all the time, and has access to information which will influence her/his


This view presumes that the individual is always an autonomous rational self, capable of exercising agency and making decisions for her/himself. What happens for persons with little or no decision-making ability or rationality nor sense of responsibility, such as the mentally ill, intellectually disabled, or children? This raises the issue of someone else making decisions for others, of acting as their 'agent', 'sentinel' or 'family health guardian', and precludes issues of caring, trust, ethics, representation, advocacy and guardianship.

Pescosolido (1992), Hillman (1995), and Bernstein (1996), correctly suggest that decision-making does not always depend on rationality, knowledge that are factual or scientific, mathematical formula or computer prognostication. Moreover, knowledge is frequently imperfect, expanding and contested (Kuhn 1962, Latour 1987). Irrationality can also prompt us to make a decision. Listening to one's intuition, 'gut feeling' or 'sixth sense' requires taking notice of the convergence of feelings and thoughts that spring from within oneself (Osfield 1997). This listening requires stillness (Cooper 1997), 'cultivating depth and sacredness' (Thomas Moore 1992), being quiet, and it often arises spontaneously. It does not rely on the 'facts' or 'truths', however construed in the modern or post-modern sense (Rosenau 1992). Intuition can also prove effective, in that it can safeguard us from harm in life-threatening situations and prevent a serious injury; prompting our reflexes to move physically and psychologically away from a dangerous situation, at just the right moment.

'Decision-making activity is restricted in terms of its actors, its duration and its setting (Atkinson 1995:51, emphasis in original). Laypeople are making decisions everyday. They make decisions about the clothes they wear, the food they eat, whether to drive a car to work or ride the bicycle. Often, we just do something out of habit, 'taking-it-for-granted', tradition, routine, and 'because we've always done that'. This lay decision-making occurs at the micro level of the individual, within her/his household, social networks and community. In terms of health and illness, these decisions address looking after our health and well-being. They involve making decisions about health education, health promotion, illness-injury prevention, diagnosis and treatment of illness-injury, and managing the household economy to provide time, resources, money and labour for health protection and production. Sudden illness or a life-threatening

condition (cardiac arrest, stroke, kidney failure) signify both immediate decision-making to improve health status and opportunities to move in another direction. These sudden events also require conscious adjustments to one's daily life habits and routines, and re-establishment of social and professional relationships on a new basis.\footnote{See Murphy (1987), Tony Moore (1992, 1994), Duff (1993), Hopgood (1997).} The 'unexpectedness' or suddenness of many illnesses and injuries also affects people's ability to act as pondering, sovereign consumers.

But, what of lay decision-making at the macro level, beyond the community? Lay knowledge is important for public health owing to its diversity of sources and specialisation of content. One person’s source of knowledge may not be the same as another’s, and they may also use the same knowledge differently. The layperson's experiential knowledge is constructed in a different way from health professionals, who learn from textbooks and clinicians in universities and hospitals about the aetiology, incidence, drug therapy and prevention of disease, as part of their clinical training and experiential practice. Here, they encounter several cases on a regular basis, as opposed to one individual being sick now and then (Foucault 1973, Armstrong 1983).

Laypeople are also participating in health care decision-making at the macro level (Charles and DeMaio 1993). The development and analysis of government policy (regardless of the issue) provides laypeople with opportunities to voice their concerns about how current policy affects their lives in real terms.\footnote{See papers by the Consumers’ Health Forum in journal: Health Forum.} Through extensive lobbying and advocacy, some interest groups have made themselves heard and counted. For instance in Australia, the women’s health movement and the Public Health Association, have gained a public profile by developing policies, public-speaking and publishing research papers. Lay representation occurs in the government and private sectors through their presence in health care organisations and committees reviewing health care policies and programs,\footnote{See Figure 2.2 in Palmer and Short (1989:31) and Figure 1.1 in Gardner (1992:16) for diagrammatical perspectives on how health policy is analysed and developed. Palmer and Short (1989:24-25) argue health policy is different from other types of policies owing to 'the medical professional's role in shaping and constraining it; 'the complexity of health care provision'; and community expectations of health care.} institutional ethics committees examining existential questions, and in research teams co-investigating a 'scientific' problem.\footnote{See Cornwall and Jewkes (1995), Springett and Leavey (1995), Daly (1996), Daly et al (1997).} However, professionalisation of lay representation becomes a problem and raises a number of questions. What constitutes lay representation? What is the representative’s constituency? To whom are they responsible? How are they nominated or elected to their position of 'power'?\footnote{See Anderson (1996), McNeill (1996), Jewkes and Murcott (1998).} Similarly, lay voices are not given equal weight to that of the policymakers, academics, scientists or health professionals (Hepworth and Krug 1997). Lay knowledge still remains in many instances 'discounted', devalued and

Given the continuing demise of public health resources available to laypeople, they are forced to rely even more upon their finite household resources (Cox 1995, 1997a). They are also likely to question current health care arrangements. C. Wright Mills (1959) suggests employing one's 'sociological imagination' to bridge individual issues with social structure. That is, making a connection between 'what is happening in themselves as minute points of the intersections of biography and history within society' (Mills 1959:7, cf. Hillman 1995), or what feminists have deemed: 'the personal is political'. Laypeople are likely to act publicly upon their cherished values when they are threatened, prompting a crisis. It is much more difficult for laypeople to articulate and implement action, when they experience uneasiness and indifference. It often takes collective or 'class' action (predicated on the basis that others are in a similar circumstance) to instigate changes to the status quo, reduce harm, and bring about improvements (Korten 1997, Rayner 1997, Saul 1997).

In this study, I use 'sociological imagination' and 'anthropological imagination' to make a bridge between what occurs for laypeople within the household setting and their position within wider society, and how it affects them. In particular, I endeavour to explain the power-knowledge relationship underlying lay healing practices within the household. Firstly, social, political and economic structures influence and impinge upon laypeople's use of health knowledge in making decisions about their embodied selves, their lives in relation to morbidity, mortality, well-being and quality of life. Secondly, this has implications for how health care services are used outside the household.

CONCLUSION

Using Turner's (1987) model as a guide, a multi-theoretical approach is employed in this chapter to provide insights to the epistemological and ontological aspects of the power-knowledge relationship underlying lay healing practices in the household. Adopting an and/or theoretical perspective to the research question overcomes the hiatus presented by the current lack of a comprehensive theory and body of empirical research. It also allows for a greater understanding of the tensions between individuals and society, agency and structure, micro and macro, rights and responsibilities in terms of health and ill-health in time and space. Furthermore, I assert, laypeople use knowledge and exercise power in their everyday lives. They are 'agentic selves', but their choices may be circumscribed by societal and cultural forces.

Kleinman (1980) offers the principal theoretical model of medical pluralism in medical anthropology. I propose the need to conceptually expand the realm of the

\[80\]

---

popular sector to include laypeople's healing practices in their households, social networks and local communities. These are: health education, health promotion and illness-injury prevention, lay diagnosis and treatment, as well as managing the household economy. Furthermore, multiple healing modalities (including lay healers, alternative therapists, biomedical health professionals and folk healers) are recognised, enabling laypeople to, theoretically, choose more than one healing option.

At the macro level of political economy, Friedson (1970a, 1985a) and Willis (1989a) assert 'medical dominance' by doctors over other health professionals is inevitable owing to the political and ideological power of the medical profession. The 'cultural ascendancy' of doctors (Sharma 1996b, Kleinman 1995b) has been critiqued and challenged by other stakeholders in the health care system, to include surveillance and restriction of medical practices. I suggest that the term patient-healer relationship may be preferable to the widely used term: doctor-patient relationship, as it removes the passive sick role (Parsons 1951), and recognises the subjectivity, health knowledge and input in decision-making of all parties, particularly of laypeople.

The 'household production of health' proposed by Berman et al (1994) presents a way of exploring how health is produced and protected within the household. This model, firstly, recognises the importance of lay health knowledge and decision-making, and the influence of individual and household activities upon morbidity, mortality, well-being and quality of life. Secondly, a connection is made between macro and micro conditions which impact upon individual and household health status. Thirdly, it involves examinations of household structure and function, lay conceptualisations of health and ill-health, household activities and their outcomes, and aspects of the household economy.

Theoretical development and increasing empirical studies on the human body are concerned with the 'embodied self'. The self requires a body; they are inter-related (Scheper-Hughes and Lock 1987, Csordas 1990, 1994, Turner 1992). I propose a model of healing the embodied self when damaged or impaired as a 'process' consisting of three stages: repair, recovery (convalescence and rehabilitation) and re-entry. According to this model, the embodied self experiences 'bodily alterations' (Sacks 1984, Seymour 1989, 1998) and undergoes a series of transitions, from one state to another, becoming reconstructed. The limitations of this model entail: temporality and severity of ill-health, co-morbidities and a need for greater integration of the mental and spiritual aspects of healing. Feminist and masculinist researchers have analysed the gendered experience of embodiment, and of health and ill-health. They have also critiqued the generalisation that women are sicker and use more health care services than men who die sooner, which is frequently cited as a means for providing gender distinct health care services. Broom (1998a, 1998b) and others argue women's and men's experiences of health and ill-health are gender specific within a historical,
cultural, social, political, economic and environmental context. Future theoretical and empirical research and clinical practice addressing gender and health must reflect this specificity. Risk to embodiment has been largely defined in terms of lifestyle and environment (Beck 1992). Zola (1972), Kavanagh and Broom (1998), suggest that 'embodied risk' (whereby the body itself constitutes risk) should also be considered; thus revealing problems of screening programs designed to identify risk as asymptomatic disease in 'healthy' populations. Risk and being 'at-risk' have become part and parcel of the 'new' public health discourses on health and lifestyle. Laypeople have been categorised by public health specialists into various groups deemed 'at-risk' of one disease or another; inevitably certain issues and individuals are left out of risk definitions, and the agendas underlying the public health discourses of risk are less scrutinised. Meanwhile lay discourses and assessment of risk remain ignored by public health 'experts'.

The multiple discourses on power (empowerment, agency, control and partnership), confirm Foucault’s (1979) notion of power as plural and strategic, circulatory and heterogenous, and exercised by multiple, not singular agents. The uncritical use of the terms 'knowledge' and 'belief' within the social and biomedical sciences, has had four consequences: i) persistent emphasis on lay beliefs rather than lay knowledge; ii) scientific and biomedical knowledge is given greater credibility; iii) biomedical health professionals are deemed to have knowledge but not beliefs; and, iv) laypeople are presumed to have beliefs but not knowledge. However, a review of the etymology of the two terms reveals their distinctions. I assert that lay knowledge derives from multiple sources and may be described as: rational, intuitive, experiential, common-sense and self-knowledge. The validity of this knowledge is no lesser nor greater than positivist, rational knowledge, and should not be readily discounted nor as constituting 'belief'. Furthermore, laypeople exercise agency within the context of their everyday lives at the micro level to include lay healing activities in the household. They also have input (although somewhat limited to-date) into health care decision-making in government and private enterprise policy and programs at the macro level; through interest groups and consumer representation. Between the micro and macro levels, laypeople use their 'sociological imagination' (Mills 1959) to 'voice' their concerns about the impact of policies and programs upon their everyday lives, as individual cases and as collective interests.
CHAPTER 3  
METHODOLOGY

There has been continual debate over whether quantitative and qualitative methodologies are epistemologically or just methodologically distinct. Popay and Williams (1996:763) claim:

people have sometimes seemed so obsessed with seeing the matter as one of either/or that it has led them to forget that the methods used should depend on the questions asked in response to a problem - not the other way around.

Public health research must reflect the complexity of the field, demonstrating multiple methods, alternative epistemological positions and intersectoral collaboration, as well as inclusion of the social sciences and humanities, and greater value to lay knowledge. It is for these reasons that this study takes a 'multi-sited ethnography' approach (Marcus 1995), working across various fields to gather and create data, to reach an understanding of laypeople's health knowledge and decision-making, and lay healing practices in the household. The study moves beyond the debate about whether or not there exists an epistemological hiatus between quantitative and qualitative research: I use both.

UNDERTAKING FIELDWORK IN GEELONG, VICTORIA, AUSTRALIA

I combine anthropological and sociological methodological frameworks to examine lay healing in the household setting. My research is far removed from the 'traditional' methodological approach of anthropologists following Malinowski, Mead, Levi-Strauss and Boas (Gupta and Ferguson 1997). Instead, my fieldwork occurred in a local context, or what Jackson (1987) refers to as 'anthropology at home'. It is the 'anthropological process of self-critique ... in the study of our own culture' (Brown 1994:720, author's emphasis). The anthropologist focuses inward on her/his own society looking for commonalities and differences; the 'extraordinariness' of everyday life. The main task, however, is also to reveal the often invisible aspects of a taken-for-granted world held in common by its inhabitants. The resulting ethnographic data contains

---

201 Marcus (1995:102) argues, 'in multi-sited ethnography, comparison emerges from putting questions to an emergent object of study whose contours, sites and relationships are not known beforehand, but are themselves a contribution of making an account that has different, complexly connected real-world sites of investigation.'
203 Variations on 'anthropology at home' are: 'native anthropology' (Macarenhas Keyses 1987, Hastrup 1996), 'indigenous anthropology' (Ganguly-Sruse 1993, Brown 1994) and 'auto-anthropology' (Strathern 1987). The boundaries of anthropological research conducted in this manner makes it difficult for cross-cultural comparison (cf. Gupta and Ferguson 1997).

No matter how fragmented and contested a local world is, there is a shape or coherence to its flow of interpersonal experiences, whose contours, if we view them from afar and compare them with other worlds, are recognisable as a particular form of life, a local way of being human (Kleinman 1992:129).

Geelong, in Victoria, Australia, was the fieldsite of this project. European settlement was established in 1802. The regional city expanded during the 1850s as a port for gold, wool and grain from nearby districts, and developed a manufacturing industry (car parts, metals and fertiliser processing) in the early 1920s. Its population boomed during the 1950s with post-World War II immigration. The current population is approximately 208,474 with people of diverse socio-economic and cultural backgrounds residing in urban, rural and coastal areas of the Region.

The ABS Census 1996 data reveals the Geelong Region population is characterised by: the full spectrum of socio-economic class groups; a small Aboriginal community; migrants who have been residing in Australia for many years, as well as recent arrivals; and a large number of young families and older persons living in the Region. There is also a very small population group of young adults (aged 18-25 years).195 Anecdotal evidence reveals that this group have tended to emigrate out of Geelong to Melbourne and elsewhere in Australia and overseas, in search of greater employment and study opportunities than currently available in the Region.

Geelong is the city where I spent much of my childhood to early adulthood. Following completion of my nurse's training at the public hospital in 1982, I left Geelong to travel in Australia and overseas. I returned in late 1993 to take up a research position and subsequent postgraduate study at the local University. During the ensuing 11 years of absence, I have noted a number of social changes accompanying the recession (1992-93), high unemployment, particularly of the youth, and the collapse of a local credit union, which affected small businesses, the building and other industries in the Region and nearby rural areas.

I chose Geelong, as the principal fieldwork site of my research, not only for its distinct socio-economic and cultural diversity, but also because I lived, worked and parented there, and was unable to travel elsewhere to conduct the research (cf. Bruenjes 1998). I resided in this city for 3.5 years during the project's lifespan, was a community member, and participated in various local activities.

194 The common experiences of the participants in this study were: parenting, having young children, residing in the same community and lay healing in the household.
CHOICE OF METHODS

In this section I discuss the array of methods and sites chosen for empirical data collection of this 'multi-sited ethnography'. In Marcus' terms, this project is designed around the chains, paths, threads, conjunctions, or juxtapositions of locations in which the ethnographer establishes some form of literal, physical presence, with an explicit, posited logic of association or connection among sites that in fact defines the argument of the ethnography (1995:105).

The methods and sites were chosen for their diversity and capacity to reveal and augment a multi-disciplinary understanding of laypeople's health knowledge and decision-making, and lay healing practices in the household, given previously limited empirical research.

Rationale

This study focuses upon the household production of health, therefore it examines relationships within the family (Backett 1990a, 1990b, Daly 1992), and specifically the lay healing practices of parents of young children. I selected parents of young children as my population group for the following reasons. Firstly, there is a growing body of research examining child health care and the differential responsibilities and division of labour between parents, their children and biomedical health professionals to meet the health needs of children, including injury prevention at home. Secondly, the majority of these studies concentrate on women rather than on men. Kai (1996a:985) rationalises 'the contemporary reality of childcare ... remains largely the responsibility of mothers', thus, it is often more difficult to recruit men - as fathers - to become participants in studies on children's health and family health. Thirdly, I am the parent of a 14 year daughter, have practical knowledge of child-rearing and extensive health care experience.

Fourthly, I conducted the research through primary schools as a result of my own experience as a parent of a child attending primary school, and the belief that participants (parents) would be able to relate to me as a parent, as well as a researcher. Furthermore, belonging to the same school community means many families are also living in the same locality. They are often friends, neighbours, and even relatives, and share similar social networks. The relationships people have with each other are integral to their everyday life experiences, and health promotion and illness-injury prevention, diagnostic and therapeutic practices (Kleinman 1980, Dean 1990).

I considered the possibility of including participant-observation as part of my research methodology for this project. Despite an initial enthusiasm, after much consultation with my supervisors, I rejected this approach because of ethical considerations given that I resided and worked in the 'field' (Gupta and Ferguson 1997). We had concerns about 'crossing public/private boundaries', about which I personally felt very uncomfortable. Martin (1987:9) reflects upon her own participant-observation.

Doing a study based on interviews meant that I gave up the rich, multi-layered texture of life that I would have experienced by living in a community or with a family. I tried to make up for that by participating in as many ongoing organisations as possible (cf. Passaro 1997).

Given these concerns, I endeavoured to participate and observe family life, social activities and cultural events within the Geelong Region in other ways. This meant being part of my daughter's school community (attending barbecues, school assemblies, Family Picnic, working bees, Food Fair, graduation ceremony) which afforded opportunities to meet other parents and teachers at the school. Local events in the Region were the annual Pako Festa (a multicultural weekend of song, dance, theatre, music, food), Australia Day Regatta Weekend (sailing organised by the yacht club) and the Gala Day parade. I also attended meetings of a men's health group, local craft markets, art gallery exhibitions and theatre productions. At each of these events I met other residents of the Geelong Region who were my friends, colleagues or 'strangers' (co-residents), who through conversation provided insights on the parent-child relationship, risk, health and ill-health, gender relations, embodiment, emotions and suffering, diagnosis and treatment of illness and injury.

I used both quantitative and qualitative methods in this study, to provide insights on lay healing practices in the household setting and laypeople's lived experience of health and ill-health. Quantitative data collection through a 'questionnaire' provides a socio-demographic 'picture' of participants in the sample, and their use of formal health care services outside the household. For this project, the ABS Census five yearly questionnaires were used as a guide for constructing the questionnaire which was couched in user-friendly language. I refined the questions on health care services utilisation following consultation with colleagues experienced in surveys and statistical analysis, noting issues of presentation, administration and response rates (cf. de Vaus 1991, Bryman and Cramer 1994, Taylor 1996).

Interviews and focus group discussions provided qualitative data on participants' lay health knowledge and decision-making within the household. I asked

---

198 This visible participation assisted in my later undertaking a pilot study at the school, because I was 'known' and an 'insider' as a result of being a parent.
199 Some tables are presented throughout the thesis text, whilst others are located in Appendix G.
200 See Appendix F.
participants how, why, where and when they use external health care services, and/or lay treatment. To avoid 'stealing the words out of women's [and men's] mouths' (Reay 1996), each participant was given a copy of tape transcript of the research interview and/or focus group discussion they had participated in, as their personal record of what was said. Narrative accounts of health and health care are employed in this thesis, to enable the 'self', 'embodiment' and 'voice' of each participant to speak for her/himself, be interpreted and understood by the reader, and ultimately be heard in a wider context by healers and policymakers. Narrative is drawn from the interviews and focus group discussions. Narrative as quotes (lengthy and short) are located within the thesis text (Chapters 4-7).

The 'case study' data (Reinharz 1992, Stake 1994) are drawn from select tape transcripts from interviews and focus group discussions, where the issue was of great concern to the 'storyteller'. The case studies have a temporal characteristic, related to a particular moment; not only the incidents that occurred in the person's 'private history' but also when the narrative took place, becoming a 'public account' by being told to me (and to others). They indicate individual/household health status as well as the events, crises and experiences which influenced participants' (lay) conceptualisations of the body, self, health and illness, and their production of health within the household. These extractions contain much detail on particular issues: alcoholism, smoking, infertility, private health insurance, alternative therapies, as well as chronic illness (depression, epilepsy, asthma, back pain).

Intersectoral consultation is one of the key principles of action that Dean and Hunter (1996), and Popay and Williams (1996) assert are crucial for including laypeople's knowledge (and decision-making) in public health research. To this end, I held formal interviews (appointments with set time and date), contributed to informal conversations, had chance meetings, and actively sought advice, confirmation of similar pathways of thinking, commentary and suggestions on the research topic: the power-knowledge relationship underlying lay healing practices in the household. In all cases, people I talked to were informed of the nature of the research. The individuals I 'consulted' were laypeople, healers, government policymakers, and other researchers


See Appendix F for schedule of questions for interviews and focus group discussions.


from multi-disciplinary backgrounds. Some discussions took place in people's offices in hospitals, trades hall, primary schools, government agencies, self-help groups and universities. Other people I met at their or my home(s), in the field (on the street, having a coffee or lunch, at a street stall), or at public arenas: workshops, seminars, conferences and public health forums where I was more likely to have encounters with public health colleagues.

The results of all this 'free-flowing conversation and dialogue' (Okley 1994:23), 'thoughts which came at unexpected times' (Okley 1994:31), 'crystallisation' (Fetterman 1989:101) and exchanges of 'knowledge' were documented, filed in a folder and also in a (series of) notebook(s) which I kept with me at all times. On each page I annotated the person's name, position, contact details, place and date, including the topic. This 'written' source of oral language constituted a my 'reflexive journal', which I maintained throughout the project's lifespan. I continually referred to it and added further ideas, elucidated methodological problems in the field, cogitated theoretical conundrums, undertook preliminary data analysis, established emerging themes and sub-themes in the tape transcripts, restructured the questionnaire and the schedule to incorporate or subtract topics, listed useful references, and planned strategically for the next stage of the research process. Extracts from my reflexive journal are woven into the thesis text.

Before undertaking the pilot study and the larger project, the University Ethics Committee gave approval in July 1994. All participants were given a plain English statement of the project's aims and objectives, a consent form to sign (indicating their voluntary participation), and assured of confidentiality and anonymity during and after their involvement in the project.

PILOT STUDY

The pilot study was undertaken in March and April 1995 at my daughter's primary school in Geelong. The school principal and the school council gave approval for the project, and placed notices in the school's newsletter. I conducted a focus group discussion with five parents (all women), and interviewed them separately.

---

206 See Appendix B for further details.
207 Also called a 'chronological journal' by Okley (1994).
208 See Appendix D for further details on ethical considerations, the plain English statement and consent form.
209 This primary school was established in 1878 in an older well-established inner city area of Geelong, with a upper middle class, mostly Anglo-Australian population. In 1995 it had about 320 enrolled students aged 5-12 years, with 16 full-time teaching staff. The school offers a range of facilities: a playground, art, music (violin and guitar), sport, library, canteen, Italian as a language other than English (LOTE), canteen, and more recently, childcare (before and after school). The school maintains an 'open door' policy, encouraging parent and teacher involvement in decision-making and participation. It is located in the midst of a small community, where there is a shopping strip area (still developing) well served by public transport, a doctors' surgery and alternative therapies. All traders are known to each other and to members of the school's community (teachers and parents) who support the local economy. The shops are sponsors and donate goods and services to the school on several occasions, fostering a symbiotic relationship based on goodwill between all parties.
using a schedule of themes and related open-ended questions. Following introductions
and refreshments, they were relaxed and confident to speak about themselves, their
partners and their children, health education, health promotion, illness-injury
prevention, and diagnosis and treatment of illness and injury, in their everyday lives.
Each participant completed a questionnaire containing socio-demographic and health
care services utilisation variables.

The primary aim of the pilot study was to provide some understanding of the
actual everyday life experience and practices of lay healing for families. The signs and
symptoms of childhood illnesses and injuries were the principal issue for the focus
group discussion and research interviews. Secondly, the pilot study enabled me to
refine the focus of the larger project, and evaluate my overall methodology and
sampling techniques for the project. Conclusions drawn from the resulting data formed
the basis for modifying the questionnaire and schedule of questions for subsequent
focus group discussions and interviews. Participating parents and the School Council
received a copy of a report on the pilot study.210

LARGER PROJECT

Sampling

My initial proposal was to recruit at least 100 participants to the study. A
sampling frame was established from a current list (April 1995) of primary and
secondary schools (state and religious) operating in the Southwestern District of
Victoria - from Geelong to Portland (N=172). Of these schools, I was interested in state
and religious primary schools operating within the Geelong Region - including the area
of Meredith to Queenscliffe to Lorne. The total number of state primary schools in the
Region is 64, and there are 20 religious primary schools. Therefore a total of 84 primary
schools formed the basis of a purposeful sampling frame for this project (de Vaus
1991). I proposed commencing contact with 20 primary schools (17 state schools and 3
religious schools) in the first instance. This sample of schools selected for the study
were stratified by geographical location, that is, urban, rural and coastal areas of the
Geelong Region. The population of young children (up to the age of 12 years) at these
schools, and their parents, reflects the socio-economic and cultural diversity of the
population in the Geelong Region.

Preparatory Work

The above mentioned list of schools included details of the name of school
principals, and the schools' phone, fax and address details. I wrote a short letter to each
school principal, to introduce myself and the project, referring to the completion of a

210 See Appendix E for further details on the pilot study: data analysis.
pilot study, and seeking their cooperation in obtaining access to parents of young children attending their specific school, to invite their participation in the project. I followed up that letter by a phone call within two weeks, to make a personal appointment with the school principal, and sought their cooperation in person, their advice on how to obtain access to the parents, their permission to use the school’s facilities as required, and how I might make a reciprocal contribution to the school. Where I had the consent of each school principal, I wrote a formal letter seeking approval from them and the school council.

Access to a group of individuals whose behaviour, activities and rituals are of interest to the researcher was a crucial issue for this study. Since I wanted to speak with parents of young children, the question was how to obtain access, i.e. recruit participants to the study. The school principals acted as 'intermediaries' (Fetterman 1989, Peerson 1990, Hammersley and Atkinson 1993). In all instances, they were most helpful in meeting my request, and used different means to invite parental participation, including placing notices of my project in the school's newsletter. This indicated formal and explicit approval of my project by both the principal and school council, and enhanced my legitimacy as a researcher and an 'outsider' to the school's community (cf. Fetterman 1989, D. Wellman 1995). Some school principals approached particular parents in person, whom they believed would be interested in the issue of health care in the household or whom had been involved in previous 'school activities'. I also attended parents' club and other types of meetings at particular schools, as a way of introducing myself to parents in person and inviting their participation in the project. In some instances, a combination of these approaches were used by the school principal.

On each occasion of visiting the schools, I was warmly received by principals with morning tea, shown around the school or given a considerable amount of the principal's time. I was given details of the school's community; that is, its catchment area, and the wider community within which it is physically and socially located. This information alone is very interesting, as each school is very different throughout the Geelong Region in terms of its history, location, size, physical environment, socio-economic status of its population, teacher:student ratio, range of facilities available and programs offered, and level of parental and local community participation in school activities. Some of the school principals saw direct links between health care in the family and in the school.

Of the 20 schools that were part of my initial sampling frame, I was able to conduct focus group discussions and research interviews with interested parents through 16 primary schools. This stage of fieldwork provided me with an opportunity to refine my (piloted) questionnaire and discussion/interview schedule.
Fieldwork

Kvale (1996:3-5) uses the metaphor of 'miner' to describe researchers 'mining' pristine 'knowledge nuggets' from human subjects. The data from collection to text remains constant (modernism). In contrast, 'travellers' undertake a 'journey' to 'converse' with 'local inhabitants' in a specified area. The resulting data consist of narratives which provide insights and meanings of the local world, and are reconstructed as text (postmodernism). I take the second position in this study. I also agree with Kaufman's (1994:128) claim:

Data are not simply collected. Rather they are created only through the collaboration between the researcher and informant. Data emerge in the process of dialogue, negotiation and understanding.

The data do not magically appear nor are they simply sitting somewhere waiting to be gathered like pebbles on a beach. Rather, the data are shaped by the researcher's theoretical framework and research questions, the fieldsite, the methods of data collection, the researcher's ethnocentric position and interaction with participants, in addition to her/his interpretation of meaning and reflexivity upon the research process (Kvale 1996, Gupta and Fergusson 1997).

For this study, I collected data from late July to late December 1995, using the following methods as discussed above:

- *Fourteen focus group discussions* had 2-11 people participating per group. They were of 1-2.5 hours in length, audio-taped and transcribed. I concentrated on aspects of lay healing. As a forum, the discussions facilitated people to voice their views, experiences and lay practices, ie. what is they do when aware someone is ill or injured;

- *Twenty-four individual research interviews* of 1-2.5 hours were audio-taped and transcribed. Participants in both the focus group discussions and research interviews received a copy of the transcript, as their personal record, which they could check for accuracy and make additional comments; and,

- Each participant in the project completed a *questionnaire* (N=98).

The majority of participants were women (N=78). The discussions were held 0900 to 1100hr during the week, at a time which was convenient to participants (when they took their children to school in the morning), and to the individual schools' timetable. Interviews were arranged at a time and place of convenience to the

---

211 See Appendix G. Some participants who had contributed to focus group discussions also agreed to be interviewed. Other interviewees were of the same school community through which I had initiated contact with parents.

212 Only one participant out of 98 contacted me to 'correct' what and when I had incorrectly noted her as the speaker during a focus group discussion. Sometimes background noise from babies and pre-school children playing, school bells and music playing on occasion made it hard for me to hear what the participants were saying during focus group discussions.
participant at my home, their home, or the school. Some of the women were heavily involved in their children's school activities, whilst other women worked part-time or were not working. Some spoke to me out of their interest in lay healing in the household. Whilst the women spoke of their own healing practices for themselves, their partners and their children, and other people (relatives, friends, neighbours), I wanted to establish whether men (as parents of young children) - and a 'hidden population' (Fitzgerald 1996) - also provided health care in the household, and how they went about doing so. An additional reason was my observation of changing dynamics between women and men in Australian society, as a result of feminism and men, more recently, questioning their masculinity. Family and work relationships appear to be moving towards greater flexibility and integration, and I wanted to test the degree of blurring of gender roles in the home.

Since only seven men had participated in the group discussions, I used snowball sampling (Bernard 1988, Gifford 1996) as a sampling method to contact 13 other men to interview on an individual basis, through personal contacts and networks in the Region, for example, a child care centre, trades hall, tertiary education institutions. Again, the total sample of 20 men is non-representative of the wider male population. Furthermore, given different sampling methods, the samples of women and men cannot be compared.

The final sample of self-selected 98 participants (78 women and 20 men), representing 98 households in the Geelong Region, in the study is not representative of the wider population, owing to sampling techniques. Non-random sampling provides an indicative sample of trends in a particular population group. Despite not being representative, this sample raises key concerns which the literature suggests is relevant to lay people's health knowledge and decision-making. The sample includes factors of gender, age, ethnicity (country of birth, ancestry, language and period of residency in Australia), family structure (including number and ages of children), social class (education, occupation, income), health status (mobility, disability, chronic illness), health insurance arrangements (public and private mix), use of health care services (in Geelong and Melbourne) and geographical location (urban, rural and coastal). These variables form the basis of a questionnaire. The questionnaire also contained two open-

---

21 Gender, is constructed as 'other', because there are only two categories: female and male. Therefore, what is not visible or is kept hidden of one gender reveals the other. In this study, dealing with the 'man question' in the context of household economy and the family home as the domestic sphere meant addressing the invisibility of men as parents and as lay healers; long regarded as the domain of women. Buckett (1990b), Daly (1992) and Edgar (1997), note the difficulty of recruiting men and their under-representation in 'qualitative family research'.

21d See Appendix G: for details of the sample's socio-demographic characteristics, as well as Geelong Region (City of Greater Geelong 1994, 1998), where applicable.
ended questions for participants to comment on the project, and on health and illness that had not already been addressed in the focus group discussions or interviews.\textsuperscript{215}

**DATA ANALYSIS**

The majority of data reported on in this thesis are qualitative; drawn from the interviews and focus group discussions with the 98 participants. This thesis privileges their lay 'voices' and experiences of lay healing practices in the household in everyday life. The sole purpose of the quantitative data is to provide a socio-demographic 'picture' of the sample and participants' use of health care services outside the household.\textsuperscript{216} I chose not to use qualitative data analysis computer packages such as Ethnograph and NUD*IST because I found that they did not suit the type of analysis that I was undertaking. Previous studies are referred to, for comparison with the project's findings (see Chapters 4-7).

I did initial manual coding and cross-referencing of qualitative data. Tape transcripts resulting from the research interviews and focus group discussions were individually analysed for their content and discourse. Atkinson (1995:12) remarks:

> The tension between readability and fidelity is a recurrent issue for ethnographic analysis, and there is no pure or perfect mode of representation. There seems to be no point in the preservation of details in the transcripts if they detract from the analysis rather than informing it.

Themes within the tape transcripts were identified using the edit command 'find', with the software Microsoft Word, for keywords to construct 'datafiles'. The themes include: health education, risk, bodies, smoking, private health insurance, home remedies. Each datafile was analysed for sub-themes.

Univariate and bivariate analysis of quantitative data, on socio-demographic and health care services utilisation variables, was undertaken using the computer software: EXCEL Spreadsheet and SPSSx (4.0). Each questionnaire was manually coded numerically for identification and for each variable. Where there was no response given, the question was coded as a missing value (de Vaus 1991). These codes were entered into an EXCEL Spreadsheet as a basis for using SPSSx for statistical analysis. ABS surveys served as a guide for coding participants' responses.

Participants were asked some open-ended questions, for example, health care services utilisation which resulted in multiple responses. Everyday speech is not always precise (Hammersley 1992, Bernstein 1996). Participants used the terms 'sometimes', 'regularly', 'now and then', 'often', 'several times', 'occasionally', 'frequently', 'many', 'all

\textsuperscript{215} Participants' responses to Q.27 and Q.28 of the questionnaire are not reported in this thesis owing to word constraints.

\textsuperscript{216} A full discussion of the total statistical data is beyond the scope of this thesis and will be addressed in forthcoming papers.
the time', 'few', 'as necessary', when referring to how often they used health care services outside the household. Other data revealed reasons why a particular health care service was used (specific illness or injury, checkup, diagnosis, treatment, medication, advice, other), and where by indicating the location (local suburb, Geelong, other suburb, Melbourne, interstate) and the setting (recreation centre, dental van, home, community health centre, doctor's surgery, infant welfare centre, hospital outpatients). When these questions were coded, a numerical value (arbitrarily defined) was ascribed to the 'qualitative data', to become 'quantitative data'.

A command file (input file) was written for SPSSx to enable statistical analysis of the socio-demographic and health care services utilisation variables. Commands included frequencies, cross tabulations asking for mean, mode and median, and for testing significance using chi square and Pearson's r (de Vaus 1991). A pilot of 10 coded cases was entered onto the EXCEL spreadsheet and then run with SPSSx to check for consistency and program viability. The values for variables of the remaining 88 cases were progressively entered. The codes were checked for accuracy and out-of-coding errors, and the statistics were subsequently re-run. Upon reviewing the frequency tables, new variables and values were constructed, and re-run. I also referred to existing databases such as the National Health Surveys and ABS Census, in their public and aggregate form.

**REFLECTIONS ON THE RESEARCH PROCESS**

**Reflexivity**

Giddens (1984:3) defines reflexivity 'as the monitored character of the ongoing flow of social life'. Several authors make commentary upon 'reflexivity', the necessity for it and its usefulness for the social sciences. Williams and Calnan (1996b:1612) refer to reflexivity as:

the susceptibility of most aspects of social activity, and material relations with nature, to chronic revision in light of new information and knowledge; a situation in which the social sciences themselves play no small part.

Whilst James and Prout (1990:27) assert that

All ethnographic material has to be understood reflexively, that is a product of a research process in which a particular interpretation is made by an observer in relation to the settings in which the observations are made.

---

217 These were checked with a sociologist specialising in quantitative data analysis. See Appendix G for further details on coding of participants' responses to the questionnaire.

Furthermore, 'there is a need to develop a much more reflexive understanding of the ways in which expertise - whether professional or lay - is structured' (Popay and Williams 1996:766).

Throughout the project's lifespan, I documented in my 'reflexive journal' the pros and cons of each stage of the research process, made changes where possible, and used other viable strategies. Re-reading the reflexive journal at later dates, I noted it comprised changes in thinking, orientation and approach to the project. It provided a means for lateral thinking and flexibility of thought and action: 'what works and what doesn't' (Taylor 1996). The reflexive journal fostered a 'self-consciousness' (Cohen 1994), a continual subjective evaluation of myself as researcher and public health professional, as well as my actions in both capacities (Anderson 1996).

A major personal and methodological lesson I have learnt whilst undertaking fieldwork is that despite much goodwill, best intentions and observing the social protocols (letters, phone calls, making appointments, arriving on time) (Fetterman 1989), 'things can still fall in a heap' (cf. Morgan 1995). Maintaining flexibility throughout the project was an issue, particularly whilst conducting fieldwork and recruiting participants to the study (Taylor 1996). When I spoke with Mary, a parent who had participated in the pilot study, of the re-scheduling or cancellations of interviews and focus group discussions, I expressed my initial disappointment and the emotional 'let-down' I felt at the time. She said, 'not to worry about it'. A possible reason for this situation was the type of population group that I was studying, that is, parents of young children.

Everyday life is not static, but is rather dynamic and ever changing. Children get sick. Appointments occur and so do life crises. Asking parents of young children to fit in or be available to be interviewed or contribute to a group discussion, is not always possible, despite their and my good intentions. They are also likely to have their own personal and family priorities, which means that their own agendas must also be flexible.

Listening to Mary, I felt better able to cope when things didn't work out, and became elated when everything fell into place: I had willing participants, happy to speak with me. Being flexible became an important state of being, so that I could emotionally cope with the 'let-downs' and attempt to follow through those occasions when 'everything seemed to fall into place'.

The Researcher as Multiply Constituted Self

Marcus (1995) argues the 'multi-sited ethnographer' is also a 'circumstantial activist' in that s/he negotiates several identities whilst moving between and working within various sites. Levi-Strauss (1966) uses the term 'bricoleur' to describe the
researcher using qualitative methodology; a 'Jack-of-all-trades [sic] ... The researcher-as-bricolour-theorist works between and within competing and overlapping perspectives and paradigms' (Denzin and Lincoln 1994:2-3). Ganguly-Screase (1993) refers to 'the self as research instrument', meaning s/he is also the subject of others' scrutiny and becomes the 'observed' when undertaking fieldwork (cf. Bruenjes 1998). Hedican (1986) has noted the multiple positions assumed by anthropologists in the field: advocate, mediator, ombuds(wo)man, hired hand, observer, adviser, consultant, counsellor and executive. Sociologists have also played these roles (cf. Daly et al 1997). Each adopted role encompasses ethical considerations, a degree of involvement and 'social responsibility' towards the participants (and their immediate social groups), and may have a bearing upon the political ends of social science research, which becomes no longer an esoteric exercise.209 Inevitably, there are potential tensions and conflicts when alliances are made, whilst at the same time the researcher endeavours to maintain a neutral and objective position.

The researcher as an embodied self, is also 'multiply constituted'. Reflecting upon the pilot study and the preparatory stage of fieldwork, as a process and its outcomes, I recalled that in obtaining access to school principals, and through them to parents of young children, the following factors appeared to be important: being a parent of a (then) 11 year old child attending primary school; a health professional (registered nurse since 1982);210 a researcher (doctoral student at the local university); and, a teacher (lecturing in medical anthropology and health sociology to first year nursing students at a university in Melbourne). Singularly and collectively these roles or my 'wearing of many hats' (Peerson 1990) affected my relationship with school principals and their willingness to give approval, and with parents voluntarily participating in the study. Sometimes there were tensions between these roles, because of a change in my relationship with them, the nature of social dynamics between participants and myself during a group discussion or an interview; but characteristic of the research process. I also had to consider my own humanity: being human like everyone else with emotions, thoughts, attitudes, knowledge, beliefs, experiences, and skills.

Additional factors, I believe to have had an impact upon the conduct of my research were firstly, my personal presentation. Personal presentation included grooming as well as being confident and flexible, with a willingness to reciprocate, negotiate and compromise by inviting comments, and observing 'social graces' (letter of introduction, phone call to make a personal appointment, visiting the school in person, formal letter seeking approval from the school principal and council). Secondly.


210 I adopted an non-judgemental position during fieldwork when laypeople (including participants) spoke to me of diagnosis and treatment of illness and injury. I was open to hearing their ideas and practices. Whenever, I felt concerned for someone's health status or safety, I made referrals to diverse healers within the Region who could address the issue with greater ease and experience than myself.
flexibility in the field meant a willingness to negotiate a convenient time and place for
meetings with school principals, and hold discussions and interviews with parents.
Thirdly, being aware of the ethical considerations of research, I assured school
principals and councils, and parents of confidentiality, anonymity, participation,
reciprocity, involvement in decision-making, and acknowledgment of the 'other' as
being important, ie. each person having their own agendas, life histories, experiences
and knowledge.

Jenkins (1994:447) asserts:

The anthropologist is not an individual without a history face to face with his or
her 'people', but is in a sense a multiplicity, a certain kind of person who will be
'read' in certain ways by those encountered, and who will perform certain

'Reading' a situation is a two-way process as the encounter takes place between two or
more people (Fetterman 1989). No longer is the individual a self-image but presents
her/himself and is 'read' by others who reflect her/him (Goffman 1959). The reading
requires sensitivity, listening and communication skills, 'emotional intelligence'
(Goleman 1996), awareness of personal qualities (sincerity, honesty, integrity,
competency), and human fallibility. It is possible that I, the researcher, did not always
correctly read a situation. Each party may have different perceptions of it and of each
other. Whilst all participants in the study volunteered their time from busy schedules as
parents of young children and other roles and responsibilities, I remained an 'outsider' to
their private and intimate worlds. First impressions on meeting them and vice-versa
were crucial to the 'success' of the interview or focus group discussion: measured as
congenial relationships and data collected.

**Participants as 'Agentic Selves' and 'Reflexive Subjects'**

'Self' and 'personhood' are recurrent themes in this thesis. In all of the narratives,
participants related, at length, aspects of themselves as embodied, reflexive, agentic
selves and autonomous, knowledgeable and decisive beings.\(^{221}\) At other times, they
viewed themselves as helpless, ill, and frightened, requiring the assistance of others
during crises and life-threatening emergencies. They conceived of themselves as both i)
a state of being that was self-determined and existentialist\(^{222}\) or essentialist,\(^{223}\) and ii)
constructed in reference to social relationships.\(^{224}\) Participants conveyed a contradictory
representation of their 'selves' as both essential and constructed. Some participants also
viewed their 'selves' as continually evolving as the result of life experiences: they

\(^{222}\) See Sartre (1956), de Beauvoir (1974).
argued that who they were as a person when children or teenagers is different from how they are now as adults (1995).

Focus groups presented a different set of issues to the interviews. With the former, it was essential to 'assist' participants to become comfortable with one another. Although residing in the same community, participants did not always know each other (Bender and Ewbank 1994). In addition, being part of the school community meant some participants were friends, relatives or acquaintances, had worked together on school committees or been involved in other activities, knew each other by sight or as the parent of a particular child, ie. 'Alexandra's Mum' or 'Jamie's Dad', or they did not know each other at all (especially if new to the school community). I would introduce myself and the project over a cup of tea or coffee with added cake and biscuits provided by myself or the school, chatting to make everyone feel at ease with a 'stranger' or 'outsider' in their midst (Peerson 1990, Berg 1995). Everyone in the focus group was asked to introduce themselves, before I began the session with some open-ended general questions on health and illness.

The social and interpersonal dynamics of each group were unique on each occasion. Overall there was a very congenial atmosphere with parents of young children willing to give me some of their time. Participants cross-questioned each other for more explanation or to provide a rationale for actions, exchanged information and ideas (home remedies, healer referrals), offered advice and mildly disagreed. They sometimes aired alternative viewpoints on a single issue: an indication of their different experiences and values. There was much laughter and joking, and display of support, courage, wisdom, delight and respect. At times, several people would be talking at once, jumping in and interrupting each other. At others, their heads would be nodding in agreement with one another: to confirm a similar experience or expectation (Carey and Smith 1994). In some groups, certain participants 'dominated' the discussion more than others, were more confident or held strong views. I encouraged 'quieter' participants to speak out, use their voice, and present their personal perspectives and experiences. Some health and ill-health issues were most topical (women's health, private health insurance, smoking, defining health and illness, safety) and prompted so much lively and prolonged discussion, it was difficult for me to get a word in edgewise. I had to wait for a lull in the 'multilogue' to pose a new question, request more details or clarify an issue raised by participants.225 The interviews had their own shape, in many ways dissimilar to the focus groups. Two parties - the participants and researcher - were engaged in dialogue (Kvale 1996).

Throughout the focus group discussions and research interviews, information was exchanged between myself (the researcher) and parents (participants). Our roles held in

common were that of parents, concerned about the health of our children. In my
capacity as a researcher, I also had input in the discussion and interviews. At times I
felt I was also a participant. It was not always a clearcut role, as I was also sharing
personal life experiences as a human being and as a parent. This admission of 'myself'
often led to the participants discussing an issue in greater detail and eliciting further
data (Daly 1992).

In encouraging parents to speak of their everyday life experiences, I adopted the
passive role of 'listener' with minimal active input as a speaker, asking research
questions. The questions in turn supplied answers; the basis of qualitative data. Each
active participant exercised agency and readily determined what information to provide
me. They were their own 'censors' of information, guaranteed the additional proviso of
withdrawing from the project, and hence their freely given information, at any time
should they choose to do so. At the same time, participants requested an explanation or
further information (oral and written) about various health issues: relationships
(emotional well-being), menopause, miscarriages and infertility, mental health,
alternative therapies, Medicare and private health insurance, Pharmaceutical Benefits
Card, medication and other drugs, faith healing and stress (age and work related, coping
mechanisms). This situation occurred throughout the fieldwork, despite the fact that I
emphasised to all participants that I was not a medical practitioner and not undertaking
the research in my capacity as a registered nurse. On these occasions I answered their
questions and made referrals to other healers personally known to me or recommended
to me by colleagues (through my own professional networks). These referrals were
made to: naturopaths, family and child services, acupuncture, myotherapist (massage),
psychological counselling, general practitioners with experience in women's and men's
health, folk healer (dealing with spirituality and energy levels), and the 'miscarriage'
clinic at a women's hospital in Melbourne.

Time and again, I was struck by participants' memory and their ability to recall the
minutiae of previous and current episodes of diagnosing and treating illness and injury,
either at home or by other healers and institutions. The context of the storytelling was
always set in everyday life; family activities. What they were doing, where and when.
For example, going for a walk, swimming at the beach, playing in the backyard, in
contact with other children, observing biomedical health professionals provide care at a
hospital's outpatients department or infant welfare centre.

**Narratives of the Self and 'Tales of the Unexpected'**

The narratives contain colloquialisms, anecdotes, symbols, abstract concepts and
concrete realities. Narratives from the interviews and focus group discussions are

---

227 See also Oakley (1981), Daly (1992).
replete with people's names, indicating 'significant others' and 'distant relationships'. The discourses convey subjective imagery and representations of individuals' (and collective) embodied selves in relation to health, illness and injury. Metaphors of the body are bountiful, as well as descriptions and meditations of incidents, crises and transitions in participants' lives. Life for them stood still through memory (past) and moved forward to where they were at the time of speaking (present), whilst fostering self-reflexivity upon their subsequent actions (future).278 Within the narratives is an implicit trajectory of lay healing in everyday life. They reveal lay discourses on health and ill-health, sources and types of health knowledge, decision-making and how laypeople undertake lay healing practices in the household.

There were also 'tales of the unexpected'. The qualitative data reveal certain 'skeletons in the personal or family closet' and 'taboo illnesses' (Kitzinger 1994). Examples are: epilepsy, baby with cancer, alcoholism and abuse, disabled child with spina bifida, nervous breakdown, mid-life crisis, anxiety, accidents, hormone replacement therapy for a pre-menopausal woman, manic depression, benzodiazepine dependency, suicide attempts. There were also issues I least expected to encounter: the importance of rest and sleep, negotiation, gender role reversal, divorce, unemployment, retrenchment, moving house and nuclear testing. Participants revealed some issues and experiences during interviews and focus group discussions that they had not discussed with their own significant others, but which are part of understanding the human condition which affects us all. Participants' accounts also indicate those matters they consider 'public' as distinct from 'private' (Cornwall 1984). These insights into family life and lay healing, enabled myself as researcher to 'gain [sic] opportunities to understand private-public [and intimate] boundaries as well as process by which these boundaries are presented and maintained' (Daly 1992:5). When I 'sensed' that the conversation was veering towards a sensitive issue, or the participant appeared upset, I stopped the tape recorder and asked them whether they wished to change the topic, have a coffee break or discontinue the session altogether. Keeping ethics in mind, confidentiality was assured. In all instances, participants asked to continue. Participants were assured that in reporting the results, their identity would be concealed and they would be given a pseudonym.

CONCLUSION

Often evaluation of a research project is either not undertaken or is done as an afterthought. For this reason, 'evaluation-on-the-run' (Wadsworth 1991) has been included as an integral part of this study. Reflexivity, through keeping a 'reflexive journal', assisted both the shaping of the project's contours, evaluating its many

theoretical, methodological and data components, as well as consideration of its implications for healers' clinical practices, public health research and health policy. Whilst the data reveal laypeople's views and experiences of lay healing practices in the household, their health knowledge and decision-making, and how macro conditions affects households and health status, the study has the following parameters.

Firstly, the sample includes more women than men owing to sampling techniques, time and resource constraints to expand the sample. Non-random sampling techniques were used to recruit participants to the study, therefore the sample is not representative of the wider Australian population, although, each participants represents a household in the Geelong Region (City of Greater Geelong 1998).

Secondly, the study primarily focuses on a particular population group - parents of young children. Each participating had at least one child under the age of 12 years. Therefore, this project did not examine other population groups such as adolescents, young adults or older persons and their lay health knowledge and decision-making, nor their lay healing practices in the household. These population groups - of different age cohorts - are only referred to in relation to the sample: participants aged mid 20s to late 40s.

Thirdly, most participants were Australian born or of Australian or British ancestry. Very few were born overseas or of non-English speaking ancestry. Ethnicity as a structural factor was not a significant variable in this study.

Fourthly, some participants (and their partners) were also health professionals, and it may be argued that their experiential and specialist knowledge of the health care system does not give them the status of 'laypeople'. However, as previous studies readily indicate, when health professionals and folk healers are themselves sick, they no longer enjoy the same status as their colleagues who treat them; rather they are regarded as 'patients' and obligated to fulfil the 'sick role'. Given participants' self-selection and the methodology, it was not possible to exclude these as I was not aware of their occupation prior to their participation. This data were revealed in the questionnaires which were administered to them after an interview or focus group discussion.

Finally, feminist critiques of the research process tend to assume participants as passive victims of research within an unequal power relationship vis-a-vis the researcher (Oakley 1991, Roberts 1991, 1992). I assert, that during this project, participants were both 'agentic selves' and 'reflexive subjects'. They 'volunteered' their self-selection, determined and censored what would and would not be discussed during interviews and focus group discussions, and the extent of information provided in the questionnaire.
CHAPTER 4
L A Y C O N C E P T U A L I S A T I O N S O F H E A L T H A N D I L L N E S S

Global Indicators of Health and Ill-health

The World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (in Hetzel 1976:16). 'Health' in this sense is an utopian state delayed to the future, an ideal or goal to work towards, but its achievement is difficult to assess. Whilst maintaining a holistic view of health, this ideal is open to individual and population interpretation in time and place, for it assumes that good health is constant throughout the lifecourse, and it overlooks the socio-cultural and physical environmental conditions of people and their genetic predisposition to ill-health.229 This iconoclastic definition has been used as the basis for health policies and programs on a global scale since 1947. It was constructed within the context of post-World War II and the ravages of such a war upon the health and well-being of people, particularly in the countries directly involved and indirectly affected. Given the historical antecedents of this definition and significant social change that has occurred since, I pose the question: is it time for a substantial re-thinking of this definition of health (Peerson 1996b)?230

Health and illness are frequently described as either dichotomous or being on opposite ends of a continuum. The medical model uses a dichotomy of health equals the absence of disease. The mid point of a continuum is 'a neutral point of no discernible illness or wellbeing' (O'Donnell 1986:4).231 This has been the basis for health promotion campaigns, using 'the science and art of helping people change their lifestyle to move toward a state of optimal health' (O'Donnell 1986:5).232 Radley (1994) asserts that lay concepts of health and illness are not set in concrete but are based on past experiences of illness and disease, and they do not form two ends of a continuum. 'Chronic illness tends to oscillate between periods of exacerbation, when symptoms worsen, to periods of quiescence, when disability is less disruptive' (Kleinman 1988a:7).233

A social model of health has increasingly been used in developed countries to plan for health improvements.234 The women's health movement in particular has adopted a

---

230 Kickbusch (1994) recognises that there is a need to change an emphasis to health henceforth, as the basis of all policies and programs, rather than illness and disease. Illich (1994) suggests that instead of viewing health in terms of illness and disease, emphasis should be given to life and death.
231 It is possible for this neutral point to be non-existent. When people say that they feel 'so-so', perhaps at this neutral point, it really means there is something wrong.
232 See O'Donnell (1986:4, Figure 1) for a diagrammatical view of the health continuum.
233 See also Duff (1993) and Kagawa-Singer (1993).
social model of health given the feminist view that 'many of women's health's concerns have been identified as being social in origin' (Hunt 1994:390).

The social model recognises the interconnected nature of people's complex lives and contextualises biological health in its social, economic, cultural and psychological dimensions ... [this model] incorporates wellness, a philosophy which moves beyond freedom from illness to models of human fulfilment and self-discovery. The solutions go beyond cure, illness prevention and health promotion to social action for a healthier society (Hunt 1994:390).

The 'new' public health focuses both upon individuals taking full responsibility for their health and well-being, as well as addressing the social, economic, political and environmental factors affecting population health (Lalonde 1974, Ashton and Seymour 1988, Pederson et al 1994, Bunton et al 1995, Petersen and Lupton 1996).

In this chapter, I commence reporting the results of my research by discussing laypeople's conceptualisations of health and ill-health as indicated by participants.

**BEING HEALTHY: GENDER AND AGE/GENERATION**

A review of key medical and public health journals reveals that health professionals have varying and often contradictory discourses on health and illness. Is this also true of how lay individuals conceptualise health and illness? What are the discourses about the healthy and unhealthy body used by lay individuals? In this section I address these questions within the context of public health, contrasting the 'etic' discourse of health professionals with an interest in measuring health (paradoxically as indicators of ill-health) with how laypeople of diverse backgrounds give 'emic' accounts of what constitutes health. Radley (1993:2) argues:

such research not only tells us how people think of health and what causes it to be breached; it also tell us about the assumptions (or social representations) that articulate people's experience of the sick and of their own periods of illness. Therefore, the worlds of illness and of health cannot be wholly separate because they inform each other; how this happens has important implications for theory and methodology in this field of research.

Similarly, the relationship between health and illness informs the interpreting of the patient-healer relationship, the use of language to describe the body, and how knowledge is used and power is exercised by laypeople to provide lay healing for themselves and others.²⁴⁶

Participants in this study conceptualised 'health' in a positive sense as daily functioning, in terms of life expectancy and longevity, well-being and quality of life. They tended to perceive illness negatively as: the opposite of health, not functioning (i.e. as a dichotomy rather than as a continuum), due to microbial infections, resulting in

²³⁵ See Chapter 6 for further discussion.
²⁴⁶ See Chapter 7 for further discussion.
dependence upon others, and experiencing pain. Mental health and spirituality (in addition to a focus upon the physical body) were important dimensions of participants' lay conceptualisations of health and illness. At times, participants referred to health as a gender-neutral concept, and at other times as gendered. They also considered health and ill-health as states of being indicating a confluence of gender and age. Participants perceived 'age' in terms of generational differences (adults and children) and the ageing process (individuals).

Critique of the Biomedical Definition of 'Health'

Participants in the study both used and critiqued the negative and reductionist definition of health as 'absence of disease'. For Geoff, health as 'the absence of disease' was linked with being a 'reasonable weight' and being 'fit to lead a lifestyle that you wish to lead'. Peter defined 'the word healthy' as 'a general state of being.'

Fairly good welfare ... You're feeling a fairly good quality of life ... I see health as being able to participate in everything around you.

Jack believed 'it's a state of mind that you feel healthy'. He explained 'it's a subjective judgement of a person, or an organisation or whatever, that they're in a healthy state.' It depended on the standpoint and whether an individual's health or a population's health was being measured by 'a health survey or a government department'. Health is also a 'subjective view of what your clients haven't got'. That is, it is possible to determine their health as 'the absence of disease'. 'So you'd consider them a healthy population if they sort of passed a series of standard measures.' This criteria of health has been used as the epidemiological yardstick for measuring health (Beaglehole and Bonita 1997).

Both women and men in the study did not agree with the biomedical notion of health, but rather, viewed it in terms of daily functioning, well-being and quality of life, and as a value that was sometimes taken-for-granted (cf. Cornwall 1984, Pill and Stott 1986, Calnan 1987, Herzlich and Pierret 1987, Blaxter 1990).

Daily Functioning

The functionalist notion of health refers to being able to fulfil all one's social obligations and not be dependent upon others (Parsons 1951, Gerhard 1989). Energy, happiness, balance, responsibility and adhering to a daily routine were key terms participants used to describe health as 'daily functioning'. Some participants claimed that being healthy meant 'you feel good and energetic ... Not tired all the time. Happy.' 'Happiness and having energy are important for daily functioning.' Dixon et al (1993:4) note that 'energy is an aspect of health self-assessment and self-knowledge', and serves as an accurate barometer of laypeople's well-being. Sudden changes in daily energy
levels or extenuated fatigue may indicate early warning signs of disease pathology. Other participants claimed a person in good health is 'well balanced physically, emotionally and spiritually.' Balance implies a functional equilibrium, and 'being able to do the things that you want to do.' Sandra defined health as:

It's that feeling that you have when you wake up in the morning and you feel really good ...
You have a feeling of wellness and nothing's hurting. You can get through your day really well.
And all the things that your life requires of you.

Furthermore, health means also 'being able to do what you need to do. To think clearly.' Michael, Jack and Scott agreed that health means: 'I can do what I want to do when I want to do it without having to have any concern about my health.' Health is being able to maintain a healthy lifestyle ... maintaining your circumstances in such a way that it gives you a chance to be healthy; and, being able to 'cope with the stress of daily living' as well as 'enjoy and find satisfaction in the things I do' such as 'going to work, coming home' and 'spending stress-free time with the family'; fulfilling a myriad of responsibilities. Ian stated that for him, good health entailed being 'able to perform all the normal, simple duties ... looking after yourself. Looking after the family, ferrying them to and fro, up and down to school, and then going about your normal work duties.'

Family routine provided 'ontological security' (Giddens 1990) for Gemma and Kirk. For Gemma having a daily routine was essential for good health. She works part-time teaching children with intellectual disabilities, helps voluntarily with children's reading at the local primary school 'two mornings a week', and takes her youngest son to playgroup. Her husband is self-employed working from home.

For our general health it's important for us to all fit in together and have a routine for the kids and ourselves ... I do a lot of thinking about what else they might need to do.

At the same time Gemma endeavoured to include some variety into the daily family routine (such as food and activities), 'I try to sort of fit in the social needs of the kids too', since they are also important and can be often forgotten.

Kirk viewed health as functional by being able to do 'the things that you want to do, in terms of lifestyle, fulfilling responsibilities.' He was concerned not only for his personal well-being, but also for his wife and three children. Kirk believed he had a legal responsibility for family in the sense of 'maintaining a home and conditions to the point where it is health related in terms of they're adequately provided for.' Furthermore, if any of the children became sick, he regarded it his duty to ensure they

237 See Popay (1992), Research Institute for Gender and Health (1996).
had 'proper health care' and 'that they're seen to quickly'. By caring and providing for his family, Kirk considered his family's health was maintained. He believed the 'most caring relationships really take care of themselves'. However, 'it's minor illness which just sort of interrupts routine, to serious illness which can incapacitate yourself'. Kirk emphasised 'the responsibility of making sure that you looked after yourself ... to maintain your lifestyle and carry out your responsibilities.'

Being in good health and able to function on a daily basis meant women and men in the study were able to fulfil their parental responsibilities towards their children and provide for their families.

*Life Expectancy and Longevity: ageing bodies*

Age emerged as an important dimension of difference defining health. Chronological age, their ageing bodies, life expectancy and longevity were of greater concern to men in the study than to women. Throughout the human lifespan, chronological ageing manifests changes in the body's shape and form, abilities and functioning. Turner (1994b:110) argues that the 'disjuncture between the ageing body and the continuous self' appears inevitably, producing a "mask of ageing" in the post-modern lifecourse. As the body ages, it may be limiting for the embodied self, and lifestyle changes may be necessary to ensure a healthy body, and maintain or improve its functioning. Hazel stated:

As you get older too, you learn about certain illnesses that affect you. And you learn to look after your body and to cope with those illnesses.

Hugo and Owen spoke of their ageing bodies as setting physical and social limitations (Margo 1998). Hugo compared his body as a teenager and currently (in his late 30s at the time of interview). When he goes bushwalking now, he tends to get a 'sore back' and 'sore knees'. He maintained that he still considered himself 'as healthy, but there are just minor inconveniences'. Moreover, 'I certainly can't do what I did 20 years ago ... it's [my body] just wearing out a little bit.' Owen (aged 42 years) claimed a mid-life crisis had prompted his self-awareness of the visible aspects of his ageing body and the effects on him emotionally, socially and in the workplace. Not only were his friends of a similar age dying around him, he also had younger bosses at 28 and 32 years of age.

---

291 'Mid-life crisis' is also called 'male menopause; andropause, viripause; depression; a watershed; or a time of emotional stocktaking' (Margo 1998:23, cf. Peter O'Connor 1981). It is a time of 'reappraisal' when men in their late 30s to early 50s discover their 'vulnerability' and fragility; emotionally, physically, spiritually, socially and sexually.
on high salaries - 'sixty grand [$60,000] a year' - and he missed out on a work promotion. Even though Richard perceived his body as getting older and less productive, he maintained a continuity of his 'self'. His partner (a health professional) 'explained to him' that "there is no reason why a 45 year old body can't function like a 25 year old body if it is well cared for and exercised and all those things." However, he asserted it was much better to incorporate exercise into daily activities rather than undertake what he called 'pseudo exercises': that is, 'where you're not doing anything productive except making your body healthy'. Unlike Owen, Richard was more inclined to towards the notion of ageing of 'you're as old as you feel', rather than being a chronological phenomenon.

Desjarlais et al (1995:5) state:

greater longevity has been accompanied by an increasing burden of chronic disease and social and behavioural health problems. In part, the increase comes about simply because more people live to later ages, when heart disease, arthritis, stroke, dementia, and other chronic diseases first appear.

Other reasons for longer life expectancy are 'improved survival among infants during their first year of life' (Miles and Brody 1994:5), lifestyle changes with better nutrition and sanitation, more exercise, and the medical profession's use of drugs for treating diseases and keeping people alive longer. There are gender differences in life expectancy. More male babies are born than female babies (105:100) each year, and yet women's life expectancy at birth is six years longer than men's (AIHW 1996). Men's life expectancy is less than women's in most countries around the world. There is also intra-country variation in life expectancy. Life expectancy remains to date a limited indicator of health, as it does not consider quality of life. That is, how life is lived, enjoyed or valued by a person. Rather, it is only measured in terms of how long a person lives or as chronological age. It is only more recently, that the AIHW (1996) is developing a new indicator of life expectancy to incorporate quality of life.

Participants in the study, especially men, aimed to live longer than their middle aged friends and their elderly parents, that is to a 'ripe old age'. Richard and Owen, aged 46 years and 42 years respectively claimed that they had experienced or were experiencing a mid-life crisis at the time of interview. Both men had male friends of a similar age group who were either in poor ill-health (heart attacks, cancer) or had died recently. Both men expressed their desire to live 'until a reasonable age'. When I asked them to define this, Owen answered: 'Certainly older than my father's death at late 60s.

---

243 See also Taylor and Salkeld (1996).
think that if you're still healthy then, you could be looking at a good 80'. For Richard, this meant being 'able to live about 75 years of age'. He placed his desire for a longer life in the context of his working class background. He indicated that for a working class person to live beyond 60 years 'you've had a good life', but 'to think that you could live to 75, you're just kidding yourself.' He explained: 'I've always rebelled against those sorts of ideas and left home very early' when he was 'about 18 or 19 [years old] and went off and discovered other ways of doing things.'

The two men's awareness of their own age and lifestyle, and the examples of others, prompted questioning of personal health status and life expectancy. For Richard, these existential questions occurred when he was 35 years old; 'the bell rang basically and I heard it'. He explained:

> Alarms go off, constantly throughout your life. And there was an alarm and it said, 'if you keep doing what you are doing, you are going to be very sick by the time you are 50, which is four years away from here.' Do you want to be very sick? ... 'You're really enjoying what your doing but do you want to continue to live like that?"

Between the age of 30-35 years, Richard was smoking 40-60 cigarettes a day, as well as taking drugs (legal and illegal). A change of lifestyle for Richard entailed moving away from a 'feral existence' led by peers in a coastal area who maintained these habits, to living elsewhere in Australia. 'And it was extremely difficult to step away from it because I was surrounded by people who lived the same lifestyle and they were my friends.' In contrast, Owen wanted to 'live longer than bad health would allow', rather than 'die at 30 or 40 or 50 [years of age].' He did not change residency or his social circle, but instead he evaluated his health status as 'healthy', and sought to reduce his dependency on cigarette smoking and drugs (marijuana).

Age, their ageing bodies, life expectancy and longevity were of greater concern to men in the study than to women.

**Well-being and Quality of Life**

The present health status indicator: quality of life, enables examination of the relationship between subjective (personal) and objective (clinically measured) health status. The health indicators: QALYs, DALYs and DFLE are based on physical ability and function, quantify health in measurable terms, and are used by clinicians, psychometricians and economists to evaluate health outcomes of treatments, measure health status and allocate health resources.\(^{247}\) The WHOQOL Group (1994, 1995) is developing cross-cultural measures of health, which are broader and holistic indicators

\(^{247}\) See Hall (1994), Beaglehole and Bonita (1997).
of quality of life, by including physical, psychological, level of independence, social relationships, environment, and religion-spirituality-personal beliefs dimensions of health. Allison et al (1997) argue that quality of life is not static, but rather a 'dynamic construct'. There are differences between subjective (personal) and objective (observer) views. Quality of life changes over the lifecourse, is mitigated by life stresses and crises, and is a multi-dimensional concept.

For women and men in the study, well-being and quality of life were important indicators of health, for ensuring the physical, mental and spiritual integrity of individuals and families. Families in the study were married or defacto couples with children (N=89). The remaining families were of sole parents: women-headed households (N=9). Married men in the sample considered 'family security' essential to well-being of all family members. They asserted that children seeing their parents' affection for each other, who in turn, spent time (quantity and quality) with their children contributed to 'healthy families'. Where a family member suffered an acute or chronic illness, the change in status from 'healthy' to 'unhealthy' had a major impact upon their roles and responsibilities in the short to long-term. Households made adjustments to daily living arrangements - who does what and when - and sought outside social support from friends and relatives to assist with 'caring for' the sick person, whose participation in social and sporting activities was curtailed. This was the experience of Adrian who suffered chronic pain, of Kelly and Andrea whose children had been diagnosed with epilepsy, and of Belle whose father was experiencing Alzheimer's disease.

In a rural area, Elizabeth, Gail, Isabel, Donna, Fiona and Hannah indicated 'health' from an individual perspective meant:

To be happy ... No illnesses ... Lack of disease ... Ah, I guess a feeling of well-being and able to participate in sport and general life - healthy mind, healthy body - that sort of thing.

For other women in the study, health was much more than the absence of disease. Andrea stated:

To be physically fit, not to have any signs of illness - physical illness. Not to be fatigued. To be able to cope mentally and psychologically with the pressures of external things that come up in your life - external environment issues that come up, and other external factors that influence your life.

---

External influences meant drugs and alcohol, illnesses, work and peer group pressures that are beyond the individual’s control and situated outside the household, and yet influenced family members’ health and well-being. Other participants viewed health as: ‘Well-being.’ 'Feeling good ... Physically, mentally and spiritually.' 'To me, it means everything. Good health.' Being 'happy and to feel good in yourself', and having a ‘happy lifestyle’ (cf. Litva and Eyles 1994). Well-being and quality of life, Sarah and Neil agreed, rested upon physical and mental strength and fitness, and being independent of others. However, there was no guarantee that by following a healthy lifestyle and feeling well within oneself would lead to quality of life nor extend life expectancy. Despite individuals taking ‘good care’ of themselves, chance or fate may intervene and affect both their health status and life expectancy.²³² Pam asserted:

“I knew a woman that was a vegetarian, a vegan, sorry ... and she led this most spartan life. She was dead at 24 because she was hit by a bus ... so what was the quality of life?”

Participants suggested 'you might do everything in moderation but you still die of something' whether it is a 'heart attack', 'stroke' or an accident. They were aware that an individual’s genetic predisposition to certain diseases did not absolve them from the potentiality of death, despite leading a life of quality.²³² Vicky and Natalie remarked:

“Vicky it also comes down to the hereditary things as well. People might do everything right by their heart but may still have a heart attack or something because ...”

“Natalie Their family [a member] may have died from it.”

However, current screening programs are testing asymptomatic - but 'at-risk' - persons for various diseases: breast cancer, cervical cancer, diabetes, hypertension,²³³ by ‘visualising the invisible’ (Sachs 1995).

Men viewed health as being independent whereas women emphasised interdependence and social networks.

Valuing Health

Finkelstein (1994) comments upon the taken-for-granted activities of our daily lives, noting that:

“What we do each day, the routines of life seem utterly normal and natural. We do them almost without thinking - we drive a car, go to work, drink with friends, shop for clothes, take in a movie. None of these appear very interesting because they are unremarkable and common (Finkelstein 1994:ix).”

²³² See Litva and Eyles (1994).
These taken-for-granted, 'unconscious' activities of our lives would not be possible if we did not also enjoy good health. Participants valued health as an important component of their lives, whilst at the same time, many also considered that it was 'taken-for-granted' until ill-health occurred. Alice viewed health as 'everything flows', whilst for Beth health is very important 'because nothing is interrupted'.

You can do whatever you wish. The children are happy when they're healthy and they're not so grumpy. It doesn't make you irritable, because you're worried about them. Everything seems to run smoothly, when everyone is healthy.

For Neil, the importance of health meant physically being 'able to walk around and do what you want to do'.

Participants in the study spoke of taking health for-granted before they suffered an illness. Their health and well-being was not a 'worry' to them until there was a dramatic change in health status, or the 'body turns nasty'. Belinda and Ian agreed: 'You realise when something happens, and you were healthy [previously]. When you're healthy you don't worry about your health.' Good health 'represents being able to do those very simple, taken-for-granted things.' When illness or injury occurred, it means not only being unable to function and perform daily duties as expected, but 'until you've been very sick' an individual doesn't realise 'how vital and important they are.'

The suddenness and severity of an illness or injury can dramatically alter a person's perception of good health and their whole lives. Ian remarked that 'if you live with some sort of illness, or have had major illnesses in the past, you can be brought down to earth, savagely ... You become acutely aware of what a massive thing good health is.' And so value health more highly. He qualified his explanation: 'Yes you may have some small disability or whatever, but we still function. We still do our normal things with the imposition of whatever limitation we might have.' Health *vis-a-vis* a minor ailment, disability or chronic condition may be 'denied' or 'absorbed' by the person (Litva and Eyles 1994). Ian acknowledged individuals varied in their value of health.

People who have a very minor cold or something and to them that's a major thing. But on the whole scale of things, oh it doesn't even scratch the surface. We live in a country that is free of wars, free of famine. A very affluent country. I know we have extremes in the health matters.

---

That is, both health and ill-health are subjective and relative states of being. Given the unpredictability of illness and injury, both women and men in the study valued health for themselves and their children.

Health as Gender-Neutral

Some participants in the study did not perceive any gender differences in health and illness. They talked of 'people' - rather than 'women' or 'men' - being healthy or unhealthy. Thus in some cases, health was a gender-neutral concept. Hugo stated: I think if you're going to apply [a] definition to health, it shouldn't be gender specific.' Rather, he considered health and well-being in terms of 'biological constraint' and what is normal and natural. For instance, 'what's normal for a male my age [37 years]. Such a definition of health, Hugo asserted, should be equally applied to both women and men.236

In a rural town, Ingrid, Kay, Marcella, Patricia, Christopher, Jo, Libby, Nadia and Rose discussed female and male roles, and how they influenced gender constructs of health and illness (cf. Verbrugge 1983, Broom 1998a, 1998b). In the study, few participants viewed a gender difference in illness behaviour. Rather, they believed an individual's illness behaviour was due to their personality. Christopher indicated: 'that the motherly component of it continues on whether that person is at work in the family or the child giver. The caregiver.' Even when he is feeling unwell, he is unlikely to take a day off work. Although, he was not adverse to some sympathy, care and attention. Another primary caregiver, Blair gave the example of him and his wife's differential responses to illness and injury.

My wife's one where she doesn't like to miss a day of work no matter what. Whereas I've always been more conscious of how I don't feel well in that the hand is very sore from what I did yesterday and going to take the day off to get over it.

Blair considered his wife learnt 'a very valuable lesson a few years ago by not stopping home getting over a cold, she developed pleurisy.' As a result, she spent three weeks at home in bed rather than two days 'to get over the cold'. Blair believed that regardless of gender, 'it's very important to look after yourself ' and prevent ill-health.237

236 Interestingly, the recent National Health Survey 1995 (ABS 1996b, 1997) the survey contained questions related to 'health' in general and to women's health specifically, but did not include questions on men's health.

237 See Chapter 7 for further discussion, and examples of health and ill-health as gender-neutral and as 'gendered'.

Confluence of Gender, Age and Health

Analysis of the data reveals health is a 'state of being' irrespective of gender and age. Or rather, health exists as a confluence of gender and age. Women and men, adults and children are either in a state of health or are in ill-health. Secondly, participants themselves claimed there is no gender or age difference in health.

Michael did not perceive any gender or age differences in health and illness: 'if you want to be able to do something and ill-health means that you can't do it ... then you're not healthy.' Sarah regarded healthiness as: 'You are active and reasonably fit. Sleeping well ... even with a variety of foods to keep up your health.' Libby and Sarah commented that when they met somebody they would assess their appearance 'whether they are off colour' or are 'physically strong' and 'have clear eyes and skin'. The personal feeling of being healthy or unhealthy had an outward manifestation apparent to others, related to their energy levels (Dixon et al 1993, Mullen 1993, Saltonstall 1993). Libby said:

I think too, that if you're feeling healthy and you're feeling well, it shows in your energy levels, and outwardly how you are ... if you come in looking like something that the cat dragged in, you think, 'well, something is wrong'. Like, when you're healthy there's a spring in your step and all that sort of thing.

Other participants related gender and age differences in health of their daughters and sons. Kirk commented upon his 15 year old son, John, 'that even as a child' when he is sick it was 'always worse than anybody else.'

He always tended to be a sick, sick baby. When he got sick he was awful. He was awful in the sense that when he would get it, he'd get it twice as bad as anybody else.

Despite, experiencing good health in between episodes of ill-health, John is 'so solid and a good eater' that his parents expected him to enjoy good health on a continual basis. Whereas, Lana, his youngest daughter (aged 10) 'has a tendency to put on weight.' Therefore she (and her parents) self-surveil her diet, eating habits and body weight as a preventative measure against illness (cf. Mayall 1986, 1993b, Bordo 1993).

Both the human body and one's health status change with age. Being old is a state of mind as well as chronological.²⁵⁶ Whilst being healthy is both self-reported (subjective) and biomedically defined (objective). Participants variously reported age as creating differences in health status or as having no effect on health status, in terms of belonging to a generation (adult or child) and the ageing process. Richard's main

concern was to 'live to about 75 years of age' as well as 'be healthy enough to enjoy every day.' Blair believed children get colds and flus because 'they're around' and 'the more contacts you have, you're bound to get it'. At school there could be an 'epidemic' of chickenpox so that many students are resting in bed at home. Children may also injure themselves through sport. Whereas for adults, because much of our lives are spent in the workplace there is a need to ensure that good health is maintained to avoid absenteeism as a result of sickness (Wadsworth 1997). Tammy viewed the health status of children and adults in terms of energy and vitality. She perceived little age difference in assessing their well-being. Healthy children and adults in her view are 'energetic and vital ... vibrant ... happy'. 'It would be very apparent if they [children] just sat down and looked depressed'. Tammy regarded some children's tendency to stoicism:

no matter all the terrible things that might go on in their lives, sometimes they may not forget, but blot it out and still go to school ... keep going. Yes. They mightn't do as well academically if they have a few psychological problems or worries.

She believed that if children 'can get outside and run around and play', and 'also get encouraged with their school work they can overcome a lot of their problems'.

In an urban area, Tracey, Amanda, Carmel, Valerie, Sandra, Debbie and Belinda discussed age variations in health and illness. Being sick 'when I'm old' is 'to be expected' reasoned Carmel. Belinda related from her experience that 'flu was much easier when I was younger' because 'you just took it easy for a day and you got over it. But now you suffer for three weeks perhaps with one particular virus. And you still have to do the housework and things like that.' Sandra rationalised 'your lifestyle, your eating [habits] as a person gets older influences their health status. Whereas,

when you're younger, your body hasn't had as much of the bad stuff so you get over it [ill-health] quick. As you get older you have lived this lifestyle for so much longer. So your body system is down and so it takes longer.

Valerie recalled nursing an older person through sickness, and considered 'your expectations get less' and 'your health does deteriorate as you get older'. She said:

I used to spring out of bed at 20 [years old] and go 'whoa'. I now get out of bed and think, 'nothing hurts. My head doesn't often do this'. [Laughter] And I feel very optimistic about being able to complete my daily tasks and chores, feeling a sense of well-being, rather than feeling, 'oh, God! You know. How am I going to get through my day with this leg hurting?'
Diet, exercise and a healthy lifestyle, were factors Valerie believed gave a person control over their health and ageing (cf. Bunton et al 1995).

ILL-HEALTH
Being Ill, Injured or Disabled

Toombs (1987:233) describes illness as 'a state of disharmony, disequilibrium, dis-ability and dis-ease in which the individual finds himself [sic] separated from his [sic] familiar everyday world' (cf. Seymour 1998). Currently, there are several paradigms of disease causation. These are: stress and lifestyle factors, germs, socio-economic and cultural factors (new public health), 'sin' (AIDS and other sexually transmissible diseases, alcoholism, drug abuse), and 'deviance' (race as 'other', deafness, homosexuality, uninhibited sexual desire, crime, madness and infertility).²³⁻²⁴

Laypeople's self-assessment of their health status has been reported by researchers as a relatively accurate reflection of reality.²⁴⁻²⁵ Radley (1993:1) argues that 'the biographical and cultural context in which illness arises and is borne by patients and those who care for them' gives emphasis to individual self-reporting of health status in time and place.

The study of health and illness must include an analysis of the way in which people take up (or refuse) the dominant discourse in Western culture that defines these things as 'medical matters' (Radley 1993:6).

The National Health Survey 1989-90 and 1995 (ABS 1991a, 1996b, 1997), and the Australian Women's Health Longitudinal Study (Research Institute on Gender and Health 1996) asked respondents to describe their health as: excellent, very good, good, fair or poor, so as to analyse changes in population health status over time.

Whilst, I did not ask participants to self-assess their individual health status, I did ask them to describe their household status in terms of whether their 'self', their 'partner' or their 'children' had experienced illness, injury or a disability in the previous 12 months. See Table 4.1. Illness occurred in the majority of households: self sick (42), partner sick (35) and child/ren sick (65). In 20 households children experienced injury, whilst in 5 households a participant was injured. In two households, one participant and one partner were disabled.

I also asked participants how they conceptualised ill-health. Their responses to the question: what does it mean to experience ill-health, feel ill or be sick? entailed: i) ill-health is the opposite to health; ii) not functioning; iii) germs and infections; iv) a loss of independence; and, v) pain.

Table 4.1: Household Health Status in Previous 12 Months (N=98)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self sick</td>
<td>42</td>
</tr>
<tr>
<td>Self injured</td>
<td>5</td>
</tr>
<tr>
<td>Self disabled</td>
<td>1</td>
</tr>
<tr>
<td>Partner sick</td>
<td>35</td>
</tr>
<tr>
<td>Partner injured</td>
<td>-</td>
</tr>
<tr>
<td>Partner disabled</td>
<td>1</td>
</tr>
<tr>
<td>Children sick</td>
<td>65</td>
</tr>
<tr>
<td>Children injured</td>
<td>20</td>
</tr>
<tr>
<td>Children disabled</td>
<td>-</td>
</tr>
</tbody>
</table>

* Missing cases (13-14)

Ill-health as the Opposite to Health

In the above section, we saw that participants conceptualised health as daily functioning, well-being and quality of life, a value and living 'to a reasonable age'. In these terms, ill-health is the opposite of health for many participants. 'It's the perception that there is something wrong with you', said Jack. The subjective state of being may be confirmed by diagnostic tests indicating changing pathology of the body's anatomy and physiology. Ill-health for Andrea, Beth and Connie was 'physically tiring', 'feeling bad emotionally and physically'; and 'to have physical symptoms or anxiety symptoms, or continuous chronic sleep problems'. Michael believed a person’s health status influenced their ability to do something.

If you've got a sore throat, you can't go and talk to people. If you've got a sore arm, you can't swing a hammer. If you've got a sore leg you can't walk. You know I basically look at health as how it affects me and my choices.

Whilst for Peter, ill-health meant the absence of well-being and quality of life, and a lack of control.

Both women and men in the study viewed ill-health negatively, and narrated experiences of ill-health sustained by themselves, their partners and children.

Not Functioning

Earlier I discussed health as being able to function and fulfil responsibilities in everyday life (Parsons 1951). Ill-health for many participants meant difficulty with daily functioning. In general just finding it difficult to carry on normally', said Sarah. And especially with 'children whether they're at school. Husbands at work. Us in the

262 See also Toombs (1992), Duff (1993).
the house' argued Helen. Kirk perceived ill-health in terms of severity of the condition. 'It's minor illness which just sort of interrupts routine, to serious illness which can incapacitate yourself.' Ill-health of any family member created 'turbulence. The household is upside down'. 'Everyday is a bit of a trial ... It's hard to get through. You might not relate well to other people. Especially your children' admitted Dawn. Caroline acknowledged a person 'can be 100% physically fit and still not want to get through the day'. When ill-health occurred, Ian considered 'you can no longer function normally within your family unit or within society'. Metaphorically,

\[
\text{you're off the merry-go-round for a little while, and you need help quite often. So you're taken off the merry-go-round and put aside, and you watch it all going round.}
\]

Ian asserted that all a person can do in this state is to 'be patient', seek help and accept the situation, until health and well-being returned, and they could resume their roles and responsibilities (Parsons 1951, Sacks 1984, Tony Moore 1992).

Adrian has suffered chronic pain or many years. Ill-health for him meant 'not being able to function'. Blair, a tradesman on stress leave and the primary caregiver of his three children, indicated that he gets 'very angry at being sick.' He felt angry at not being able to 'perform the normal duties' such as: 'Being able to get out and cut grass or simply the household duties, visit people. Simply the things you would do on a day-to-day life.' He was displeased when 'according to Murphy's Law', illness occurred just when 'you're going to go away somewhere for the weekend' or 'if you've got something planned and you're looking forward to it.' As a result, when headaches or flus or throat infections occurred, 'I always sort of feel slow, no sort of energy, no motivation.' Hugo viewed health as having a mental or psychological component; 'that is, to feel happy and comfortable with myself.' He explained ill-health as 'If I'm not feeling comfortable with myself. If I'm distressed in pain, mentally or in pain physically, or inconvenienced mentally or physically.' Therefore, 'ill health is a decline in functioning' and it means 'being limited in my lifestyle.' Hugo gave the example of having hay fever and 'a bit of a cold' during the spring season. Whilst someone else would (he believes objectively) define him as unhealthy, he regarded himself as healthy and happy despite these minor conditions; because they didn't impede his daily functioning and he had made adjustments by learning to live with them.\textsuperscript{263} 'So ill health would be any state of health that requires some sort of physical or mental adjustment.'

Gillian, Heather and Irene agreed that ill-health is being 'at less than at your peak'. Heather remarked: 'Feeling ill-health physically makes you feel lousy but also mentally makes you feel lousy as well. So you're less likely to cope with things.' Gillian indicated

\textsuperscript{263} See Kagawa-Singer (1993), Litva and Eyles (1994).
that when illness occurred in her family, 'Everything is just a drama. You're at the bottom end of the scale. Everything is just falling in of top of you.' Whilst for Irene, 'the general routine of the day becomes so much harder'. To cope with children, housework, meals ... you just push yourself through', even though you feel ill. Francesca and Helen considered ill-health as: 'lack of energy', feeling 'lethargic', resulting in 'not being able to cope with everyday.' Whilst pregnancy is not an illness, many women experience ill-health during pregnancy. Sarah was pregnant at the time of interview.

Being pregnant, nausea was a hell of a hassle. Any sort of nausea, anything that puts you off just doing your general things around, so that you don't want to do things around the place, you just want to lie around and do nothing.

To Fiona, ill-health is when 'you're not feeling very well, unable to go out and do things, interact with other people, or enjoy what's life is all about.'

Both women and men viewed their difficulties in daily functioning when ill or injured as restraints upon their everyday lives.

**Germs, Viruses, and 'Bugs'**

As discussed in Chapter 1, germ theory as the cause of disease continues to enjoy popularity amongst public health specialists (Tesh 1989) who are concerned with maintaining 'homo hygienicus' (Labisch 1985), in addition to immunisation and quarantine measures to reduce the incidence and spread of infection. In the late 20th century, despite the WHO's and international efforts to eradicate smallpox and polio, a resurgence of various infectious diseases is occurring in industrialised countries, most notably tuberculosis and malaria. There is also the public health challenge of dealing with AIDS, Hepatitis and 'rare' micro-organisms causing 'disturbing' morbidity and mortality.

Participants cited germs, viruses and 'bugs' as indicative of ill-health. Sarah stated: 'I tend to assume sickness as being an actual virus or something on those lines - colds and flu or things like that.' Rita said:

> when I am sick it means that something is really reducing my capacity to get out and do things. Usually it means that I have picked up something that is foreign to my body and it is making me unwell and having side effects.

---

Flus and viruses can affect not only individuals but the entire household, as micro-organisms are transmitted from one person to another through contact, poor hygiene or breathing the same air. Ian stated:

We'll pick up some up some stuff like staphylococci or whatever. Some bloody bug that's floating around that we pick up on our hands and stick in our mouths. There are all those sorts of things which are incidental bugs.

Tracey recalled experiencing the side-effects of 'vomiting at one end and shitting at the other' due to 'that flu or virus that was going around three to four weeks ago' (late 1995). As a result, she felt 'crook as a dog'. However, whilst these 'bugs' were picked up, they didn't stay for very long. Rather, 'they'll come and they'll go.' Tom's experience of ill-health in the family was confined to 'coughs and colds and sniffles' from 'one of those sort of occasional bacterial viruses' going around 'causing a respiratory infection. Gillian related illness in the family 'is a thing we hate', and believes viruses 'come along or someone brings it home.'

And then quite often when the rest of the family isn't particularly on top of things ... it filters through the whole family and then you have a very sick and miserable family, which wears you down emotionally and physically and everything.

Good health is important for the 'prevention of illness'. For Gillian, this meant staying 'on top of things' and making sure your nutrient levels are fairly high so that you can prevent a lot of viruses invading your family. Jackie's views on cleanliness, hygiene and preventing contamination from micro-organisms stem from her childhood, whereby her father 'was very eccentric about cleanliness' and had an 'intolerance to sickness'. She currently maintains a strict standard of hygiene in her home, by encouraging her husband and children to be clean in their habits through frequent handwashing, tidy rooms, food preparation and storage, bathing each night, and no pets.

There was no gender difference in participants' views on ill-health caused by micro-organisms. Each gender equally disliked being sick due to an infection. They also worried about their children's exposure to germs, viruses and 'bugs' and undertook household measures to prevent infection.

---

267 Note lay misperceptions of the scientific distinction between bacteria and viruses. For example, respiratory infections may be caused by either a bacterial or viral infection, but not a 'bacterial virus'. It is possible for a person to contract a viral infection which usually clears with 7-14 days. If the symptoms persist or worsen, it is likely that the sick person has also acquired a secondary bacterial infection and requires treatment with antibiotics. Viruses do not respond to antibiotics.
Loss of Independence

Women tend to ask for help when sick or incapacitated. Women's sources of help may derive from friends, relatives, partners, children, biomedical health professionals, alternative therapists or folk healers. Being ill was of more concern to men than to women in the study, because they perceived a loss of independence. Having to ask for help and rely on others when incapacitated presents a threat to many men's sense of self and masculinity (Sacks 1984, Margo 1996, Hopgood 1997).

Scott remarked that when he was ill, he disliked 'the experience of pain and discomfort. Being a burden.' Neil held a similar view: 'you'd be dependent on other people, which I wouldn't like ... you'd lose your independence'. Richard explained the psychological reason for his attitude. 'Being sick is absolutely difficult for me ... Because I am reluctant to show a dependence on anybody. I don't need anyone's help.' He then went on to quote from a Harry Nielson song.

Tie my tie, then I'd rather be dead ...
I'll tie my tie until the day I die ...
I'd rather be dead than wet my bed.

A second reason for Richard's attitude towards sickness and dependency was related to his working class background: 'Dependence is something that working class can't afford, and the middle class can well afford.' He explained the social class differences as:

Preventative medicine ... is an expression you'd never hear in a working class environment.
You go to a doctor because you are about to die. You don't go for any other reason. Whereas my understanding now is that you go to a doctor to make sure you don't die, or don't need to go to a doctor. So you go to a doctor so you don't need to go to a doctor. Now that's an interesting psychology.

Loss of independence when sick is a major source of gender difference in ill-health. Independence and freedom from having to rely upon or ask others for assistance when sick sustains men's sense of masculinity (Margo 1996). Whereas women appear to have no difficulty in communicating their need for help when sick, and tend to rely on their social networks and a range of healers (Broom 1992).

---

Pain

The International Association for the Study of Pain defines pain as: 'A sensorial and emotional experience associated with a real or potential tissue damage or described in such terms.' Djité-Bruce (1994:2) points out that

In this now universally accepted definition of pain, the words in italics are important. Thus, the main thing is that the pain is physically experienced by the individual concerned. The patient is taken at his or her word. Pain is not just in the head.

Therefore, pain is both universal (no-one escapes it) and individual (each one of us has our own experience of it). Frailty expressed through pain and suffering is part of the human condition and shared embodiment.270

Pain can be shared but not exchanged; it is a subjective experience, often difficult to assess objectively. Numerous studies by pain management clinics, biomedical professionals such as physicians, anaesthetists and psychologists, and alternative therapists in their clinical practices have attempted to construct objective scales of pain. Ultimately, the assessment of pain and its relief rests upon the individual case (Osterweis et al 1987). Writers such as Good et al (1992), Anderson and Anderson (1994), and Porter (1994b), articulate the historicity and cultural variability of pain as a human experience, connoting questions about self-identity.271 The lay and biomedical discourses on the sources and types of pain (childbirth, toothache, gout, migraine, ear infection, muscular cramps, separation and divorce, death of a partner), demonstrate that the subjective experience is related to suffering and physical, emotional or spiritual impairment.272 Furthermore, Good et al (1992:14) observe

Neither in the biomedical research literature nor in the pain clinic does the suffering of pain patients and their intimate social circles receive much attention, as such, that is, as a moral burden or a defining existential experience. Pain as human suffering in the dominant institutions that deal with it in our times is a question of therapeutic means - analgesia, surgical procedures, rehabilitation, psychotherapy - not of human (or suprahuman) ends.

'You know their pain threshold' was a frequent remark made by participants in the study. Parents gave numerous examples of their children and themselves having different pain thresholds. What may be a mild ache to one person may be acute to another. The inter-subjectivity of pain (and its suffering) is related to an individual's gender and age. Their subjective experience, and the objective assessment of pain by


271 See also Sack (1985), Kleinman (1988a).

laypeople and other healers, has implications for its relief and management (Osterweis et al 1987, Good et al 1992, Kleinman 1995b).

In a rural town, Marcella, Libby, Jo, Ingrid, Nadia, Rose, Christopher, Patricia and Kay discussed the gender and age differences of pain thresholds of their children and adults. Four parents noted how one child in their families appeared to suffer more pain than the other. For instance, Patricia has children aged two and four years. She stated:

Jeremy [my son] will complain about the slightest pain, whereas Robyn [my daughter] tells me she's in pain, I know she's in pain. Because she never complains. So we always treat her as serious whereas with Jeremy we'll say, 'you'll be right'.

Some children (six months to 16 years old) in this group had experienced pain from a very early age. Libby related that her son Craig had sustained several injuries; from burning his fingers to cutting his knee to the bone. As a result, 'he got used to a certain level of pain' and 'he's a bit of a sook'. It appeared that in many families, one child (regardless of gender or age) complains of pain more often and more severely than another, although they may suffer a similar injury. Further, how children cope with pain relates to their attitude. For example, Rose described her two children: 'In our case, it seems that one child is always sicker than the other too. One always seem to have something. The other soldiers on, no problem.' Whilst Christopher, father of four children, indicated his despair at assessing the pain threshold of his eldest daughter when to her, hair brushing - 'screams in pain every morning' - and a broken arm equals the same pain. 'So you wonder how you can judge their level of pain in that situation.' Meanwhile, these parents agreed that children's pain threshold is not 'much different to adults. You have your own level of pain, too.'

In a coastal area, Rachel, Vicky, Teresa, Olivia, Natalie, Marcia, Pam and Simone commented upon men's responses to pain. From their experiences of living with men as their partners in the same household, the women agreed that 'pain, doesn't make them the most friendliest of people ... They get very short tempered and unable to concentrate.' As a result of pain, men become frustrated and angry that 'they can't go out and do things that you know, an non-injured father or husband would do. So therefore everyone is stressed out by that.' It would seem that some men tend to retain a 'stiff upper lip' and not truly indicate their pain threshold. The virtues of manhood as courage, strength, endurance, autonomy and competence are severely threatened in the face of acute and chronic pain suffered by men (Connell 1995), and impacts upon their relationships with significant others and daily activities.

---

See Chapter 7 for further discussion of pain in section: diagnosis of illness and injury.
Adrian has been ill with chronic pain for many years. He suffers from back pain, a
duodenal ulcer and Crohn's disease (affecting the bowel). His physical well-being has
had an impact upon his relationship with his children aged 11 and 14 years, and his
capacity to play with them. 'I found with my back, with the kids growing up, I couldn't
get out and play with them' such as kick a football, 'play cricket in the back garden or ...
having a "rough-and-tumble" on the floor.' When his children wanted to do things with
him, Adrian indicated that he persevered until 'either your pain, a migraine or your back
is playing up' and 'you couldn't do things'. He perceived it unfortunate that 'the kids
missed out on life' as they were growing up and 'unlike a lot of families' he couldn't do
more for them. However despite his chronic pain, Adrian was heavily involved in the
his children's schools which he believed he does 'out of guilt'. 'I enjoy coaching kids at
basketball' and 'helping different families'.

MENTAL HEALTH AND MENTAL ILLNESS

The public health emphasis on the physical, visceral, material body continues in
spite of growing demands by laypeople, health professionals and academics to
creatively address mental health, which remains labelled as a 'problem'. Mental health
is predominantly cast in the negative sense as documenting, mapping, preventing,
diagnosing and treating mental disorders, following the international DSM-III and
DSM-IV psychiatric manuals, and ICD-9-CM and ICD-10 diagnostic categories

'Mental health is often compromised in times of stress such as bereavement,
relationship breakdown, unemployment, social isolation and in times of accident or
perceived life-threatening illness' (Whiteford 1992:351). In Australia,

Mental health problems and mental disorders are estimated to affect over 20% of
the adult population and between 10% and 15% of young people in any one year.
The economic, social and personal cost of these problems and disorders is
enormous (Commonwealth Department of Human Services and Health

De-institutionalisation of persons with a mental disorder occurred during the 1980s in
Australia, from hospitals to the 'community', resulted in greater dependency upon
families. The 'promised' infrastructure to support them remains absent (Human Rights

In time, mental health services, along with other forms of health care, have been progressively de-funded and under-resourced with

---

276 Barham and Haywood (1995) have documented the experiences and perspectives of women and men
with schizophrenia in England. Their narratives reveal how de-institutionalisation from the psychiatric
asylum to the community has affected their personhood, access to employment and housing, managing
their relationships with family, friends and others, as well as confronting stigma and exclusion.
less staff, despite evidence of increasing use of people requiring these services (Raphael and Sprague 1996). These structural processes provide a context for examining the household production of mental health.

In contrast to these professional discourses, mental health and mental illness were a significant component of participants' lay conceptualisations of health and illness. Participants' responses to open-ended questions of health and ill-health included data on mental health and mental illness. I did not ask them specific questions on these topics.

**Mental Health**

The National Health Survey (1995) reports Australian men rated their mental health as 77.3/100 and women as 74.5/100 (ABS 1996b:10). Protective factors against mental illness are: i) external supports through peers, school and the workplace; ii) close affectionate ties with significant others; and, ii) individual temperament. The WHOQOL Group's initiative to develop a broader cross-cultural instrument for measuring health encompasses a 'psychological dimension' addressing: positive feelings, thinking, learning, memory and concentration, self-esteem, body image and appearance, negative feelings (1993a, 1993b, 1994, 1995). More recently, the focus within public health has switched to the concept of 'mental health promotion' as positive functioning and well-being (Tudor 1996, Orley 1997). The reorganisation of WHO in 1998 involved a focus on mental health as an urgent area for research and programs (cf. AIHW 1998).

Participants indicated that for women, men and children, having self-esteem, social relations with others and coping with life crises enhance their mental health; an important dimension of health. Sandra considered health as not just referring to physical well-being or 'the medical problems that you can have.'

"It's also your outlook and attitudes towards life. How you cope and respond to stress ... and how you respond to things in life."

Imogen, Tammy, Bianca and Rose summed up mental health as: 'sanity', having a 'healthy mind', 'to feel psychologically good about yourself' and 'happiness'. Rose prescribed the means to achieve mental well-being by:

---

277 NHMRC (1991, 1995b), ABS (1997) and AIHW (1998), report significant gender differences in the prevalence and incidence of mental disorders. For example, women are more likely to be dependent on benzodiazepines, whilst men suffer alcoholism.

Taking in information. Hearing other people's information. Understanding it. Keeping the grey matter primed ... mainly through interaction with other people, exchanging views. I mean exchanging, not just putting your own [views] across all the time.

Her response is in terms of social relationships and personal interaction.

Branden (1994) indicates having a purpose in life is one of the six pillars of self-esteem, and entails: productivity, efficacy, competence and self-discipline. Michael and Jackie acknowledged the importance of having good self-esteem. For Michael self-esteem relates to pursuing and achieving life goals. Jackie's philosophical view of the human condition was:

Any person from any form of life is going to fall down badly at some stage. How they pick themselves up again ... it's how they went ... and if you are going to rob a bank today. Well, it's how you take on life after that. Whether you're remorseful for what you've done or whether you take on a life of crime ... it's how people pick themselves up afterwards and not having the shame to go and get help. And there's no shame in not being able to cope.

Kubler-Ross (1995) calls these life crises as 'windstorms' and as essential for shaping oneself. She argues that people's responses to them would shape their mental health or could lead to mental disorders.

Children's mental health was of concern to participants, and they strove to demonstrate love, affection to enhance their children's self-esteem so that they had positive feelings about themselves, and developed fulfilling social relationships with other people. Referring to her two sons (aged five and eight years), Tammy remarked 'their self-esteem is terribly important'.

And they're feeling good about themselves, and feeling loved ... will effect their whole existence. So if they [children] don't feel loved, and don't feel happy, then they're not going to do very well at school. They're not going to form good relationships, even at this very young age.

Similarly, Michael and his wife endeavour to maintain the physical and mental health of their two daughters (aged 1 and 3 years). He stated: 'we try to be positive with Ann and with Katherine. [And] show them that we love them ... So there's a lot of physical contact'.

---

279 Branden (1994) defines the 'six pillars of self-esteem' as: living consciously, self-acceptance, self-responsibility, self-assertiveness, living purposefully and personal integrity. The absence of these 'pillars' leads to loss of self-esteem.

Mental Illness

Factors affecting mental health status are: the type of mental disorder or mental health problem; multiple disability and disadvantage; age or stage of life; gender; indigenous status; ethnicity; and, recent migration and refugee status (Commonwealth Department of Human Services and Health 1994a). There is limited community awareness and knowledge of mental illness: much confusion and ignorance reigns. Common stereotypes of mental illness are: 'out of control', crazy, unstable, over the edge, violent, dangerous, unpredictable, moody, weird, 'a nut case'. Goffman (1961) discusses how the stereotypes of sanity and insanity can cause a person with a mental disorder to become an outsider to a social group, because they are perceived as not fitting in nor conforming to the socially prescribed norms of behaviour. The affected person becomes subject to labelling, stigma and much misunderstanding, often leading to discrimination in their lives, such as housing, education, health care, employment, participation in social and recreation activities.\(^{291}\)

Foucault (1967) has revealed the historical surveillance of persons with a mental illness through the technique of 'panopticism' in institutions such as asylums and hospitals, and in its contemporary form of forensic psychiatry. Furthermore, Burdekin (Human Rights and Equal Opportunity Commission 1993) documents the incidence, problems and treatment of mental illness as a human rights issue, given the systematic and pervasive discrimination that individuals with a mental disorder suffer, whilst Desjarlais et al (1995) provide evidence that global well-being is compromised when mental health is jeopardised. Social, political and economic conditions as well as individual lifestyle and behaviour have an impact upon people's mental health. There is also scant attention to 'morbidity or dysfunction' associated with mental illnesses and problems or the underlying causes, and their under-representation in 'conventional public health statistics' (Desjarlais et al 1995:4-5). The NHMRC (1995b:vi) reports on mental illness in Australia.

In adulthood, men experience more alcohol and drug abuse and antisocial behaviour, while women experience more anxiety, depression and eating disorders. In childhood, boys have a higher overall prevalence of mental disorders than girls, but again this hides a different pattern of disorders (cf. ABS 1997, AIHW 1998).

During interviews and focus group discussions, participants reported incidents in their personal lives and family history of mental health problems associated with benzodiazepine tablets addiction, alcoholism, violence, nervous breakdown, illicit drug use, eating disorders, manic depression, poor body image and suicidal tendencies. Gillian, Heather and Irene indicated: 'Worry. Irritability ... Anxiety ... Feeling unwell.

Feeling down' as symptoms of impaired mental health. Fran remarked: 'For me, if I'm stressed I don't sleep as well and or if I'm tired I'll lose my patience more quickly.' In addition, Neil related depression affected daily functioning, 'because it gets you down, because you are always so sick. Sadness, because the depression makes you sad, and because you can't do your normal day-to-day living things.'

The Women and Mental Health report (NHMRC 1991) records women's mental health issues are related to reproduction and biology, life cycle and development, violence, work and unemployment, ethnicity (Aboriginality and being of non-English speaking background), social roles, and health care (psychotropic medication and health care services utilisation).

Groups of women more likely to be vulnerable to mental and emotional illness are young women; mothers; single mothers who are poor; bereaved women; women who are isolated due to language or geography; survivors of violence; and elderly women living alone (Subcommittee on Women and Health 1993:27, cf. Research Institute on Gender and Health 1996).

Elsa, Caroline, Wendy, Bianca, Amalia, Dawn and Yolanda in an urban group discussion considered being mentally ill as: 'To feel lethargic all the time ... Tired and cranky ... A shortness of temper.' For Jennifer, it's the 'feeling that you can't cope with things because you can't do everyday things, because you're not feeling well.' Whilst for Libby, 'it's all a big drama'. The difference between physical ill-health and mental ill-health for the women is that the former is visible as a 'cold', or 'aches and pains'. However, whilst they may feel unwell mentally, there was agreement among the women, 'that you've got to get on with your life, and so you do all the practical things. So mentally, you're probably not there.' Women, in other words, carry on with their daily activities and responsibilities, despite feeling unwell (Broom 1989, 1991).

Tammy dismissed illness as the presence of disease, believing it was also important for a person 'to feel psychologically good about yourself.' She continued: 'I just feel a real blob sometimes and it's probably something that's worrying me, that's making me feel so.' Instead of feeling healthy, Tammy believed the underlying cause 'could be psychosomatic or it could be something that you're not aware of'. However, they resulted in symptoms of a 'lack of energy [and] feeling a little bit depressed, lethargic.' At the same time, Tammy somewhat berated herself for her perpetual tiredness and crankiness whilst caring for her two sons aged 5 and 8 years, working part-time as a social worker in Geelong, and being a partner to her husband who worked full-time. At the time of interview, Tammy also suffered physical ill-health (anaemia and heavy periods) which would partially explain her tiredness. Her multiple roles and health status affected her self-esteem, whereby she blamed herself for her difficulty in meeting the demands upon her (cf. Verbrugge 1983, Steinem 1994). I'm a failure you see' as a wife and mother.
I waited and became a mature age mum thinking that 'now I could be a better person, and I could give up work' ... I was a very, very, good mother I think. Excellent mother while they were young, and even though I only ever had two hours sleep or whatever, and stayed home all by myself ... but I feel that I'm a bit of a dragon and a failure now. [Why's that?] Oh, I am. I yell too much.

Tammy considered herself inadequate when the children needed her attention whilst reading school books 'every single night' and her husband's desire for intimacy. As a result, 'I get really frustrated and tired and I'm so grumpy by that time [of the day] that I'm not the best' (cf. Research Institute on Gender and Health 1996).²⁰²

Both Jorm (1995) and Wilhelm (1995) have surveyed previous studies on the 'effects of men on the mental health of others' (NHMRC 1995b). They note that men's symptoms of depression, anxiety and schizophrenia, alcohol and drug abuse, parental absence, poor communication with their partners, and parenting style have an immediate impact upon the emotional well-being of their partners and children. Both women and children suffer poor mental health when the spouse/father is uncaring, emotionally detached, violent, abusive or has himself a mental disorder. Men's mental health remains a concern of the men's movement as health professionals and men's groups endeavour to encourage men to communicate their feelings in positive ways and improve the quality of their relationships with significant others (Commonwealth Department of Human Services and Health 1996a, Biddulph 1997a).

Lewis reflected upon his own depression and anger. He recalled his previous smoking habit and the effect it had on his asthma and his relationship with his wife and two pre-school age sons. 'Everytime I looked at my kids ... My heart was broken because I'd think, 'I'm killing myself'. Because I used to get asthma ... through the smoking.' He was also depressed. 'Everytime I felt crook ... I [would] take that out on the family'. He described his anger as: 'I'd get angry and when you're angry you'd take it out on the people that are around you. So I'd become a 'yeller' [shout a lot].' Lewis now believes that since he quit smoking, 'it's been a much happier household.' He reflected that 'I know myself, I can't be perfect in everything I do. I try but I can't be.' Furthermore, worrying only makes things 'three times worse'. 'When you feel you're not sure of things, you feel bad. You worry about it and that makes everything twice as bad.' He felt it was best to 'get the worry off and then put the salve on or whatever it is and everything's cool'. Therefore, when he suffers from acute anxiety, Lewis doesn't

²⁰² See Popey (1992) for gender differences in tiredness. For women, their accounts of tiredness are related to caring for small children, sole parenting, and the 'second shift' if they are working (Hoelscheld 1989). It was not easy for them to adopt the sick role and put their responsibilities to one side. An additional factor, was that their experience of chronic tiredness was trivialised or delegitimised by their male partners. In contrast, men indicated their tiredness were relative to the pressures of work and lack of relaxation.
consider it a 'waste of money to go the next step', by seeking help and reassurance from his family doctor. 'So you get rid of the anxiety and you're back together. You feel heaps [better].'

A recent survey of children's mental health was included as part of a larger project, by the ABS (1995) in Western Australia. Of children aged 4-11 years, 16% suffered a mental health problem, in comparison to 20.6% of children aged 12-16 years (adolescents). Delinquency was more likely in the younger age group (10.1%) than in the older age group (8.6%) which was more predisposed to thought problems (10.4%). In terms of gender, more male children (20.0%) were diagnosed with a mental health problem than female children (15.4%) aged 4-16 years. Other significant mental problems were social, and related to somatic complaints and attention.

Children’s mental health and well-being was of major concern to participants in this study. Francis spoke of his ten year old daughter being bullied at school. 'She was coming home feeling that she was victimised and left out. Wasn't getting on with the other girls. Always the target of their jokes.' Francis and his wife established her anguish from her 'general attitude and demeanour' and 'not being ready to go to school'. Fran stated: 'I do look at mental health as well as physical health.' She gave the example of her eldest son, Andrew (six years old) and how she determined the cause of his distress.

I know if he's stressed or there's something worrying him because he'll start wetting the bed.

And that has happened a couple of times this year, and once the problem is sorted out, then he's fine again.

The National Health Policy for Children and Young People (1995) seeks to address inequities in health care as a key action area. The policy acknowledges children’s health issues include: 'mental health issues and suicide, health-damaging behaviours, alienation of young people, child abuse and neglect, behavioural and emotional problems and learning difficulties' (Commonwealth Department of Human Services and Health 1995:34).

SPIRITUALITY

To date, spirituality has been poorly defined. What is important for one person may not necessarily be the case for someone else. In western society, some people change their religion, moving from one religion to another, or give up on religion altogether in search of their spirituality. My study focuses upon spirituality as understood and practised by laypeople (a loose and broad phenomena), rather than formal, institutional religions (and their policies and practices).263

Theologians, nurses, psychologists and health educationists have begun addressing spirituality in their clinical practices.264 Other writers use parables, myths, poetry, or stories based on ethics or mysticism to present quests for 'happiness, freedom and love', spiritual enlightenment, pilgrimages of the soul, and an understanding of life's mysteries.265 A deluge of literature on New Age therapies and pop psychology with a self-help orientation has become available in bookshops, heavily promoted by 'gurus' with answers to life's problems.266 Very few of these writings are scholarly. Many are based on personal trajectories of the author who claims to have found Nirvana or the way to spirituality, and with professed goodwill seeks to share her/his experiences with others.

The spiritual well-being of individuals is virtually ignored in government policies and everyday parlance, and D'Az (1993:324) notes that it continues to be 'subsumed under the mental/emotional/psychological dimension of health'. To date there is no consensual definition or measurement of what constitutes spiritual health. Health educationists and persons delivering pastoral care have attempted to define it,267 whilst Bensley (1991) in his review of the literature has provided the following categories of spiritual health:

(a) a sense of fulfilment in life, (b) values and beliefs of community and self, (c) wholeness in life, (d) a factor in well-being, (e) a controlling higher power or 'godlike' force, and (f) the human/spiritual interaction (1991:287).

Spirituality involves notions of how to maintain one's embodied self in this world, this life. It means discovering the 'essence' of a person and what drives them, their passions, and a sense of connectedness between themselves and other human beings, and Nature.268 For some people, spirituality may incorporate elements of religion and

263 A full discussion of the differences between lay and 'professional' (organised) forms of spirituality is beyond the scope of this thesis.
religiosity (edifice, shrine, altar, prayer, rituals, attending services), but does not necessarily adhere to a 'religious or denominational structure' (Goodloe and Arreola 1992:224), whilst for others it means taking care of one's soul and finding re-enchantment in everyday life (Thomas Moore 1992, 1996). Disconnectedness results in self-alienation, loneliness, a lack of meaning or purpose to one's life (Bellingham et al 1989), and 'anomie' (Durkheim 1964).280

As discussed above in Chapter 2, to date the major emphasis in studies on health and ill-health is upon the physical body, and to a lesser extent on emotional well-being. Spirituality as a vital dimension of health continues to be a poorly acknowledged and unexplored aspect of public health. It is imperative to redress this balance. The WHOQOL Group (1993, 1994, 1995) attempts to incorporate this dimension in its developing cross-cultural instrument. Religion-spirituality-personal beliefs are recognised as integral to individual and population health and quality of life, but the components of this dimension remain to be established.

This facet addresses people with different religious beliefs (eg. Buddhists, Christians, Hindus, Muslims), as well as people with personal and spiritual beliefs that do not fit within a religious orientation. For many people religion, personal beliefs and spirituality are a source of comfort, well-being, security, meaning, sense of belonging, purpose and strength (1995:1409).

Further development of the WHOQOL instrument will enable cross-cultural comparison, thus highlighting diversity of spiritual health for people around the world. This study contributes to a better understanding of spirituality, in relation to health and ill-health, for laypeople.

I did not ask participants specific questions on spirituality. Their responses on aspects of spirituality came from open-ended questions on health and ill-health raised during interviews and focus group discussions. Participants conceptualised spirituality as a component of health and ill-health, at the same level of importance as physical and mental dimensions of health and ill-health. Pam, Imogen, Francesca, Natalie, Jane, Wendy, Irene, Mandy, Gillian, Ian, Heather used various terms related to spirituality: 'spiritual beliefs', soul, spirit, 'transmigration of souls', energy, chakras, balance, 'alignment', 'discernment', 'detachment', aura, 'astral and etheric bodies', 'life purpose', meditation, yoga, Tai chi, faith healing and 'laying on hands' to heal others.

(1998). The notion of the 'aboriginal' or 'essential' self flies in the face of social constructionist arguments of the self. That is, culture and society determine personhood (Giddens 1990), rather than it is pre-existing, independent of outside influences (Campbell 1988, Turner 1992, Sejoe 1998). Australian Aboriginals, for instance, believe their original selves are inextricably linked with the land, with Nature, but have become distorted through European acculturation (Tacey 1993).

280 Durkheim (1964) believed religion played an important part in social cohesion through clergy and churches which brought people together. He defined religion as: 'a unified set of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden - beliefs and practices which unite one single moral community - all those who adhere to them' (1964:37).
Spirituality is a prominent theme in the thesis. Women and men spoke of spirituality in relation to the 'self' (as a state of being and as an evolving self) and the body (as body-mind-spirit), and in terms of health and ill-health.

**Body-Mind-Spirit**

Where the body is concerned, some participants in this study indicated that the body, mind and spirit are inter-related, and hence goes beyond the Cartesian notion of body-mind dualism as opposing entities. Rather, 'a healthy body also means healthy mind and soul.' A person's soul (also referred to as the spirit by others) was important to Francesca. She stated:

I believe that if you're not a happy soul, i.e. if you don't love yourself _per se_, that can lead to what they call dis-ease or disease. So I believe in a happy soul.

Natalie explained a healthy spirit was essential for personal well-being. 'But you've got to have a detached emotional body also. Because it's the emotions which create most of the health problems.' The human body is a vehicle for the spirit, as a place for it to reside and inhabit, whilst a person lived in this world. Natalie related that the spirit consists of many layers beyond the visible physical body, including the aura and the etheric body (cf. Meck 1977).

And not only do all of us living on this planet have etheric bodies, but the planet itself has an etheric body. And it all does need to be healed. And that's where all illness stems from. It's starts in the etheric body. It comes out and then attaches to the physical body. So when you're working as a healer you're getting down to the root cause and not just the effect.

Pam believed there was greater emphasis in western society (including Australia) placed on the physical body and material things, than attention to the mind and spirit. This becomes evident in laypeople's discussions of death as something to be feared. Pam stated:

---

280 A full discussion of the self and body in relation to spirituality is beyond the scope of this thesis.
291 Spirituality is also discussed in Chapter 7 of laypeople's reasons for seeking spiritual healing from a folk healer rather than another type of healer.
Well, if you've got material values, you're going to fear mortal death. Because you don't want it, because you're collecting too much. You've got your house here and you can't take that with you when you die. And your collection of little possessions and all these sort of things that are important to you. And your physical beauty ... It's just totally obsessive with the materialistic physical plane. And that to me is very symptomatic of a society that totally lacks any spiritual belief. And that area has been totally neglected.

Blake is a father of three children and an education professional. He was actively involved in regional Christian church activities. Spirituality, inner peace and having time out for himself was important. He narrated how he maintained his spiritual well-being which he viewed as related to both the body and mind.

I can take my kids for a walk along the beach of an evening and feel at peace too. [heads nodding - general agreement] So where we find peace sometimes ... I don't have to be sitting in a church to find peace. I can find it in lots of places. Sometimes, I can't find any at all. [Laughter] That's why I've got to break the cycle and do something a bit different.

Ian described his self-healing when faced with cancer - benign spinal tumours - by integrating the body and mind together. For him, visual imagery was a successful and self-initiated healing tool that could reduce and eliminate the tumours (cf. Achterberg 1985, Csordas 1994).

I close my eyes at night time and I'll visualise something and then I'll create little bugs or whatever that will come and nibble away at it, and reduce it to nothing.

Ian asserted that 'the mind is the most powerful tool. It probably creates, causes a lot of illness within people. By the same token, it can heal too.' He also used breathing and relaxation exercises to heal his body, mind and spirit during ill-health.

Hazel, Leah, Imogen, Nicole, Jane, Mandy and Karen living in a coastal area spoke of the 'spiritual side ... it can help you with the body as well.' Whilst these women acknowledged that not everyone considers themselves religious, believing in God or a Higher Being, or goes to church, for others spirituality is contained within oneself. Mandy spoke of healing and looking after herself.

---

294 Some tumours are benign, whilst others are malignant and may metastasise elsewhere in the body.
295 Wendy, Pam, Blake, Tammy and Jackie related the impact of religion upon their lives. During their childhoods they recalled Sunday was either a 'day of rest' or it meant 'going to Sunday school' or to 'church services'. As adults, they sought to 'find peace' in their lives. They noted 'religious differences' between Catholicism and Protestantism, whilst embracing 'the Christian outlook' on life: 'you should be able to see when your fellow man [sic] needs help'. Jane commented on her lack of a religious upbringing. See Morris (1987), Sullivan (1989), Bouma (1992), Thomas Moore (1992), Csordas (1996), Jones (1998) for further discussion on religion and spirituality.
I do some yoga. And I know that I can touch a greater balance now, having done it over the last few years with physical, mental and certainly spiritual ... I know there are greater powers within, because I've been exposed to this other energy, I suppose. Which is yoga. For some it can be Tai chi, or the church.

At times, a sick person is not always able to heal themselves of their ailment, it 'needs somebody else to bring that out' to heal 'from within'. 'So that other person is the channel [sic] who will help you'.296 Mandy asserted that 'there are numerous instances of people who have said that they've gone along to the naturopath and they've done their yoga and meditation and it's actually cured terminal illnesses like cancer ... it has been known to happen.' She noted that many of these illnesses were of a chronic nature, and often not healed by biomedical specialists (cf. Fuller 1989).297

**Spiritual Well-being**

A single accepted definition of spirituality and spiritual health remains somewhat elusive, nor is there a language that readily conveys the intangibility of spirituality (Bensley 1991). However, unlike many health professionals, academics and policymakers, laypeople do have a notion of spirituality. Given the lack of a concept to describe spirituality as related to health in positive terms, I suggest using the term 'spiritual well-being'. It is the sense a person has when they feel all is well with their world, a connectedness to others, Nature and a Higher Being. In separate interviews, Pam, Ian and Wendy in the study discussed at length aspects of spiritual well-being.

Pam had a fatalistic approach to life.298 She had been recently diagnosed with Hepatitis C.299 Now 43 years old, married with two children, she believed it was important to incorporate spirituality into her everyday life. 'Spiritual values ... to me are an understanding of my purpose in life'. 'Continuing soul growth' was essential for her well-being, in coping with the possibility of an early death. Her personal belief 'is that I have a destiny. That I was dealt a deck of cards.' She reflected that previous events in her life, including drug abuse, 'made me all of that' (cf. Kuhler-Ross 1997).

Who I am now. I couldn't have been the same way if I had, had it all different ... and you see that's the spiritual belief that I hold to, that everything is a learning experience and that everything should be enjoyed as a learning experience, including the painful aspects.

---

297 I further discuss the role of folk healers and alternative therapists in healing as practitioners of 'unorthodox medicine' in Chapter 7.
Similar to Pam and Natalie, Ian did not regard himself as a 'church, religious type of person'. He believed the spirit played a vital role in health and well-being. That is, sick persons could help heal themselves by focussing upon the inner part of themselves, because that is how they will remain spiritual. 'To describe your spirit is to describe yourself.' Ian explained:

But I think for healing purposes, if [at] any time people do think about the spiritual matters ... and it doesn't have to be religious, does it? When you're sick, you are focussing in on yourself. So your thoughts are more inward. So I think perhaps people's thoughts are more susceptible ... to thinking about their wellness and how well their spirit is ... all of your emotions ... How you relate to other people. How you relate to the world around you. Your beliefs that you behold in. The emphasis you place on life and living.

As father of two boys aged 7 and 10 years, Ian regularly instructed them in the mysteries of life, and sought to develop positive attitudes and approaches toward themselves and others, and Nature.

Maybe being able to listen to and perceive what is around us. You can take in good health by looking at what is around you. By hearing something. We listen to a lot of music in our household, and we play a lot of music and that feeds the spirit. And that's part of you and that's part of health.

Ian also considered music, painting and drawing as important for health, which in totality 'is a collective of all the things you take in around you'. Ian appeared to have a strong sense of connectedness to being in this world and his physical environment. In addition, he viewed relationships with other people as vital for spiritual health, fostering a sense of connectedness (Campbell 1988, Suzuki 1997). 'Lots of other people all having different experiences. Being able to fit in and function with those other people. I see that all comes into me as a health thing.'

Wendy had a lifelong interest in alternative therapies. One example was Reiki, 'a Japanese healing art' which she viewed as being closer to folk healing than to an alternative therapy (Barnett and Chambers 1996). 'It gives you a lot of energy' whilst addressing emotional well-being. She developed an interest in this form of healing and spirituality through a girlfriend, and together they went to the classes in Melbourne. Other friends in their circle also joined them. Wendy related her own perception of the healing effects of Reiki.

---


*Natalie regarded this approach to life as basic commonsense.*
I've done Reiki. And that has a similar effect to meditation upon your body - it lowers your metabolic rate to that of when you are meditating and it's a healing art. And you can use it on cuts and bruises and your children.

I asked her what Reiki involves. Wendy responded: 'Just the laying of hands onto ... the body. But fully clothed. You don't have to be undressed. And then if you do Reiki Level 2, you can do it in absentia over distances and things like that' (Barnett and Chambers 1996). Reiki, is not the only form of spiritual healing that involves 'laying on hands' on the person being healed. McGuire (1988), Frohock (1992) and Csordas (1994), document laying on hands as integral to ritual healing, meditative healing and Charismatic healing. It is also a technique used in 'therapeutic touch' developed by Krieger (1979) and Macrae (1988) for nursing practice, and in 'healing touch' for esoteric healing.

Both women and men viewed spiritual well-being as an important aspect of health and their everyday lives. They endeavoured to retain a sense of connectedness with their significant others (including their children) as well as with Nature.

**Spiritual Impairment**

The WHO (1980) defines 'impairment' as 'any loss or abnormality of psychological, physiological, or anatomical structure or function' (quoted in McCallum 1993:2). This definition is cast within the body-mind dualism and does not refer to spirituality as another dimension of impairment. A partial reason for this, is that clinical pathology of the biomedical paradigm continues to be the framework for explaining health and ill-health of individuals and population groups. Secondly, even classical sociologists and anthropologists, such as Weber (1965), were interested in the increasingly rationalisation and secularisation of the world, which provoked people's 'disenchantment' with the world (Morris 1987). A third reason, I suggest, as discussed above, is the relative recent interest in spiritual health and well-being by the WHOQOL Group (1993a, 1993b, 1994, 1995). Given there is not yet an agreed term to connote signs and symptoms of spiritual ill-health, I propose the term 'spiritual impairment', although this was not used by participants.

Problems with spiritual well-being can lead to illness or spiritual impairment. Diminishing social capital, intimacy and connectedness within everyday life may manifest as personal alienation, atomisation or anomie. Thomas Moore (1992:xvi) suggests symptoms of spiritual impairment may be: 'emptiness; meaninglessness; vague depression; disillusionment about marriage, family and relationships; a loss of values; yearning for personal fulfilment; and, a hunger for spirituality' (cf. Moody and Carroll

---

1998). Syme (1997) claims that having control over one's destiny and mastery of hope are important for health and well-being. The absence of these qualities of life, he suggests, may help explain people's tendency to disease when all other risk factors are accounted for. Moore asserts the importance of taking care of one's soul (1992) and rediscovering the enchantment of everyday life (1996) as imperative for preventing spiritual impairment.

Spiritual impairment was a key issue for women and men in the study. They equally perceived their spiritual well-being most at risk when they had no time to themselves, separate from their daily roles as partners, parents, siblings, friends (Dowrick 1991). Negotiating intimacy and personal space appeared elusive whilst managing couple, parent-child and other social relationships. As a result, some participants indicated they felt a sense of 'self' being steadily eroded or lost; ultimately making it difficult for them to relate to others. This was particularly the case for Blake (an education professional) and Tammy (a health professional), who took care of others in their paid work, and then came home to their significant others and also took care of them. Both individuals are married with young children aged 4-14 years and live in coastal areas. Blake is religious and active in a Christian church, whilst Tammy described herself as an atheist, despite a Protestant upbringing. For Blake, 'time out' meant walking along the nearest beaches or bushwalking, to commune with Nature. Tammy relished peace, quietness and stillness, as well as freedom to determine how she would spend her limited leisure. She sought 'individual time' by reading the newspapers or books without interruption.


> There's always a problem ... you just think to yourself, 'well we've just got through that one. And we'll go along this smooth road that we're supposed to be following for the rest of our lives, and then there's another curve thrown at you and you veer off ... another mountain to climb.

Rita considered her spiritual well-being became impaired when she, her husband and children moved house, from remote Australia to a working class suburb in Melbourne to an urban area in Geelong, in less than five years. Each transition meant establishing and re-establishing personal and work relationships through her husband's occupation as a minister in a Protestant church and her children's primary school. Rita was not working at the time of interview. She had previously furthered her qualifications by

---

a13 See Rilke (1954), Cooper (1997).
taking classes in weaving and textiles in Melbourne. The stress of moving house and managing social relations beyond the household substantially affected her personal well-being.

To sum up, a significant gender difference in health and ill-health, is men’s difficulty coping with loss of independence when sick, in contrast to women’s reliance on social networks and other healers regardless of their health status. More women than men admitted experiencing a mental disorder although the sample is skewed by more female than male participants. Both women and men were equally concerned about their children’s mental health. In terms of spirituality, there was no gender difference; it was of equal importance to both women and men.

GENDER, HEALTH AND ILLNESS BEHAVIOUR

In this study, gender is a key dimension of laypeople’s conceptualisations of health and ill-health. Age and health status are lesser but still significant dimensions, although generational relationships (parent-child) was an important differentiator of health actions. Parents behaved differently in light of their own ill-health than they did with their children’s ill-health. Ethnicity was not so important in this study because the majority of participants were of Anglo-Australian birth and ancestry. Furthermore, participants’ narratives of gender and health express their lived experiences as ‘gendered bodies’, and their social relations with others within the family and the workplace. Women and men noted gender differences in health and illness. Their lay discourses contrast markedly with public health discourses, and are rich in metaphors to describe their ‘gendered selves’.

Gender Differences

Despite suggesting the need for gender-neutral approaches to health, the majority of participants in the study considered women and men displaying gender differences in their responses to health and illness. Christopher stated: ‘Men do spit the dummy very quickly when it comes to ill-health. And women I’m sure just soldier on.’ He admitted to not knowing ‘what causes women to soldier on’, but believed ‘there is a difference’ in women’s and men’s illness behaviour. Pam reasoned that in caring for other people and putting their needs first, ‘a lot of mothers put their own health to the background’ (cf. Cornwell 1984, Graham 1984).

Women in the study spoke of their husbands’ and children’s responses when they were sick themselves. The majority of female participants indicated that women continue their roles and responsibilities ‘regardless’. Vicky and Teresa agreed, ‘You get by’, although ‘you may fall apart.’ Very few of them actually stopped all activities and

\[^{\text{nd}}\] See Chapter 3 and Appendix G for further details.
rested in bed, to convalesce and recover from ill-health. Rather, when feeling ill women tend to 'keep going', 'regardless', although they are fully aware that it takes them longer to recover and hence their morbidity is of longer duration. Rachel explained: 'If you’re sick and you know something’s got to be done you just keep going, even though you know that it’s going to take longer to get better.'

What appeared remarkable within the women’s discourses was men’s attitudes towards their wives when they were sick. The expectations and demands of a woman’s time and energy continued, despite her ill-health status. There was a moral imperative for women to complete all their household tasks, regardless of 'whether you're on your own or feel like doing it or not. You just do it.' In her experience, Vicky remarked that even though her husband and children 'know how to do it', that is whatever task needs doing, she would 'still get up get up and do it anyway.' As Tracey explained, 'You’ll still have to do the ironing and the cleaning and the washing up.' Tammy commented that 'often it's not reciprocated'.

In an urban area, Sandra, Debbie, Valerie, Belinda, Tracey, Amanda and Carmel discussed the trivialisation of women’s ill-health by men, their husbands. Each woman has one to three children, aged 3 to 18 years of age. Two women are sole parents as a result of divorce, whilst another two women are migrants from Europe and Asia, married to Australian men. The women commented that when they felt ill, their husbands associated their signs and symptoms of flu or another illness with their imagination. Therefore, their ill-health was not real or legitimate. Debbie stated:

You've just got over it but no, you didn't have it as bad as him. Oh, no. If I'm sick, he'll say, 'it's all in your mind, love! Get up and do something. And you'll feel better'.

In a rural town, Rose, Marcella, Ingrid, Patricia, Libby, Jo, Nadia and Kay indicated that they have to be 'quite bedridden' before they are taken seriously by their husbands. They joked about their personal experiences:

*Rose* My husband says, 'if you're sick, you're in bed'. Now as soon as you put your foot to the floor, you're well again. [Laughter] [heads nodding]

*Nadia* So, if you can walk to the bathroom, you’re up and out.

*Rose* Yes, You maybe throwing up in the toilet, but you're up and out of bed. You're capable.

[Laughter]

*Kay* I had an operation and I was in bed. And I happened to just put my feet to the floor, and 'oh, what’s for tea tonight?' And I thought, 'oh my God!' [laughter]

Participants in both groups agreed that women have greater inner strength and stamina than men to continue with their daily responsibilities, despite their general malaise. Jo
remarked: 'I think that we're more perceptive to mental health because you know that you've got to get on with your life, and so you do all the practical things.' Whereas, men seem to stop everything altogether. 'Men, they can't really take the pain. 'They're "sooks".' And Amanda indicated: 'Even if I feel sick, I really wake up and do something and prepare all the kids, while my husband says, 'I cannot do [it]'.'

Few women in the study admitted that they halted all their household responsibilities despite others' expectations. Simone said: 'Sometimes, when it suits me.' However, there was a difference between men (and children) having 'ultimate responsibility' and 'helping' with household tasks which women had performed before illness. Both Natalie and Pam admitted that in the past, they used to keep going with their household tasks. However, more recently, they were resistant to the stereotype of 'housewife' (Oakley 1985). Rather, they encouraged other household members to be more self-reliant and independent.

I don't anymore. If I'm not well, I say, 'time out. You guys are running the house. I'm going to bed'... There's food in the cupboard, go and get it.

Jo discovered she gets some release from household demands and expectations when she feels unwell by gardening. 'I love gardening ... so if things are getting on top of me I just say, 'to hell with the housework! I'm just going to indulge myself in my garden and work off some of the stress'.' As a result, when 'you go back in, things are so much better.'

You're not screaming at the kids the minute that you step in the door. You have some time out. For everyone it's something different. But every now and then if everyone takes time out to re-group, go back and tackle the problem.

Rarely would there be someone else to assume women's roles and responsibilities, albeit for a temporary period - to fill in whilst they were incapacitated. Patricia explained:

I think that if you've got someone to fall back on too. If you've got family and grandmothers up the road ... and you're feeling lousy, you'll have a day in bed if you can off load the kids. But if you can't, you just soldier on. So it's a matter of how hard you have to push yourself perhaps.

If there wasn't someone else to relieve them of childcare and household duties, Marcella, Kay and Patricia reasoned: 'Sometimes you've got no choice ... You're Superwoman ... Yes, if you've got no choice. You have to keep going.' Rose disagreed with this stoic position and referred to the example of a 'few ladies' who did not hesitate
to ask their mothers to stay at home with the kids, even when 'they have something minor'.

'Can you look after the kids and pick them up for me?' Yes, they're a bit crook, but you get on with it still. You can still do things. But they don't.

There was general agreement among women in the study that when men are sick, 'they're sicks'. Moreover, men 'don't believe in prevention', but when they're unwell, 'everything is wrong at once', they 'won't do anything about it' and 'complain the whole time'. 'They're real hypochondriacs'. Pam and Vicky agreed: 'They're useless' and 'they're hopeless'. Tracey said: 'My husband is just about dying.' The women joked about men's illness behaviour and 'the whole scenario of having to look after them'. Francesca remarked that if men get to 'that stage' of 'collapse', 'they are the worst patients in the world.' Irrespective of the severity of their condition, 'whether it's their sore toe or a heart attack', Jo argued, men 'have a tendency to find everything's wrong all at once.' Even if they got a 'bad flu' or a cold, Nadia claimed: 'that's the end of them until the cold has gone.' Whilst Marcela said:

When my husband gets a cold and he sneezes and he gets abusive to himself, but he doesn't do anything about it. He doesn't put himself to bed. He doesn't stop work.

In addition, men 'won't take medicine' unless it's analgesia for pain relief, preferring to complain loudly of their symptoms. Debbie and Tracey joked: '"Oh, can you get me a Panadol" ... And you've got to run off and buy the Codral tablets and the Panadol tablets, and all of them have to work'. Tammy described women's nursing role: 'because we're the caregivers, often we've got to look after them when they're ill!' (cf. Wicks 1995), as well as perform other roles and responsibilities (paid work, shopping, cooking, child care, voluntary community work). In keeping with their stereotyped nurturing and caring roles (Sydie 1989), women are expected to provide infinite emotional capital: 'coddling', 'TLC' (tender loving care) and 'sympathy' to the sick man, since 'no-one has had it as bad as him'.

The women reasoned that their partners' socialisation as children, by their mothers, had an impact upon their masculinity and present illness behaviour. Pam surmised, 'I reckon to a great degree on the way that their mothers brought them up.' It

---

Note the paradox of men presenting the two extremes as 'stoic' (maintaining a 'stiff upper lip') or as 'wimps' (complaining profusely) when sick or in pain (Fletcher 1995, Margo 1996). I recall a man presenting at a hospital accident and emergency department - describing his chest pain as 'crushing' and yet rating it only 5/10!

The women's partners were aged late 20s to late 40s, whilst the male participants in interviews and focus group discussions were aged 35-47 years.
also encouraged men’s expectations of their wives to continue fulfilling the nurturing and caring role their mothers had performed, by placating and soothing the sick man. Vicky joked she tells her husband ‘every day of the week’ that it’s his ‘mother’s fault’ for his behaviour, both when healthy and unwell (cf. Dinnerstein 1976, Chodorow 1978). Pam commented:

we’re supposed to be their mothers. I think they want you to take the responsibility for them, like when they were a kid and make special little egg sandwiches ... And you go ‘there, there, there.’

In comparison to when a woman is ill, she is largely self-reliant and looking after herself. ‘You might take a couple of Disprins and go lie down for an hour or something.’

An additional reason for men’s illness behaviour was given by Christopher: men tend to put work first before their health or other considerations. ‘When men aren’t feeling well they just knuckle down and work a bit harder, and ignore the family side of things.’ Francesca noted: ‘I think that men focus on it less than women.’ The economic role of being ‘a good provider’ was important for most men, tied to their sense of masculinity. Patricia agreed that her ‘husband does that when something is troubling him.’ Many women in the study considered male behaviour of brooding, sulks and withdrawal as symptomatic of men’s difficulty in expressing their emotions or problems troubling them. Work, which occurs in the public sphere, away from women as primary caregivers in the private sphere, may become a refuge for men, even though it is detrimental to their health and well-being. Increasingly in the 1990s, women are not always available to be nurturers and carers and continually available at home to meet men’s health needs because of competing priorities upon their time and energy within and outside the household. Helen reasoned men focus on health in a different way to women ‘because they’re so wrapped up in their careers and making money. Power. The power thing. They don’t have time to focus on themselves unless something drastic happens to them.’

Marcella, Rose, Nadia, Kay, Patricia, Ingrid, Libby and Jo gave examples of their husbands and their responses to the pressures of work. Patricia stated: ‘My husband does most of his thinking under the shower. [Laughter] He copes with most things under the shower.’ Water is symbolically cleansing of dirt and debris (Suzuki 1997). We could suggest that by having a shower, a man’s ‘problems will go away’ and relieve his stress, whilst at the same time, this may be his only opportunity for solitude in a busy

---

day with no-one to disturb him (Dowrick 1991). Some of the women's partners responded by drinking alcohol. Jo spoke of her husband, a teacher:

Actually I find when Alan has had a stressful time at school, he'll come home and have a couple of beers after the children have gone to bed. He hasn't turned into an alcoholic ... If the children see a couple of bottles in the pantry, they're a bit horrified. But he'll just have two beers ...

Ron, husband of Kay, copes with ill-health and the pressures of his work by 'just keep on working'. Ron is self-employed in a family-owned 'window manufacturing business'. Therefore, he has a moral imperative to provide for his family and ensure their material welfare, but also 'we've got quite a lot of people working for us. So you've got to keep on working, because everything is to a deadline.' He had responsibilities to his employees (and indirectly to their families) by providing them with work, and to the purchasers of his company's products (West 1996, Leser 1998). Similarly, Ingrid recalled the times when her husband who works nearby 'only five minutes up the road', is suddenly 'working 10 hours a day', because of 'the pressure of trying to please everyone.' When her husband comes home, 'he's mentally frazzled and he just veges out.'

You'll talk to him and you may as well talk to the wall and get more sense out of it. Because the pressure is there all the time. And he just wants to escape. And some quiet time.

In contrast, Marcella remarked that her husband Ted, 'wouldn't stay at work. He would just get off early and come home.'

Amazed at the common experience of their husbands' responses to ill-health and the pressure of work, women in this rural group discussion questioned: 'if men became more involved in the family situation would they cope better?' Christopher, the only man present and a 'male primary caregiver' (Grbich 1994, 1995), believed men would 'cope better', as Kay prescribed, by 'being closer to their family members'. Christopher believed that historically, 'men don't cope very well with situations', but he did not 'know why exactly that they continue that way. Perhaps it's an inherent difference in attitudes to any relationship or an emotional issue.' He observed 'there's been lots of changes in the last generation' of 'our grandparents' with more changes in men's attitudes in generations to come. Christopher expressed hope that changing gender relations in this present generation (1995) and 'in the next two generations there will be

Christopher is the primary caregiver of four daughters aged 6 months to 6 years of age. His wife is a health professional working in a rural town 15 minutes drive away. Christopher's previous occupation was as a health professional working at a hospital in Geelong until he was retrenched.
more of a blending of male and female roles. And the way they [women and men] relate to each other and in crises and health.\textsuperscript{311} "The provision of health is the most-life sustaining and labour-intensive aspect of caring ... it is the least documented area of women's [and men's] health work' (Graham 1985:36). The women in the group acknowledged Christopher's views. Nadia and Marcella viewed 'the person at home is holding the whole family together' - 'who is mainly in charge', regardless of their gender - is the primary caregiver and ultimately responsible for all household members' health and well-being (cf. McMurray et al 1998). Although, Kay asserted that 'mothers aren't allowed to be sick.'

Similar to Christopher, Ian, Adrian and Blair were primary caregivers in their households (Grbich 1994, 1995). Blair was a 'househusband' and primary caregiver of his three children aged two to seven years for the previous 18 months. During an interview, he claimed it was vital for women and men to experience role reversal, so as to better understand their partner.

I think that in every marriage they should. To let both [partners] understand. So that the man understands what he's like when he comes home after work and wants to sit down and put his feet up, and the woman understands the other side of it too.

Blair acknowledged the difficulty that some women have being at home all day and every day, with the children, and wondering what else there is in their lives that could fulfil them.\textsuperscript{312} Blair's lived experience led him to understand women's experience as primary caregiver, and responsibility for family health and well-being.

Case Study: Men's Perspectives on Health and Ill-health

In an urban focus group discussion with Eric, Geoff, Francis and Dean, there was lengthy and humorous conversation of how women and men 'talk' about health. The men were aged 39-43 years, all married with 1-4 children aged 2-22 years. I explained:

\begin{quote}
We keep hearing about men's health, and men are worse off than women in terms of health. \\
Now the actual picture is that men die earlier than women but women are sicker more often.
\end{quote}

\textsuperscript{311} Christopher suggested a future move towards greater undrygeny of roles, acknowledging that women can be assertive and independent, whilst men can also be nurturers and carers (cf. Clinton 1996, Leser 1998), unlike Gray (1993) who denies the human qualities women and men share in common.

\textsuperscript{312} Following the works of liberal feminists; Mary Wollstonecraft, Harriet Taylor and John Stuart Mills, in The Feminine Mystique, Friedan (1974) questioned women's happiness and personhood in the traditional roles of wife and mother. She claimed women's greater access to education and employment outside the household would reduce their discontent and provide them a greater sense of fulfillment. Of course, Friedan was examining the circumstances of white middle class women living in American suburbia. She did not address, at the time, the house-bound experiences of women of other socio-economic and cultural backgrounds (Tong 1994). Friedan's work led the way for many other more radical feminists.
Dean was incredulous at this statement and asked me, 'on what basis do you say that?' I indicated that the data largely comes from morbidity and mortality statistics, and medical consultations rather than self-reports of illness. Dean queried the methodology of statistic gathering:

But say women are sicker more often, if that's done on the basis of how frequently men and women visit doctors, for instance, then that is not a true indication of how often men and women are sick.

I agreed and explained that women consult a doctor more often than men for three reasons: i) their own reproductive health - pregnancy, childbirth and use of contraceptives, ii) they take children to health professionals when they are sick, and iii) they seek help sooner, particularly for mental health issues. The four men agreed with this rationale. Dean explained men's reluctance to see a health professional when sick. 'There is still the macho image. Men don't go to the doctor. Full stop' (cf. Margo 1996, 1998).

The journalist, Dow (1996), reports 'most men know more about women's bodies and health problems than they do about their own.' Eric, Francis, Dean and Geoff perceived vast differences in public health (and media) attention to women's health and men's health. Francis asked: 'Hasn't there been more of a push directed at women for them to consult their medical practitioner for a range of issues, more so than men?' He gave the example of 'that lady who lives in the Outback' - Sara Henderson - a woman in her fifties, who is the popular figurehead for the Breastscreen advertisements on television, encouraging women over 50 years and/or a family history of breast cancer to urgently have screening. Francis stated:

You see [on TV] about pap smears and a whole range of issues that women are directed to, are coaxed to go and see medical practitioners about. You don't see, by the same token ... You don't see ads, you don't see Bob Hawke [former Prime Minister] saying, ‘I went and had it.' Why don't you?’ sort of thing. But you do see the other thing that is more of a push for women. Because probably from a range of issues that they're going through different things and their bodies obviously go through more changes than men's, during their life cycle.

Francis indicated that (in 1995) he had only seen one television program on prostate cancer on the channel SBS, 'and it was just interesting.' He had not seen any other programs on other men's health issues, including hiatus hernia that he had suffered during a period of unemployment, and felt the personal need for greater exposure of men's

---

health issues. Current men's health issues popularised in the mass media are: prostate cancer, obesity, bowel cancer, hypertension, cardio-vascular disease, mental health and lifestyle factors such as over-eating, alcohol intake, smoking, drink-driving.

Dean pondered: 'Isn't there a national men's health policy?' During the focus group discussion with Eric, Geoff, Francis and Dean, I brought up my own attendance at the National Men's Health Conference, Melbourne, 10-11th August, 1995 and the issues that were raised: drink driving, mental health, prostate cancer, occupational health and safety, cardio-vascular disease, violence, male adolescent health, rural health, sexual health and sexuality and older men's health, indigenous men's health, health of immigrant men. Grassroots initiatives by men's groups in Tasmania and South Australia were leading the way in state policy development. The aim of the conference was to develop a national men's health policy and the overall theme was a questioning of the social model of Australian masculinity as impairing men's health (Commonwealth Department of Human Services and Health 1996a, 1996b).

Eric, Geoff, Francis and Dean joked about men asking themselves, 'what does it mean to be a man?' They asserted the image of SNAGs (sensitive new age guys) and 'drinks with the boys is being challenged'. Geoff perceived it is only a small group of middle class men who are navel-gazing - 'a very narrow socio-economic view' - 'not most of the blokes' (cf. Connell 1995, Edgar 1997, Segal 1997, Leser 1998).

There is a such a large, diverse group of socioeconomic group of men ... a lot of them still think it's cool to have a suntan and wear a blue singlet ... I mean that's all very well for us to sit around and say, 'well, look things have changed.' We're the only guys to say that.

The history of the men's movement is recent, of low profile and overshadowed by feminism (Clatterbaugh 1990, Pease 1997). There is agreement by many men that their experiences and perspectives of life are different to women, and the importance of eliminating stereotypes of female and male work (O'Sullivan 1997, Leser 1998). Geoff commented:

---

314 In mid 1997 there was a four-part television series on men's health, including prostate cancer, hosted by the comedian John Clarke. In the first episode, six men consulted their doctors about their health and well-being. Hopgood (1997) describes his lived experience of prostate cancer: diagnosis and surgical intervention, as well as penile injections to overcome impotence and continue sexual relations with his wife.


316 A Draft National Men's Health Policy (1996) was launched by the former Commonwealth minister for Human Services and Health, Dr. Carmen Lawrence. The present Liberal/National (Coalition) Government does not have a policy on men's health (Dow 1996).
I know that this is a big generalisation... but women seem as a whole to be more together and they always find the same thing in health. Whereas for men, I don't think that much has changed, only in a little group.

Men's efforts to change the status quo are fragmented, rather than unified. Women at least have been very clear about what they wanted: sovereignty, equality, education and economic independence which they had been denied (and in some countries continue to be denied). Men have historically had access to these as a taken-for-granted right (Waring 1996, UNDP 1997).

Dean suggested that when it comes to health matters, women are more likely to talk about it openly, between themselves. Geoff stated: 'men shut up about stuff'. When I asked Eric whether he agreed, he joked: 'because we're blokes ... We've got the power tools to do the talking for us'. Francis and Dean agreed: 'gee, it's not the done thing ... Guys just don't do that' (cf. Pinnock et al 1998). Francis gave the example of his wife's girlfriend who had, had a breast removed due to cancer. When the two women met or phoned each other, 'usually the topic of conversation, everytime they met or talk on the telephone, there's always an underlying thing of "how are things going?" Owing to the continuity of the relationship, the frequent contact, and the intimate relationship women have with their bodies, Francis perceived the two friends to be 'always in that situation' of communicating about themselves, their lives, their health and well-being (physical, mental and spiritual). Women's language is contextualised, rich in detail and engaged with the multiple facets of their lives. In contrast, Francis admitted:

I don't get on the phone and talk to a mate and say, 'have you had a test for prostate [cancer]?'

Or, "how are you handling it?" Or anything like that. Or those sorts of things. It's usually of other interests or you're ringing about something specific. 'Can I borrow the trailer because I want to go to the tip?' Or something like that. [Heads nodding] It's more specific than that.

When men contact each other, their own health and well-being are rarely the subject of conversation. Rather, the focus is upon something external to themselves such as their work, sport or needing a tool to get a job done. There is then little room for expressing emotions and problems in their lives or their health. Their view of their bodies is largely instrumental, relative to work, sex or sport. Seymour (1998) documents examples of men disabled as the result of paraplegia and quadriplegia, and how they were forced to 'unmake' and 'remake' their bodies, and confront their personal notion of

---

masculinity because they had no other choice.\textsuperscript{120} Similarly, men with a chronic illness must endeavour to create a language that gives emphasis to their bodies and its changes (cf. Frank 1991, 1995). Jokes, euphemisms and silences constitute a male language about male bodies, health and illness (cf. Pinnock et al 1998). There is little reflection by men to explore alternative views or take a preventive approach to ill-health. Nor do men have a language to understand their bodies; it remains incomplete and reduced to anatomy.

I posed the following questions to Dean, Francis, Eric and Geoff:

\textit{If men do talk about health, is it more in terms of physical health or is it more in terms of your relationships with other people? Or, how you feel about life or that sort of thing?}

Much to my amazement, having 'confessed' that men don't talk about health with each other, and I was the only woman present in this urban focus group discussion, Dean, Francis, Eric and Geoff conversed at length with much humour about vasectomies. Each man in the group had, had 'the cut' or 'what's-its-name'. The men used these euphemisms for vasectomy as if it were inappropriate or embarrassing for them to use the correct term, and their assumption that I knew what they were talking about.

Eric, Geoff, Dean and Francis related their criteria for decision-making to have a vasectomy entailed: i) family size; ii) their wife taking oral contraceptives for many years and concerns about 'her' health; iii) their wife's insistence otherwise they would withhold sex; iv) their religious background; and, v) their GP's attitude and advice. The four men were concerned about the limited sources of information on vasectomies available to men, apart from their GPs or other men they knew had, had the procedure.\textsuperscript{131} Francis exclaimed that 'you never see figures or percentage of the male population who has had a vasectomy.' This had created difficulties for them in making informed decisions (Turney 1996).\textsuperscript{132}

\textsuperscript{120} See Zola (1982), Sacks (1984), Murphy (1987).
\textsuperscript{131} Similarly, Pinnock et al (1998) report on their study of urological health, that many Australian older men are misinformed and require further information on prostate cancer.
\textsuperscript{132} The statistics for this surgical procedure performed by GPs in their consulting rooms and by urologists at day surgery units at public hospitals, is held by the Medicare database at the Health Insurance Commission in Canberra (Turney 1996). In 1995, 9.7% of Australian women aged 18-49 years indicated their partners had been sterilised (including vasectomy) (ABS 1997:61). See ABS (1991a, 1997), Grant (1994), Madden (1994), Powerhouse Museum (1995), Margo (1996), Llewellyn-Jones (1997) for further discussion on historical and contemporary use of contraception, including vasectomy.
CONCLUSION

Similar to Blaxter (1990), I assert that participants’ lay conceptualisations of health present both challenges to and an expansion of i) the WHO definition of health and ii) the biomedical concept of health. Laypeople’s conceptualisations of health and ill-health reveals gender and age/generational differences.

Being healthy encompasses multiple dimensions and these are articulated by gender and age locations. ‘Daily functioning’ means being able to fulfil everyday roles and responsibilities, and having a sense of balance, equilibrium and energy. Long ‘life expectancy’ or at least living longer than one’s parents meant good health: individuals had a sense of ‘well-being’ and enjoyed a ‘quality of life’. The integrity of the body-mind-spirit, being happy, independent and being physically strong and fit are important factors. Overall, health is valued, rather than ‘taken-for-granted’. Some laypeople view health as a gender-neutral concept, making no differences between women and men. Yet for others, health exists as a confluence of gender and age. Learning sex role behaviour, i.e. notions of femininity and masculinity, and the relationship of gender stereotypes to health and ill-health influences children’s development, socialisation, and their position in the lifecourse.

Ill-health defined here as illness, injury or disability means ‘not being healthy’, exposing the embodied self’s vulnerability, and the abnormal or pathological state of anatomy and physiology. Ill-health as ‘not functioning’ entails difficulties with an individual’s roles and responsibilities, and coping with disruptions to everyday life. Laypeople may attribute micro-organisms or ‘bugs’ as the cause of disease: colds and flus. Men, more so than women, view ill-health as problematic as it means losing their independence and becoming dependent and a burden upon others. Asking for help is for many men an affront to their sense of masculinity, thus delaying diagnosis and treatment of their signs and symptoms of ill-health. Laypeople conceptualise pain — a difficult state of being to measure objectively as it is a subjective experience — as a symptom of ill-health. There are gender and age differences in pain thresholds: adults and children manifest distinct responses to pain when ill or injured. Women assert men in pain could be dichotomised into ‘stoics’ reluctant to complain of ill-health or ‘wimps’ who are deeply angry and frustrated.

Mental health has been labelled as problematic by public health specialists, and spirituality remains absent from public health discourses. Laypeople, however, view mental health and ‘spiritual well-being’ as inimical to being healthy. Living one’s life with purpose, having a good outlook on life, being sane and having high self-esteem are qualities of mental health. Some participants spoke of the taboos of mental illness or mental health problems they had experienced themselves or had witnessed within their families or of friends. Women discussed anxiety and depression, whilst men commented upon being ‘short-tempered’ and angry all the time. Both genders
considered the effects of their mental health upon their significant others: tiredness, low self-esteem, worry, being 'broken-hearted' and fallible. Children's mental health was also of major concern to participants.

Laypeople view the body, mind and spirit as being linked to one another, as a unified trinity. They also perceive 'spiritual well-being' in terms of knowing one's destiny, the linkage between self and spirituality, and having a sense of connectedness with others and with Nature. I proposed the term 'spiritual impairment' since there is yet no agreed concept to refer to intrusions to spiritual well-being, and as a way of assessing aspects of spirituality that are manifestations of ill-health. Participants referred to their experiences of spiritual impairment as: not having time out for themselves, lack of peace in their households, difficulties in balancing intimacy with solitude, having to cope with major life transitions. Consequently, they developed strategies to retain connectedness with others and Nature.

Participants related gender differences in their experiences of being healthy and sick. Social support seems to be more important for women when ill or injured, whilst men view being a burden and dependent upon others as symptomatic of ill-health. This results in a major affront to their masculinity which is based on strength and independence. Men are more likely to complain of pain and feeling unwell, and yet do little about it regardless of the mildness or severity of the condition (a cold or heart attack). In addition, men often expect their partners to provide infinite physical and emotional support. In this sense, women are performing lay healing practices in the household; providing their physical and emotional capital and labour. In contrast, when sick, women are likely to 'soldier on' and put other people's needs first before their own, and continue to take care of others. They are also expected by their partners and children to do so. As a result, when women suffer ill-health, they are sick for a longer period as they have limited resources (including rest) to be relieved of their daily roles and responsibilities.

A case study of four men reveals they, and other men, have a limited language to talk about their bodies, health and well-being. Unlike women who discuss their bodies and relationships within the context of everyday life, men tend to joke, use euphemisms or are silent. Male participants also questioned the absence of accessible published material on men's health, and argued that recent public health campaigns have unfairly highlighted the problems of women's health without also considering 'men's business'; including information on vasectomies.
CHAPTER 5
LAYPEOPLE’S HEALTH KNOWLEDGE
AND DECISION-MAKING

Lay Discourses on Lay Health Knowledge

Lay knowledge remains somewhat neglected in public health, despite its explicit importance to improve healers' clinical practices, frame research, and inform policies and programs. Where lay knowledge has been addressed within public health, it has focussed more on environmental and lifestyle risks, and less on 'embodied risk'. There has been little attention to laypeople's sources of health knowledge, nor how they use this knowledge to produce and protect health in the household. Studies by Cunningham-Burley (1990), Mayall (1991) and Lauritzen (1997), provide data on mothers' (not fathers') lay knowledge (and lay beliefs) in relation to their children's health and well-being, and Backett (1992b) on 'health knowledge in middle class families'. This chapter focuses upon the power-knowledge relationship underlying laypeople's health knowledge and decision-making. The extent of health knowledge laypeople hold is vital to their decision-making and action(s) in terms of: i) implementing health promotion and illness-injury prevention in their everyday lives; and, ii) determining which form of healing and which healer is appropriate when illness and injury occur.

Whilst in many situations, laypeople's health knowledge appears to be 'incomplete', and unsupported by scientific facts in the positivist, empirical sense, in other instances, it is both specialised and generalist. Their health knowledge base, as indicated by participants' narratives, contains both taken-for-granted notions of the embodied self, health, well-being and ill-health as well as specific examples of accidents, chronic illness, life-threatening conditions, stress and mortality. Women and men related that health knowledge 'comes from everywhere', in both direct and indirect forms, and that it is 'accumulated over a lifetime'. It was commonly thought by participants that one needs to be 'selective about information' and that one can only rely on a 'trusted source'.

Firstly, health knowledge was seen as a 'multiple' rather than a 'singular' resource. Irene, Eric, Hazel, Francis, Helen, Dean, Edith, Blair, Francesca and Geoff were of consensus that health knowledge is ever present: unavoidable, ubiquitous, implicit and

\(^{323}\) See Dean and Hunter (1996), Popay and Williams (1996), Williams and Calnan (1996b) for further discussion.


\(^{325}\) Whilst within the social sciences, academics make a distinction between the terms 'knowledge' and 'information', participants used them inter-changeably as synonyms. They were readily understood and taken-for-granted in their everyday lives (Geertz 1983, Berger and Luckmann 1985).

\(^{326}\) See Chapters 6 and 7 for further discussion.

Secondly, others defined 'direct knowledge' as coming from other people, advertising, the Internet and mass media, 'living or growing up in a particular family with its own particular idiosyncrasies' (Kirk). 'Indirect knowledge' in Kirk's view is 'something you've taken in, and it's actually built into the fabric [of yourself].' This knowledge is 'part of you' and 'ingrained': constituting self-knowledge (cf. Jones 1998).

Thirdly, Neil, Richard and Ian claimed that the accumulation of health knowledge is a lifetime process. These men admitted that prior to becoming parents, they had limited knowledge of health and of ill-health. Ian asserted that men (more so than women) don't start to take an interest in health issues until they are involved in a relationship with a woman and she becomes pregnant with their child. The 'transition to parenthood' commences when 'kids come into your household'. At this point, 'you start reading whatever books might be lying around', become 'more acutely aware of monitoring health', and 'more attuned to the daily and weekly health of Mum'.

And fourthly, participants related their awareness that some laypeople have more knowledge than others, and about different aspects of health. This raises questions about the 'professionalisation' and 'specialisation' of lay knowledge (Baum 1990, Syme 1997). When others constantly seek their advice and support in the management of health and illness, do they become lay knowledge 'experts'? Are there lay healing 'experts'? Recent American literature confirms the presence of 'lay health advisers' as community change agents. Lay health advisers or 'natural helpers' are:

laypeople to whom others naturally turn for advice, emotional support and tangible aid. They provide informal, spontaneous assistance, which is so much a part of everyday life that its value is often not recognised (Israel 1985:68).

Various authors including Zola (1972), McKinlay (1973), Kleinman (1980), Willmott (1987) and Ell (1996), have indicated the extent to which laypeople rely on their families, friendship networks, neighbourhoods and communities for advice about health issues. Laypeople depend upon each other for information and social support at times of illness, disability, rehabilitation, pregnancy, childbirth, divorce, death or migration. Exchange, reciprocity, fairness, obligation, bonds, trust, empathy as well as

---

37 See also Berman and Pederson (1987), Michaels and Goldberg (1988). The influential American experts in parenting during the 1950s to 1970s were paediatricians Benjamin Spock (1946, 1962, 1988) and John Bowlby (1953, 1958). During the 1980s and 1990s, the authoritative texts on pregnancy, childbirth and parenting are by Miriam Stoppard, Penelope Leach, Sheila Kitzinger, Christopher Green and Steve Biddulph, in addition to the magazines Mother and Baby, Parents and Practical Parenting (cf. Luke 1996).


emotional labour are qualities of these social relationships. The participants in this study exemplified laypeople's willingness to provide lay referrals and lay treatment (cf. Giddens 1990, B. Wellman 1995).

Sarah, Nicole and Kirk commented on trusting certain sources of health knowledge and distrusting others. Their 'selectiveness' of health knowledge depended upon: i) who and what the source(s) were; ii) the nature of the inquiry (what are you trying to find out?); and, iii) the relationship between the inquirer and the user of knowledge (in whose interests will the information be used?). Kirk, Sarah and Nicole agreed reliable sources are: 'our parents', 'our teachers', family tradition, 'a person who I respect and trust', and articles in journals based on research (factual evidence). Participants saw unreliable sources as being: any material that 'has the sense of fashionable or topical', magazines that have little credibility', 'anecdotal advice', or other information that did not appear to be 'sensible' or 'you didn't feel comfortable with'. The selectiveness of knowledge from a 'trusted source' has implications for lay health decision-making.

**SOURCES OF HEALTH KNOWLEDGE**

In this study, I asked participants: where does your knowledge about the body, health and illness come from? They replied: from numerous sources. Table 5.1 gives an indication of the various sources of health knowledge indicated by participants. The data were drawn from how many times each participants indicated a specific answer to the question. Many of them gave more than one answer. For the purposes of analysis, I have placed their responses into six categories. The family and community, healers and mass media are the key sources of health knowledge for laypeople, whilst the self, education, and institutions and organisations are lesser sources. These categories are further differentiated.

Fifty-nine out of 98 participants indicated that mass media was their largest source of health knowledge, followed by the medical profession (38), education and school (of adults and children) (36), family (30) and oneself (30) (see below). Other important sources of health knowledge were: mothers (22), friends (21), nurses (16), personal commonsense, intuition and instinct (13), institutions (13), allied health professionals (11), one's body (10), alternative therapists (10), and public health messages (10). The lesser sources of knowledge of participants were: self-help groups

---

30 I decided against making a distinction between participants' responses in interviews and focus group discussions. There was no qualitative difference between their responses on lay health knowledge and decision-making. It is also beyond the scope of this thesis to explore additional data concerning: changes in health knowledge in time and place (grandparents, parents and children), and the implications of absent knowledge for laypeople.

31 A full discussion is not possible owing to word constraints.
(8), the workplace (6), children (3), fathers (2), teachers (2) Cubs and Scouts (1), trial and error (1), the health food shop (1), and social movements (1).

<table>
<thead>
<tr>
<th>Table 5.1: Sources of Lay Health Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self</strong></td>
</tr>
<tr>
<td>Body</td>
</tr>
<tr>
<td>Commonsense, intuition and instinct</td>
</tr>
<tr>
<td>Trial and error</td>
</tr>
<tr>
<td><strong>Family and Community</strong></td>
</tr>
<tr>
<td>Mothers</td>
</tr>
<tr>
<td>Fathers</td>
</tr>
<tr>
<td>Children</td>
</tr>
<tr>
<td>Friends</td>
</tr>
<tr>
<td><strong>Healers</strong></td>
</tr>
<tr>
<td>Doctors</td>
</tr>
<tr>
<td>Allied health professionals</td>
</tr>
<tr>
<td>Alternative therapists</td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>Teachers</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td><strong>Institutions and Organisations</strong></td>
</tr>
<tr>
<td>Workplace</td>
</tr>
<tr>
<td>Health food shop</td>
</tr>
<tr>
<td>Cubs and Scouts</td>
</tr>
<tr>
<td>Self-help groups</td>
</tr>
<tr>
<td>Social movements</td>
</tr>
<tr>
<td><strong>Mass Media</strong></td>
</tr>
<tr>
<td>Public health messages</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>

These figures reveal multiple rather than singular sources of health knowledge (cf. Backett 1992b, ABS 1997, Lauritzen 1997). They also contradict the argument in medical sociological literature that laypeople's primary source of knowledge is from doctors, that is, as agents of biomedical science. Whilst these data demonstrate that the medical profession is an important source of health knowledge for laypeople, they are not the only source. These figures complement the qualitative data analysed below. I begin with the 'self', before discussing the other sources of lay health knowledge: family and community; healers; education; institutions and organisations; and, mass media.

---

\(^{32}\) Again, the data are biased by the gender of participants (more women than men), and their age and stage in the life course. I did not ask children or older persons (older generations) the same question which might reveal different answers (cf. Blaxter and Paterson 1982, Boll 1988).

Self

Women and men in the study indicated that their 'self' as a source of health knowledge relies heavily on: i) 'experience'; ii) 'self-observation and 'self-discovery'; iii) 'self-education and interest'; and, iv) 'childhood memories'.

Firstly, laypeople's experiential knowledge emanates from both specific 'experiences' occurring at a particular time and place, but also the accumulation of experiences over a lifetime. Many participants in the study re-told their personal experiences of growing up with an illness, such as polio and nephritis, and the subsequent effects on their personal well-being and capacity to participate in sport, social activities, and eat certain foods. Francis recalled 'having what I suppose, a mild disability ... that I would miss out' on playing football, cricket and tennis as a child. Whilst Eric, Alice and Fiona reflected upon influences in their lives when they were children and adolescents (other people smoking and the chance of dying early of lung cancer, 'heart trouble' and cardio-vascular disease, or alcoholism), and the devastating effects on family life as a result (Davison et al 1992). The personal 'experience' itself and their evaluation of other people's experiences influenced Wendy, Laura, Eleanor, Jackie, Rita, Hazel and Irene to make decisions about their own lives, and the type of experiences they wished for their own children. In some instances, this meant a nostalgic revisiting of the 'good parts' of childhood: living on a farm, growing vegetables, walking barefoot along the beach, camping and bushwalking. Conversely in other situations, Éric, Lewis, Beth, Richard, Kate and Renata did not want their children to make the same 'mistakes' in relation to drug abuse, over-medication, obesity, high cholesterol levels, and in exposing themselves to the risks associated with heart disease and cancer. As Blake remarked: 'It's those life experiences that impact on you. Especially if it's a negative one.' Participants' fears indicate notions of fatalism and pre-destination versus individual responsibility and behaviour modification, and therefore blame for these 'lifestyle conditions'. Pam, Richard, Louisa, Sian, Kirk, Sandra, Andrea and Kelly also narrated their more immediate experiences managing their children's asthma or epileptic seizures, administering first aid and seeking secondary treatment for accidents, or ongoing biomedical care for hypertension and rheumatoid arthritis.

Significant life experiences for Tammy and Jack were residency and adaptation to distinct cultures and health care systems whilst overseas, which subsequently affected their 'selves' and views of healing. For Tammy, being a mother and having two children as babies whilst living in Japan were major lifetime experiences that have extended her health knowledge and influenced her present health decision-making. Given that her

---

334 Participants perceived 'mistakes' as negative outcomes of lifestyle related conditions, resulting in poor quality of life and premature death.

husband was working each day, and she was far from relatives and friends - and their health knowledge and social support - she was often at home alone with a small child, developing strategies to cope with their ill-health. In contrast, Jack worked as a medical officer for a mining company in Papua New Guinea during the early 1980s. He treated malaria, encephalitis and other 'acute, severe illnesses ... that with simple treatment do very well and without them are very serious' and 'some fairly traumatic injuries' caused by machetes. This period of his professional life extended his knowledge of a myriad of cultural, political and economic factors influencing health, healers and healing (Singer and Baer 1995).

Secondly, laypeople acquire health knowledge through 'self-observation' and 'self-discovery' by 'finding out for yourself'. Self-observation is a way of learning about maternal and child health, and baby care. Self-discovery coupled with commonsense means being able to fulfill responsibilities of keeping one's children clean, well fed and warm. It was the view of Beth, Carrie, Neil and Alice that the process began when they became parents - 'when you have a baby ... in hospital' - and continued when the new mother and child arrived at home in more familiar and relaxed surroundings, to discover more about each other. They joked that 'some of our experiences are shocking, especially with the first one ... because we didn't know what we were doing. We were at the deep end.' These parents agreed that the antenatal classes 'teach you about going through labour and birth. That's the easy part', not the 'aftermath'. They suggested that there is a lack of knowledge conveyed by the health professional 'experts' and other parents about caring for one's infant at home, where one is left totally responsible for the health and well-being of a small dependent human being. Alice stated: 'reality hits you. Crash! Then, what do I do with this child now? ... Yes, it's screaming blue in the bath.' Neil admitted relying on his wife's nursing and midwifery experience as a health professional when their sons arrived, since he 'had no idea what to expect ... I thought she'd know everything and it just turned her life upside down.' Maushart (1997) argues that knowledge of babycare and parenting is kept 'masked' from those women (and men) who do not have children. Furthermore, women's knowledge and experience of mothering is devalued and under-valued, whilst 'Supermum' continues to be mythologised and idealogised in Australian society (Wearing 1984). Consequently, on the birth of their first child, both women and men have little sense of what their new role involves, and have no other option but to discover for themselves what babycare and parenting is all about.

Thirdly, another way a person acquires health knowledge is by 'self-education'. They are motivated to read literature, investigate and undertake courses when a

---

significant other becomes ill or injured. Kay, Fran and Jane described their self-education and interest in health as: 'you read yourself ... I've got a general interest in health ... my own interest in finding out about things.' It is also more likely that self-education will occur when a family member presents with baffling signs and symptoms for which there is no immediate or ready made diagnosis or cure. Blair, Eleanor, Fran, Wendy, Kay, Tammy and Francesca indicated they went searching for more information to enlighten themselves about various healing modalities, remedies and health issues. Some participants were propelled by the imperative of having children, they had seen 'something on the telly [television]', or 'I love reading about health' for sheer pleasure. Others remarked upon their enjoyment of sharing health knowledge with their children (Backett 1991). Francesca said, 'I've got a dictionary on health. My kids are forever trying to find out about it'. Blair explained: 'I'm the sort of person who likes to listen ... I like to understand' when he hears of something new related to health and medicine. Wendy's interest in alternative therapies extended to undertaking a course in Reiki. She also 'kept a page of herbal remedies ... garlic and wormwood are good for fleas and things like that. I have kept information.'

Finally, 'childhood memories' shape the self.\textsuperscript{38a} Kirk, Wendy and Jackie related memories of life experiences which impacted upon their health and well-being, and continue to constitute a source of health knowledge. Kirk's childhood experience of his mother's inclusion of all family members in the weekly cleaning ritual, was a lesson he carried forward as an adult with marital and parental responsibilities which he applied to personal and household hygiene, as well as vaccinations against infectious diseases (cf. Labisch 1985). Wendy recalls the simplicity of life, being part of a family, 'Christmas time' and the 'fresh pine trees', and her awareness of Nature whilst living on farm. Whilst Wendy was nostalgic for a time lost to her, she nevertheless sought out friends living in the countryside for her ten year old son to enjoy and learn from, thus augmenting his current well-being and quality of life. In contrast to Kirk and Wendy, Jackie's account of her childhood is negative. Like Wendy she grew up on a farm but described her and her siblings' contribution as 'slave labour', in that her father worked them hard and there was little leisure or freedom. He was also an alcoholic and violent. Unlike Kirk's family, her father's attitude towards cleanliness entailed being strict about germs, not eating out, dressing for dinner and not having pets. He also had an intolerance towards sickness: 'we went to school whether we had rigor mortis'. Her unhappiness and emotional problems during childhood extended to adulthood when she left home to commence studies at teachers' college. Over the years, Jackie admitted that she suffered bouts of 'I just don't know why I'm feeling down'. Now 37 years old, married with two children aged six and seven years, Jackie endeavours to give her

children more balance and happiness, with much attention to mental health and spiritual well-being.

Body

Health knowledge is 'embodied knowledge', in that the human body contains information about health and well-being (Schepers-Hughes 1994a). Firstly, health knowledge can be 'embodied'. Knowledge comes from within, beneath and the outer body surfaces. It is not merely a text to be read and interpreted by others in the postmodern sense (Fox 1993), it is also a material physical reality that occupies space, consists of 'flesh and blood', and has significance for the embodied self (Grosz 1994). Secondly, this embodied knowledge is both subjective and objective. The person who occupies their body is aware of her/his body's capabilities and limitations; affected by gender, age, height, weight and health status. An outsider 'gazing' upon the person's body 'reifies' it as a 'thing' (Taussig 1980), as 'other' and distinct from themself, and yet s/he can assess the person's health status and well-being from their outward appearance (Foucault 1973). Health professionals trained in scientific medicine are able to gaze upon the internal structure and function of the body via the senses, instruments such as the stethoscope, ophthalmoscope and otoscope, and high technology as used in diagnosis, monitoring and surgery. They thus 'exteriorise direct images of the body's interior' (Williams 1997:1047, cf. Fox 1992, Atkinson 1995, Sachs 1995).

Participants indicated that their 'embodied knowledge' came from their own bodies, in good health as well as when they, or a significant other, suffered illness or injury, and from their experience of pregnancy and childbirth. Knowledge of their bodies enabled them to make a diagnosis and treat ill-health.\textsuperscript{350} Jennifer indicated that 'if you listen to your body, it tells you'. She emphasised the importance of taking notice of one's body as a barometer of wellness and ill-health. For instance, we enjoy the aesthetics of food and exercise our 'tastes' in choice,\textsuperscript{351} and avoid foods that cause 'wind', 'indigestion', 'stomach ache' or 'sinus problems' (Gaté 1997). Adrian's concern was 'preservatives and all the additives they [the manufacturers] put in the food to keep it from rotting'. He pondered that 'it must affect you the stuff that's in the food'. Gaté's advice (1997) is to shop well at markets, buy fresh fruits and vegetables, ensure a variety of foods in the daily diet, and foster pleasure in discovering a myriad of textures, flavours, colours and aromas of foods.

\textsuperscript{350} See Chapter 7 for further discussion.
\textsuperscript{351} See Bourdieu (1984), Stoller (1989).
Commonsense, Intuition and Instinct

Saul (1997) asserts that commonsense and intuition are difficult to define since they are intangible human qualities. And yet, their existence as being on par with reason (or rationality) and other human qualities instills a sense that they are important for the well-being of human civilisation. Goleman (1996) has commented that these qualities also constitute 'emotional intelligence'. However, King and Appleton (1997) encounter persistent denigration of intuition in nursing practice, despite compelling evidence of its saliency.

Commonsense, intuition and instinct were sources of knowledge frequently referred to by participants. They relied on these in times of great stress, when there was little factual evidence, and yet they had to make decisions (Bernstein 1996). Like knowledge that comes from within and outside the human body, commonsense, intuition and instinct are also forms of 'embodied knowledge'. They are not located externally to the 'embodied self' and are unique to each individual. Debate continues within the literature about whether intuition and instinct are female qualities whilst rationality is male, and whether women are closer to Nature and men to Culture.\(^{341}\)

Women in the study to a greater degree than men commented that exercising one's commonsense (rather than intuition) was essential for healing illness and injury within the household. Whilst they did not disregard the advice of others (grandparents, friends, relatives, infant welfare sisters - and their commonsense) - women utilised their personal knowledge and household resources to deal with these situations (cf. Chamberlain 1981). Commonsense gives laypeople confidence to assess and manage a situation even when they lack prior experience, relevant resources or information (Geertz 1983). Caroline, Bianca and Yolanda agreed that 'a good dose of commonsense' was integral to their health decision-making in the household. 'You just sort of figure it out', said Marcia. Commonsense assists laypeople to 'work with what you've got'. As Caroline succinctly put it: 'people, I mean are more independent. Especially with mothers. Women. They don't need to be told what the doctors think ... you just use your commonsense.' Caroline advised other parents that

If you can't deal with it you take them [to hospital or a doctor]. But if it's something that you can cope with ... you know, there's plenty of ice, hath it, and put the Steristrip on. And that's it.

The injury will 'mend'. Natalie was not so easily persuaded by these arguments. She asserted that many people seemed to lack commonsense and tended to rely heavily on rationality although not everything can be easily explained by reason. 'Commonsense is

the biggest thing that is missing in humanity. It really is. We've gone too over-the-top with our intellectual being ... but more on a negative line'. She felt it was important to have faith and courage to believe in oneself and in others.

'Intuition' has been popularly regarded as solely the prerogative of women in much of the literature on health, possibly Osfield (1997:59) suggests, 'because men have long been discouraged from being in touch with their emotions'. It is often referred to as 'women's intuition' (Chamberlain 1981). This ignores the common elements of the human condition that women and men share, including their 'sixth sense'. The results of this study suggest that intuition is not gender-specific. Both women and men lay claim to this source of knowledge. Furthermore, with a few exceptions (see Kirk below), adults in the study tended to believe they have ownership of intuition and children do not; as if intuition comes about only with advancing age, life experience and the attainment of adulthood.

Pam said of her 'intuition':

you can't always explain ... it's an intuitive thing. You know when something is just out of the normal and you're not just talking about a cold any longer, and that it's something else.

Neil related that despite his limited education, interest in health issues, and not being a health professional, he claimed to also 'have' and 'use' his intuition with 'certainty'. He referred to it as 'male intuition'. As a new father 'I watched and watched as the baby never put on any weight for three months, and cried and cried.'

And I had my own theory. But because I had no education, and I mean, everybody talks about female intuition ... well I think there's a 'male intuition', because I believe the baby wasn't getting food and I'm certain I was correct.

Neil observed Margaret, his wife trying to breastfeed their first son. She had inverted nipples and she used a breast shield 'to try and get the nipple to come out'. His son was always crying after each feed, so Neil suspected after a while that he wasn't receiving the breastmilk. 'I was working long hours, coming home and then having to see this, and see this child cry, cry and cry', and his wife becoming very tired and upset. He believed she was also mildly depressed post-natally (Brown et al 1994, Barclay 1995). 'Every time I brought it up, I just got hammered. I had no educational background, no certificate to say that, that's what's going on'. Therefore his assessment of his wife's and his son's health status was readily discounted by Margaret, 'lactation consultants' and other health professionals (his wife's colleagues). Kirk was in awe of his youngest daughter's intuition and her rapid estimation of 'emotional situations'. 'I've always understood from a very, very early age, she's in touch with herself and she understands
me, better than I understand myself. He believed that 10 year old Lana would assess an environment and ‘you can just read it on her face’. I'll say, “no, it's OK." And she says, “no, no, no it's not alright, Dad.” Over time, Kirk came to rely on Lana’s intuition and to take her evaluations seriously.

However, most participants referred to ‘instinct’ as maternal - not paternal - and therefore belonging to women only. It enables them to: i) assess a social situation and a person’s health status; and, ii) make a decision, develop, implement and evaluate a plan of action. Rossmannith (1997:202) advises parents to ‘Know your child. Observe. Listen ... Trust your own instincts. You know what is best for your child’.\(^\text{52}\) Leah defined ‘maternal instinct’ as:

> You know your child and you know how they react to things and you know just by instinct whether something is superficial or whether it's something more serious that needs attention.

Leah relied on her instinct: ‘I find that if I follow my instinct it almost always pays off.’ Sian spoke of how she determined the urgent need for diagnosis and treatment for her baby daughter when she became ill with a potentially fatal cancer.

> I felt inside me that there was something wrong, and if you talk to any other mothers whose children have cancer - we've all had that same feeling - we've known inside that something was wrong.

Pam despaired of some biomedical health professionals (including doctors) and their attitudes toward women acting upon their instinct and presenting at a medical centre or hospital accident and emergency department with a sick child. Frequently, labelling occurs: ‘a mother is neurotic’. They do not pay any attention to what we would label as maternal instinct'. Pam admitted that some doctors, including her current paediatrician, took the time to listen and take seriously a mother’s concerns (cf. Cunningham-Burley and MacLean 1991, Kai 1996b).

**Trial and Error**

> Medicine, and increasingly nursing, is practised on the basis of ‘clinical evidence’.\(^\text{53}\) It is:

---

\(^\text{52}\) In Chapter 7 I discuss further the importance of ‘knowing your child’ when diagnosing and treating illness and injury. Participants repeatedly stated that their personal knowledge of their children, as well as embodied knowledge of human anatomy and physiology were critical factors in their health care decision-making.

the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of clinical evidence based medicine means integrating individual expertise with the best available external evidence from systematic research (Sackett et al 1996:71).

That is, data resulting from randomised clinical trials investigating the efficacy of medications and procedures with a 'control group' and 'an experimental group' over time. These trials are frequently purport to be 'scientific' and value-free (cf. Latour 1987, Oakley 1992b). Medline (online bibliographic search) and the Internet (email and World Wide Web) enable medical practitioners of all specialities (particularly in well-resourced industrialised countries) to rapidly access the latest clinical evidence from their colleagues in other clinical and research settings around the world. Williams (1997:1042) contends these strategies support medicine as 'a modernist enterprise, steeped in a scientific tradition in which truth, order and progress are seen as paramount virtues' (cf. Lupton 1998).

In contrast, as indicated by participants in this study, laypeople use trial and error as a strategy of acquiring knowledge - factual evidence - which they then use in illness and injury situations in the household. This particularly occurs when the ailment is of medically unknown aetiology, is chronic or frequently re-occurs. Or, they had given up on biomedical scientific expertise. We could call this form of inductive thinking - 'what works and what doesn't work' - as 'lay empiricism'. Practice produces knowledge, which in turn informs practice; constituting experiential knowledge.

Marcia and Natalie agreed that trial and error occurs 'heaps', because 'if one thing doesn't work, you try another'. Their responses also indicate an inherent evaluation of their strategies and their flexibility in developing other approaches to a situation. Sometimes, to reassure themselves they would 'check with someone else' (cf. Lauritzen 1997). The 'someone else' was usually a 'trusted source' because as Dawn remarked: 'I have found a lot of information to be outdated. What our parents did isn't always the right thing.' Wendy was philosophical:

Well, if it doesn't work or if you're not happy with it, you can always weigh it up and think ...
whether you agree with it or not. If you do that's fine. If you don't you can see how viable it is.

Whilst Bianca cautioned: 'It depends on the severity of it [the condition] too.'

Lay empiricism is largely based on a small sample of individuals (usually one or two people) repeatedly affected by a particular condition, in the context of everyday life. For instance, allergic reactions to pollens causing hayfever. The lay person, usually a parent, observes over a period of time what 'triggers' the signs and symptoms manifested by the affected person. They weigh up the probabilities of cause and effect, and determine what remedies or physical and social environmental conditions relieve
the ailment through experimentation (Lauritzen 1997). Adrian, Kelly, Louisa and Gemma provided succinct examples of 'lay empiricism' in their detection and treatment of allergies suffered by their children. These allergies manifested as hyperactivity, skin rashes, hives and eczema. Their range of therapeutics entailed: limitation and avoidance of foods (oranges, chocolate, caffeine and apple juice) and food colourings (in medications, cordials, processed foods) in the children's daily diet. Kelly stated: 'Everybody thinks it's the red [food colouring] really, but the yellow is worse'. She had established this fact through trial and error, with her own three children, 'because the doctors won't do it'. The aim was to relieve the symptoms and if possible cure the mitigating cause. Gemma had wrested to various laypeople's and biomedical practitioners' suggestions for a 'cure' for her six year old daughter's eczema, only to find the symptoms substantially 'controlled' by a daily routine of cortisone cream application and personal hygiene, and removal of 'acidy foods' from her diet.

Family and Community

The family as 'the basic cell of society' (Glay 1997) provides health knowledge through socialisation of its members (Parsons 1951). Living together in the household on a daily basis, and through participant-observation, family members acquire knowledge on health promotion, illness-injury prevention, diagnosis and treatment of illness and injury. The National Health Survey 1995 data indicate that Australian women and men consider family and friends as the most significant source of health information (ABS 1997:41). Participants spoke of their parents, partners (wives and husbands), and 'family networks' as major sources of information.iii

For many participants, their parents were the primary and earliest source of health knowledge. 'Probably from my parents' who teach you 'the basics' agreed Rita and Kate. 'And you just glean more information as you get older.' Their parents continue to be a source of knowledge, owing to their vast experience in child-rearing (as parents) and being grandparentsal. Nadia stated: 'Mine has come from my parents. From my mother a lot ... if there's any bits and pieces, I would always check it out and ask her.'

Whilst some participants reported they received much health knowledge from their parents; others indicated that this wasn't the case at all: 'Not my parents'. They may believe their parents' knowledge of health matters to be inaccurate. Kay described her mother's explanation for ill-health as 'everything's to do with dairy product allergies', even if she had a broken arm. Kay therefore declined to ring her mother and rely on her information. Other participants believed they learnt more about health from sources other than their parents, for example, friends, literature and health professionals, especially concerning matters of reproduction, fertility and sexuality.iv

iii The inter-generational transfer of health knowledge will be discussed in a forthcoming paper.
iv In her anthropological study of generations of women, Bell (1988) describes the relationship between
the lack of sex education she received from her mother - not her father - as a pubescent young woman on the verge of menstruation.

I didn't get anything at home. I mean when I grew up you didn't talk about things like that ... Growing up ... what was happening to all the other girls [i.e. puberty]. Because Mum didn't tell me ... she just used to say, as I was growing up ... 'you must be getting your period' and I thought, 'well, I must be getting my period', but I didn't have any knowledge of what a period was or what you used.

Connie concluded that as a result, women (and men) 'didn't learn anything' about health and reproduction from their parents. 'You got knowledge off your friends or you just read about it in books' (cf. Bell 1988, Bulbeck 1997).

'Old wives tales' and 'working class myths' were the sources of health knowledge Christopher and Richard received from their parents as they were growing up (cf. Chamberlain 1981). Both men (a medical scientist and an academic) readily dismissed the validity of the 'truth' of these 'tales and myths' as 'absolute rubbish ... pushed on you from a very early age. Being far from the truth.' Christopher gave the following examples:

'Don't ... swim within two hours [after eating]...' 'If your shirt is hanging out you'll get a chill on your kidneys' ... 'If you go out into the rain you'll get a flu' ... 'If you eat your crusts you'll get hair on your chest'.

Christopher indicated the irony of not being 'exposed to these public health campaigns and yet we all seemed to learn about it [i.e. health]'..

Our parents were our only source of learning about these things until we started learning for ourselves. Which was not school. It was only when I got to tertiary level [of education] that I actually started to learn things about medicine and health and your body and things. And then you realise that all these old wives tales we were told, had absolutely no basis whatsoever.

Christopher wondered that his parents received any health education themselves, and believed that it was fortunate for everybody now to have public health campaigns (based on positivist science) as another source of health knowledge. Jo, Marcella, Rose,

---

mothers and daughters, and the silence and secretiveness surrounding the female (and male) body. Outside of the family home, women's (and men's) access to information about their bodies and themselves was just as limiting and moralistic. 'To find out about our bodies, we turned to whatever was available: household manuals, mysterious medical texts and true-love novels' (1988:204).
Nadia, Ingrid, Libby, Kay and Patricia collectively responded with great humour to Christopher’s claims during a rural group discussion:

Oh yes, I remember that ... it’s lucky that we’re still alive. Isn’t it! ... But you lived despite them ... But they were largely for minor things. What you did or didn’t do ... But fruit and vegetables was a pretty healthy thing ... In the olden days the natural products ... there was no fast food or additives ... If they [our parents] grew up now with not knowing what was healthy or not healthy, they would be living off all junk food. [Laughter] There wasn’t the junk food about years ago. [Heads nodding]

Richard claimed his health knowledge ‘was based on working class myths that I got from my mother, father, and grandmother.’ He described them as ‘little sayings’ and ‘adages’ that tended to ‘turn up when ... you least expect them to turn up.’

So when there’s an experience occurring, there’s a flashback to childhood and to what Mum said, or what Dad said, at that particular time.

Women in the study indicated they often referred to their partners as sources of health knowledge, especially when there was an emergency situation that required first aid or a fast drive to the nearest hospital accident and emergency department. Male participants similarly consulted their wives, not just about emergencies but on general health matters. Both partners consulted each other when signs and symptoms of ill-health manifested in a family member and required ongoing investigation and therapy.

An individual with a background in naturopathy, nursing, osteopathy, herbalism, physiotherapy, medicine, esoteric healing, or aromatherapy is likely to use their skills and knowledge in providing lay healing for themselves and their immediate family, and circle of friends and relatives. Ian spoke at length of the ‘family hazard’ of having ‘an awful lot’ of GPs and specialists in his extended family. His wife is also a social worker. When anyone became ill, ‘we ring up within the family network’.

There’s a lot of opinions down at the end of the blowers [the telephone] if we want to seek them. We try and avoid them ... but occasionally we seek them. And there’s always involuntary input ... all that input that isn’t called for. It’s coming at us anyhow.

Ian’s ‘imagined community’ (Anderson 1983) of health professionals within his family network and their colleagues, expanded the availability of health knowledge sources, awareness of the professionals’ specialties and reputations, and greatly facilitated referrals.
Mothers

Mayall’s study (1986) of couples caring for their first child aged 18-36 months confirms:

Mothers ... like everyone ... carry around with them a mixed bag of knowledge, probably derived from various sources. Some bits learned in childhood, some tacked on after watching television or talking to the doctor, others learned from experience (Mayall 1986:88).

Participants indicated that ‘being a mother’, one’s own mother and mother-in-law, and other mothers were important sources of health knowledge. Mothers have both experiential knowledge and commonsense. In this role, women were sometimes the first reference point when illness or injury occurred in the family.126 With other women who are parents, sharing this role and experience in common meant their judgements of a situation could be trusted. Pam, mother of two children prone to asthma and accidents, stated: ‘You gain a lot of knowledge as a mother over the years. A lot of medical knowledge.’

Participants readily indicated that they either followed their mothers’ or mother-in-laws’ advice on health matters or ignored it. Generational differences in ideas on child-rearing and health care of children could be sources of conflict (Blaxter and Paterson 1982). Some participants commented upon their relationships with their mothers and mother-in-laws as either ‘good’ or ‘domineering’. It also determined how much credibility or importance is attached to the advice given by an older woman with adult children and grandchildren. Elsa affirmed, ‘you ring your Mum up’ because ‘they’ve either been through it or they sort of know’. She reported of her own mother that she can look at a skin rash and straightaway make a diagnosis, confirmed by a doctor. ‘My Mum can pick up those things. She had five kids. She’s been through it a few times. She knows what they look like.’ Her familiarity with childhood illnesses (chickenpox, mumps) was reassuring. Valerie and Carmel agreed that ‘Mum’ is ‘reassuring’ and ‘that even if you don’t agree with her, she’s there for backup’, whilst Caroline confirmed that ‘they give you a good dose of commonsense.’

For a migrant woman, her accessibility to her mother or mother-in-law for support and health knowledge is compromised when they live overseas. Both Amanda and Belinda are migrants recently arrived from the Asia and Europe, married to Australian men and living in a working class and industrial area of Geelong. Phone calls to their mothers overseas are expensive, disembodying and cannot replace face-to-face human interaction. Their mother-in-laws live in Melbourne and were only accessible by phone or weekend visits.

126 See Blaxter and Paterson (1982), Bell (1988).
Women found that contact with other mothers extended their health knowledge considerably. 'We bounce ideas off each other', said Carrie. Other mothers with children the same age or who are older would make suggestions to them about lay healing based on their own experiences. Their prior knowledge was particularly helpful for first time parents. Mothers and fathers also learn 'from each other'. Elsa believed that 'you pick stuff up from talking to other mothers who have got older children, who have gone through the stages that you are going through' (cf. Maushart 1997).

Fathers

Both women and men (aged 25-47 years) in the study affirmed that they learnt more from their mothers than from their fathers about health issues. Wendy considered her elderly father an important influence upon her perspective on life and health. He lived a simple lifestyle on a farm, until his death in his 80s. His naturalistic approach epitomised good health for her. Blair's view was 'I learnt a lot from Mum. Maybe not Dad so much. I think that generation was too busy working, still is.' Mayall (1993a) discusses the assumptions underlying men's participation and non-involvement in children's health and welfare, in Britain. These assumptions relate to the paid and public nature of men's work, the view that fathers are 'not the natural caregivers' unlike women, and their major input into family life is financial; 'they are not perceived as responsible for child health and welfare' (1993a:78).

Biddulph (1995), West (1996), Edgar (1997) and Mackay (1997), comment on the 'absent father' during a child's life in Australia during the 1940s, 50s and 60s, when society placed much emphasis on traditional family values and women's place in the home (Bulbeck 1997, Segal 1997). His long working hours and the nature of his work took the father away from the family hearth. The father became an economic provider but not a social or emotional provider during childhood. Women were the primary caregivers during childhood. Many men (and women) aged in their 30s to 50s today express feeling 'emotionally removed' from their fathers, and finding little or no connection with them in later life. The gender division of labour in the public and private sphere has been critiqued by feminists since the 1960s. The question arises of whether changing gender relations and employment patterns have affected the gender division of labour inside and outside of the household.\(^{347}\)

Blair, Adrian, Christopher, Neil, Ian, Francis and Geoff (aged 36-47 years) related at length their personal experiences of being the primary caregiver. They had experienced altered gender roles or 'role reversal' (Grbic 1994, 1995) either at the time of interview or focus group discussion, or in the recent past (pre-1995). Blair and


Francis respectively referred to themselves as a 'househusband' or 'Mr. Mum'. The seven men were unemployed, had been retrenched from their jobs, had given up their jobs for severe illness or stress-related reasons, or because they were working from home. Each man appeared to be positive in their attitudes towards their marital and familial relationships. They spoke of the many social and emotional benefits this 'hiatus period' - as Francis called it - had given them. These benefits included: being at home to help his wife recover from childbirth, prevent post-natal depression and fatigue, and co-parent two small children (Neil); being more available for their children's schooling, sporting and recreational activities (Geoff, Ian, Christopher, Francis, Adrian); and recovery from a 'nervous breakdown' and 'good rapport with the kids' (Blair). The costs of these arrangements were: living on a low household income; the uncertainty of obtaining full-time employment; and, others' negative attitudes towards their changed roles. In contrast Eric, working full-time in the transport industry, related his regret that his working life meant being away from his four sons (aged 7-22 years) and his difficulty in spending as much time with them as he would like. There was the social and familial imperative to economically provide for them, thus facilitating access to household resources for their health care (Connell 1995, Osherson 1996, West 1996). Petre (1998) suggests men can spend more time with their children by lobbying companies to become more 'father-friendly', with flexible working hours, part-time work, no overtime and parental leave. Male participants' comments reflect changing views on fathers and experiences of fatherhood, as lay sources of health knowledge.

Children

Parenting does not solely consist of parents teaching their children, nor is it a one-way flow of knowledge. Rather, children also teach their parents about many issues, including health. 'You know your child' was frequently commented upon by women and men in study, along with 'knowing human anatomy and physiology', as criteria which prompted parental (lay) diagnosis and treatment of illness and injury. Children's sources of knowledge stemmed not only from their parents but also from their teachers and school curricula, health professionals, other adults, and mass media including television.

Children through observation and participation in family life and attending school, firstly, learn about health and managing episodes of illness and injury. Secondly, '[c]hildren understand that health issues are complex moral issues, set in the context of human relationships' (Mayall 1993b:482). The cross-generational exchange

---

397 See Chapter 6, section: teaching versus parenting, and Chapter 7, section: lay diagnosis, for further discussion of these points.

398 See Mayall (1993a, 1993b) for a discussion of the division of labour and also health knowledge between children, parents and teachers.
of ideas, information, concepts and understanding of situations contains perceptions and attitudes towards health and ill-health. They also raise parents' and children's consciousness and expand their knowledge base of health issues, including food and nutrition, the importance of rest and exercise, and participation in social and recreational activities.\footnote{Fran enjoyed reading books on the human body together with her two sons. Both generations manifested a strong interest in health. She stated:}

The children have got the series *How My Body Works*. And in fact they're quite interested in reading those books. And sometimes we'll just sit down and I check out a few things. Or if they want to know something. And I might even use that as a basic thing to look up to help [them] understand why things work.

Children's families and schools are working together, complementing each other about health and ill-health, and coordinating strategies to promote health and prevent illness- injury.\footnote{Rose, Patricia, Blair and Gemma indicated their children learnt about health and ill-health from human development subjects, participation in sport, and health professionals and the Life Education van visiting primary schools. The children would come home with assignments, worksheets and snippets of information on smoking, alcohol, drugs, food and nutrition, human anatomy and physiology, which they shared with their parents; reinforcing notions of 'healthism' (Crawford 1980).} Rose, Patricia, Blair and Gemma indicated their children learnt about health and ill-health from human development subjects, participation in sport, and health professionals and the Life Education van visiting primary schools. The children would come home with assignments, worksheets and snippets of information on smoking, alcohol, drugs, food and nutrition, human anatomy and physiology, which they shared with their parents; reinforcing notions of 'healthism' (Crawford 1980).

In other instances, children related to their parents issues they viewed on television, videos, advertisements or read in books, and magazines, such as death and dying, mental illness, cancer, sunscreen and hats, friendship, teeth brushing, disability, divorce, drink driving and diverse family structures. The subject of interest would be discussed further, thus expanding the knowledge base of both generations. 'You talk more freely about it', said Ingrid. The influence of this source of information was that 'they come home wagging their finger at you', stated Wendy. Children are surveilling and questioning their parents' lifestyle behaviour, exercising agency. They are also preoccupied with healthism, and participate in health care decision-making within the household. UNICEF (1994:19) contends: 'children through their innocence often remind adults that their actions are unwise or unsafe. They act as the conscience of the community'.

*Friends*

*Friendship is a voluntary and intimate relation between individuals entailing trust, mutual respect, reciprocity and obligation. Sharing common interests and acceptance of differences provide a basis for sustaining a friendship over time, the degree of*
'closeness' or distance, and frequency of contact during the lifecourse. The sources of friends may relate to work, childhood or school, neighbours, clubs, through children, university or leisure. Friends may assist one another with babysitting and child care, shopping, a child's illness, house maintenance, financial advice and loans, personal problems (Willmott 1987). They are also a steady and 'trusted source' of health knowledge.

To participants, their friends provide support, encouragement and inspire confidence. They are often reassuring and confirm one's own decision-making and actions; assisting with the assessment of illness or injury, and severity of the condition. They are an added source of information replete with life experience. 'I like talking to parents who've had similar problems and how they've dealt with them', said Fran. In a coastal area, Olivia, Vicky, Teresa, Pam, Simone, Marcia, Natalic and Rachel discussed how they relied heavily on their friends as sources of knowledge when someone in their household was feeling unwell. Natalic remarked, 'If I ring you up and say, "I've got a pain in my arm and what shall I do?"' While Pam pondered, 'doesn't the friend sort of act as a reinforcement of what you've decided to do anyway?'

[Friends] just give you confidence. Especially on those decisions where you're not quite sure 'do they need stitching up or don't they?' Those sort of decisions. 'Should I take them to the doctor or not?'

Especially, when emergencies occur: 'ones I always panic over.' It helps to 'ask someone who has had the experience beforehand.'

Participants in the study who were health professionals or who had friends who were health professionals were an additional source of advice to others in their circle of friends. They would make referrals to various healers practising biomedicine, folk healing and alternative therapies. Others tended to regard their health knowledge as reliable and trustworthy, owing to their education and training, and clinical practice. Some of these friends are also parents of young children, and therefore they also had experiential knowledge of managing childhood illnesses and injuries. For Peter, a government officer, having a friend who is a 'health promotion officer' gave him 'a broader perspective' on health issues. While Mandy would ring her doctor, a personal friend, if any of her children became ill. 'I trust her, she's a good friend and she's a very good doctor.' Her medical friend is also married to a doctor and has three children of her own; an additional measure of reassurance and trust in her judgement.

In Chapter 4, I discussed that for men, good health means being independent, in contrast to women who rely heavily on their social networks when both healthy and in

---
poor health. Membership of a social network provides immeasurable support and contributes to personal well-being and health promotion. Cox (1997a) argues that social capital using the currency of trust yields a readily available resource for health promotion, whilst Jones (1998) suggests loneliness, limited human contact and the absence of social support may contribute to ill-health. Health then, is not only a human right, but also a social right. Members of a person's social networks are sources of health knowledge and reference points on health matters. Karen indicated that she would consult various members of her social network if someone 'knew what this rash is or if they had seen it before. Whether they would go to a doctor' or naturopath or chemist for further information and therapy or implement self-care at home. For Francesca, knowing 'friends or other people who have been through similar situations' was immensely reassuring. She related:

Like I had a bit of a scare earlier this year and I knew someone, a friend. I just happened to recall her telling me that she happened to have the same sort of scare. I phoned her immediately just to hear about her experience, and examinations and whatever she went through. That was really helpful.

Hazel sought her neighbour's advice when her daughter 'Annabel developed chicken pox when she was in Prep. I had no idea what it was because it wasn't the normal "bubble" [ie. blister]. She knew that 'chickenpox usually develops into huge sores.' Her neighbour told her, 'I have no idea what it is. I think that you'd better pop off to the doctor.'

The absence of a social network can impair health and a lay person's capacity to provide health care in the household. This is most likely to occur when people are socially and geographically mobile, in search of wider educational and employment opportunities and move away from significant others, including parents, friends and relatives (Leach 1994). The initial transition period of adjusting to a new environment and social circumstance can take some time. The impact of social isolation and physical distance from an established social network makes difficult the ability to develop relationships with other persons in the new setting. This was certainly the experience of Rita, as discussed in Chapter 4.

Yolanda commented that 'it's very hard on new Mums [ie. first time mothers].' In the absence of a social network and coping with a change of residency and/or social status (from childless to parent), the accessibility of nearby community services fulfills a need for human contact, support and health knowledge, and fosters social capital (Cox 1995). Amalia remarked: 'Not everyone has the social network to use as backup, so

having the [infant] health sister there [available] is really important.' Elsa related her
good fortune in being able to depend upon the social network of other young parents
initiated by the infant welfare sister, at a time she was new to an urban area of Geelong,
and coping with a small baby.

We were lucky. Where I went, the mothercraft nurse organised ... they had social groups, like
playgroups, they had pre-natal and post-natal exercise classes and they organised guest
speakers. They had people coming in all the time. It was just a wonderful social network. And
it was really supportive. And the group that came through with you all had each other's phone
numbers.

Elsa found this network reliable and supportive at times of crisis, such as difficulty
feeding her baby 'at 2 o'clock in the morning', meant that she could phone another
mother for reassurance and advice. She believed the network was crucial to the well-
being of members 'without family support'.

**Education**

Participants related that their personal education had contributed substantially to
their sources of health knowledge. Learning about health occurred at both primary and
secondary school. Scott recalled his experience of health at school: 'the basic principles
of good health were taught there' such as 'diet and exercise'. Blair, Lewis and Fran
encountered 'a little bit of health' during their secondary education through learning
biology, human development and 'social studies'. Fran stated 'I've got a reasonable sort
of basic knowledge' about health and the human body as 'I did biology up to Form 6
[Year 12] at school'. In contrast, Owen and Michael related that the subject of biology
and learning about the body were absent from their school curricula, they didn't enjoy it
or weren't interested in the subject, and asserted they learnt much more about bodies
and health 'from behind the shelter sheds'.

Secondly, other participants acquired additional knowledge on health from their
tertiary education when they studied biomedicine or were exposed to other influences
outside their disciplines. When healers undertake tertiary studies, the acquisition of
generalist and specialist health knowledge expands their pre-existing health knowledge
base. In the sample, some participants were either health professionals themselves
(N=16) or their partners were health professionals, ie. midwives, registered nurses,
enrolled nurses, social workers, doctors, pharmacists, a medical scientist and a carer for
intellectually disabled children. It is likely, then, that their personal education and
training, and clinical practice (experiential knowledge) are sources of health knowledge,
which they utilise in their everyday life within their families and friendships, and make referrals to others. Andrea indicated that her health knowledge came from 'biology in school and nursing.' Hugo recalled having had 'basic health stuff at school, and I have a vague memories of that.' Most of that was 'teaching by rules and not by explanation'. 'You know, "brush your teeth".' Hugo reflected his medical training 'hasn't given me a very good view of health', despite exposure to public health, perceived by his colleagues as 'a new trendy, hippy thing' in the early 1980s.

...What it's done is given me a basis to work on. Most of my knowledge about health has been in recent years, has been to do with lifestyle and stuff which was not at all heavily promoted in the 1970s.

From the late 1980s to early 1990s Hugo became more heavily oriented towards lifestyle issues affecting health status, and was in 'contact with people outside medicine (such as the 'peace movement' from 1988).

Thirdly, some participants indicated that doing a first aid course, either themselves or their partners, had also increased their knowledge and given them confidence to handle life-threatening situations should the need arise. Participants who were health professionals, especially nurses and doctors, learnt first aid as part of their tertiary education and training. The likelihood of managing emergency situations in their clinical practice, especially in a hospital setting, is quite high. And yet, their familiarity and expertise may also be called upon by others outside their workplace. Scott - a social worker - had learnt about first aid whilst obtaining his 'surf bronze medallion' during adolescence and from doing a 'St. John Ambulance course'. As a result, 'I have a bit of knowledge, or some knowledge about first aid.' Three participants (who are not health professionals) indicated that either themselves or their partners had undertaken a first aid course with the St. John Ambulance service, which gave them confidence. Peter said, 'I've also done a course in first aid - Level 2.' Sarah revealed she had completed a first aid course held at the local kindergarten.

I did that because I felt that if I had the knowledge, if nothing else, for CPR and things like, knowing what to do for the children in case they choke or insect bites. I would much prefer to do something like that and have the knowledge there rather than sit there panicking.

Whilst Lewis indicated, 'I'm not one for reading first-aid brochures ... but yes, a lot of it is discussion with Cindy [my wife], who has done a St. John's Ambulance course.' He considered his health knowledge came from 'thirty-five years of general pick-up'.
Healers

Nurses

The ethos of nurses is to care (Wicks 1995). Owing to their biomedical education, training and practice, nurses in a myriad of settings are a source of generalist and specialist knowledge on the human body, health and ill-health (Kneipfer 1989). The Code of Professional Conduct set by the Australian Nursing Council (1995) includes: 'promote and support the health, well-being and informed decision-making of patients/clients in the provision of nursing care'. And, 'treat as confidential personal information obtained in a professional capacity'. In Australia, the increasing professionalisation of nursing from the early 1980s has led to: i) nurses attending three year pre-registration courses at universities; ii) hospital-trained nurses completing a Bachelor of Nursing in order to retain their registration; iii) the prerequisite of specialist courses (such as intensive care, renal medicine, accident and emergency, midwifery, psychiatry) for advancing promotion; and. iv) university post-graduate courses in nursing at Masters and Doctorate levels (McCoppin and Gardner 1995).

In 1995, 233,100 Australians (100,200 men and 132,900 women) consulted nurses in the two weeks prior to interview. Children aged 0-14 years were the most likely age group to be seen by nurses (ABS 1997:40). Participants in the study narrated their experiences of contact with nurses and their availability for acquiring health knowledge. 'I have a huge respect for nurses. I would go to them', said Francesca. Hospital nurses provide clinical care at the bedside. They participate in patients' investigative tests and procedures, and contribute to clinical decision-making about therapy. Frequently, they provide patients with further insights of their diagnosis and prognosis, drug regimes and the implications of their bodily alterations in daily life. They also mediate between the patient, her/his family and friends, doctors and other biomedical personnel. District nurses through the Royal District Nursing Service (RDNS) provide daily home visits to patients and assist with wound care, showering and bathing, and other followup care after a bedstay in hospital within the context of the person's home and everyday life. The state health department has funded this service for many years, prior to the establishment of the Hospital-in-the-Home program (Victoria) in late 1994 (KPMG 1995, 1996). Both Andrea and Imogen are registered nurses. They indicated that their 'nursing friends' are also their colleagues, and are a significant source of health knowledge for them. Participants related that they learnt much about health when they took their babies and toddlers to infant welfare sisters and mothercraft nurses\(^{386}\) for checkups.

Elsa, Wendy, Bianca, Amalia, Caroline, Yolanda, Dawn, Beth, Carrie and Alice in two urban areas, and Rose, Jo, Marcella, Ingrid, Kay, Patricia, Nadia, Elizabeth, Gail,

\(^{386}\) These nurses are officially called 'maternal and child nurses'.
Donna, Isabel, Fiona and Hannah in two rural areas, commented upon the 'disappearing' role of the infant welfare sister in their communities (Crooks 1998). With a small child (infant or pre-school age), it is reassuring for mothers (and fathers) to visit the local infant welfare sister for practical advice.

*Alice...* the [infant] health centres. They helped me so much.
*Elizabeth* You could go in for a chat, have a cup of coffee.
*Gail* If you had a real 'downer-of-a-day' you could go in.

The women expressed mixed feelings about infant welfare sisters; perceiving them as both good and bad. And as helpful versus a 'bad experience' when they depended upon the infant welfare sister's expertise on babycare and parenting, especially with their first children. Jo stated: 'when the children were little, the infant welfare sister at the centre was helpful. I don't think that service now is as good as it was.' The extent to which infant welfare sisters and mothercraft nurses were a source of health knowledge depended upon the quality of parents' relationship with her: 'provided you have a good rapport with the sister' and she was accessible noted Alice.

Amalia, Dawn, Elsa and Wendy also perceived marked changes in the infant welfare sisters' role in 'five years ... due to limited funds'. 'They are not making themselves available as much as they were' and 'now they don't encourage you to go ... except when they like to see you at the main month' to check child development 'or else by appointment'. 'They don't encourage you to come between those appointments or those specific growth times [of the child]. So they monitor a baby by appointment'. Meanwhile, the state health department is developing protocols to identify gaps in child development between the ages of 2-5 years (pre-kindergarten).

*Doctors*

In 1995, more GPs than specialists were consulted by Australians: by women more so than men, and by children aged 0-14 years more so than persons of other age groups (ABS 1997:38). Medical practitioners were a significant source of health knowledge cited by participants. Opportunities for an exchange of health knowledge with GPs and specialists occurred in hospitals, community health centres, medical surgeries and bulk-billing clinics. 'A general practitioner is a doctor who provides primary, continuing, comprehensive whole-person care to individuals, families and the community' (Royal Australian College of General Practitioners). GPs act as 'gatekeepers' to the Australian health care system: delivering primary health care; diagnosing and treating minor injuries and illnesses; influencing use of hospital

---

services; prescribing medication; making referrals to specialists, and increasingly, to alternative therapists. Their role has expanded to include: education, participation in professional associations including RACGP and Divisions of General Practice, public health programs, research and health service planning (National Health Strategy 1992a, Commonwealth Department of Health and Family Services 1997).

Ingrid affirmed 'taking your children down to the doctor for a checkup, and you ask a list of questions.' The doctor fulfils a role of not only curing and healing, but also being a source of information for laypeople (Tuckett et al 1985, Waitzkin 1985). 'Each time you've got something wrong with you, you go to the doctor. He explains a little bit ... fills you in. Because as you get older you start to question. "Why is this sorr or why didn't this work?"' said Owen. He reflected that with advancing age, he no longer accepted a doctor's diagnosis or prescribed remedy at face value. Now in his late 40s, Owen is more likely to question a doctor with greater confidence.

When you go there as a youth, you know, he just says, 'take these pills.' And you just grab the pills and run away. Whereas now, you tend to question why he's giving you these pills and why the body has failed in some way.

Owen thus acts like a sovereign consumer seeking more explanation and information about a particular health issue in order to facilitate informed decision-making (Wood 1996).

Jennifer was at a loss to understand why her body 'failed' to menstruate regularly and sustain a pregnancy as she suffered repeated miscarriages despite fertility drugs. Her consultations with GPs and gynaecologists, including biomedical health professionals associated with the IVF program in Melbourne, did not fully explain her ailment. Kelly related that her seven year old son visited the local paediatrician and neurologist for monitoring and treatment of his epilepsy, and at these times she sought clarification of his diagnosis, medication and prognosis.

Allied Health Professionals

In 1995, Australians consulted a significant number of allied health professionals (N=1,167,980) in the two weeks prior to interview. They used services provided by a audiologist/audiometrist (19,400), chemist (424,500), chiropodist/podiatrist (111,100), dietitian/nutritionist (54,700), optician/optometrist (152,800), occupational therapist (21,400), physiotherapist/hydrotherapist (276,600), psychologist (60,900), social worker/welfare officer (71,800) and speech therapist/pathologist (39,400) (ABS 1997:40).

Of allied health professionals mentioned by participants as sources of health knowledge, pharmacists (popularly known as chemists) were the most significant. Elsa,
a pharmacist, stated: 'A lot of people come to community pharmacies.' They are located in most suburbs of the Geelong Region: shopping strips and malls, or nearby a hospital or bulk-billing clinic. Some are also open extended hours. Pharmacists dispense over-the-counter drugs as well as prescribed medication. They also sell medical supplies (Band-aids, bandages, ointments, antiseptic solutions), aids and appliances, cosmetics, herbal remedies, hair care, sun care and baby care products. Pharmacists provide advice to laypeople about the dose, preparation, storage and side-effects of their medication. They're very good for explaining drugs and stuff like that, more so than your doctor' said Mandy. Elsa noted that 'some people go to doctors as a last resort. They prefer to go to the pharmacist when all else fails ... unless of course the condition is serious.' Ian believed that 'a lot of people tend not to use the pharmacist [whom] they only see as a dispenser. But quite often their knowledge is overlooked'. Francis agreed that 'the chemist is another one that you tend to use a lot.'

Your kids might develop a rash of some sort and you're not quite sure what it is. You go into the chemist and he has a look at it. And immediately he'll say that, 'it's something that you should see your GP about or it is not serious. It's probably such-and-such. Just put some calamine lotion or whatever to relieve the sting, the itch, etc.'

Participants also reported that some Australian pharmacists have user-friendly computer assisted information, 'leaflets' and 'self-care cards' 'about every conceivable thing': acne, diarrhoea, fever, hives, head lice, scabies, constipation.

Participants also found dietitians, physiotherapists and dentists helpful and trustworthy sources of information about health and illness. Dietitians provide information on the nutritional content of foods and the appropriate selection of foods for particular conditions: gastro-intestinal disorders, renal disease, diabetes, cardiovascular disease. They also devise daily diets for weight gain or loss where this is medically recommended. Ian would see his local physiotherapist for manipulation and massage of his back, particularly when he was suffering benign spinal tumours. Blair and Sandra took their children for regular checkups at the dentist. Blair found his dentist a useful source of experiential knowledge when his daughter Janice 'fell over in the house and bent one of her teeth and it was just hanging.'

---

558 See Dunnell and Cartwright (1972), Cunningham-Burley and MacLean (1987).
And I pushed it back in and we went to the dentist and they x-rayed and she was on antibiotics and all that to make sure the gum would heal. And it's since turned out fine.

That episode gave him more confidence as primary caregiver of his three children to manage other minor illnesses and injuries at home.

Alternative Therapists

Recent studies indicate that Australians are selective in their health knowledge on alternative medicines, assisted in many cases by alternative therapists and GPs with a clinical interest in nutritional medicine (Easthope 1998). MacLennan et al.'s (1996) Australian study reveals '20.3% of respondents had visited at least one alternative practitioner in the past year and there was no significant difference between males and females'. However, women 'were significantly more likely to consult naturopaths, iridologists and reflexologists than males' (1996:571, cf. ABS 1997).

Out of 98 participants, 31 indicated that their households had consulted an alternative therapist during the previous 12 months. Of these, 22 women responded 'the whole family', themselves, their husbands or their children had consulted alternative therapists, whilst nine men in the sample reported they had sought treatment for themselves, their wives or children. Naturopaths, chiropractors, masseurs, a Reiki healer, reflexologist and aromatherapist were consulted for a range of conditions: back pain, chronic constipation, skin problems, glandular fever, stress, relaxation, general checkup, 'bedwetting, chest problems', allergies, influenza and injuries. Jack, a medical practitioner, provides acupuncture, hypnotherapy and nutritional medicine to his patients. Wendy related her GP practised clinical ecology and hypnotherapy, and similar to Jack, she also referred patients to various alternative therapists in the Geelong Region.

Laypeople's consultations with an alternative therapist involve an exchange of information about the presenting condition, signs and symptoms, a diagnosis and therapeutic interventions (Sharma 1992); similar to biomedical health professionals, folk and lay healers. Following a session with her masseur, Wendy would 'find myself massaging my arm while I'm walking down the street. Or at home, you'll sit down and massage your feet perhaps at night whilst watching TV.' She had also undertaken a 'one day workshop' on reflexology with a qualified reflexologist, and completed a course on Reiki with a friend. Reiki as a form of healing and laying on hands addresses emotional problems (Barnett and Chambers 1996). After attending a 'public talk' by an aromatherapist who practised in hospitals in a rural area outside the Region, Wendy learnt 'how different people react differently to different [essential] oils' such as lavender, chamomile, rose, sandalwood and jasmine. Blair indicated that monthly visits to his chiropractor for the whole family were 'essential' for their health and well-being.
Institutions and Organisations

Participants reported further sources of lay health knowledge are institutions such as: community health services, hospitals, hospices and community libraries (cf. ABS 1997). These formal institutions are federally and state funded to provide services within local communities and regions. They are centralised sources of information and instrumental support for laypeople.

Bianca indicated that the 'community health service' is an important source of health knowledge for her. Community health services are situated in electorate areas of Geelong, and in rural and coastal areas of the Region. They are staffed by medical practitioners, community health nurses, physiotherapist, social workers, podiatrist; providing services from pathology collection, aids and appliances to referrals to other health professionals and health care services in Geelong and Melbourne. Some community health services also offer special programs such as stress relief, massage and women's health. The waiting rooms frequently contain a plethora of pamphlets and other literature, and medical videos about various public health issues, for instance, breast cancer screening, child injury prevention, immunisation. A hospice consists of multi-disciplinary personnel providing palliative care for terminally ill patients. Both biomedical and alternative therapies are employed to relieve pain and suffering, and enable the dying person to die with dignity (McNamara et al 1994, McNamara 1998).

Libraries - located for general use in communities and for staff use in hospitals - are replete with health knowledge, and staffed by librarians. Both Bianca and Amalia would 'go to the community library. It's got such a high profile' when they are searching for more information on ailment suffered by a family member. Publicly funded community libraries are continually expanding their resources - books, magazines, newspapers, CDs, cassette tapes, reference books. In the late 1990s, some community libraries also provide public access to the Internet. A hospital library contains medical scientific books and journals in various sub-disciplines. Most hospital libraries are connected to the Internet, and have facilities for hospital staff to undertake CD-Rom and online bibliographic searches. The library is usually accessible to medical and other health professionals and scientists employed at the hospital. Laypeople's access to this store of information in most instances would require negotiation with library staff and/or permission from their consulting physician.

Workplace

The national body, Worksafe Australia, requires employers to 'remove hazards' (structural changes) from the workplace that would expose employees to industrial injuries and disease (Germov 1998a). Current workplace practices include inservice

---

597 Citizens' advice bureaus were not mentioned by participants, but are an information service and community resource, staffed by volunteers in regional centres.
meetings and workshops, seminars and professional development courses; often incorporating aspects of occupational health and safety as well as 'screening for unhealthy lifestyle factors'. The rationale is to expand employees' skills and identify their at-risk behaviours (alcohol, smoking, lack of exercise, being overweight), as well as to 'avoid hazards' (individual behaviour) in the workplace.

Fran, Dean and Gemma indicated they 'get things through work' about health. Fran, a teacher would regularly receive a newsletter and questionnaire from the teachers' union when she was living interstate.

And every year they would still send me a progress assessment: 'What sort of foods do you eat?' 'What weight are you?' ... 'How much do you exercise?' And then I send that questionnaire back and then they give me a report back, and I've been doing that for three or four years. And occasionally they'll send me free books, about health and fitness.

Both Gemma and Dean obtained health knowledge on occupational health and safety through their respective workplaces: at a school for intellectually disabled children and at a bauxite-aluminium processing plant. The differential nature of their work required employer and employee awareness of safety, both for themselves and others as strategies to prevent injuries and productivity losses. Recent Australian television ads on occupational health and safety depict graphic events of work accidents, fatalities, injuries, loss of limbs and rehabilitation. They also emphasise that safety is everybody's responsibility: think it, talk it, work it.

Health Food Shops

Health food shops in Australia have gained popularity since the 1960s. They are perceived as related to alternative lifestyles, and served as the initial locales for self-help groups, nutrition books, food co-operatives and food fads (macrobiotic, yoghurt, bread-making). The moral emphasis is upon foods that are 'healthy', 'natural', 'whole', 'raw', 'fresh' and 'green', and cosmetic and hair care products which do not involve animal testing. Dubisch (1994) likens the health food movement to a religious sect with its symbolic representation of foods as mana (pure) versus taboo (dangerous) (Douglas 1966).

Out of 98 participants, only Gillian indicated that 'in health food shops you find brochures and all sorts of things.' Books, magazines and pamphlets on health at health food shops are a source of literature for laypeople.\textsuperscript{301} The commercial intention of

\textsuperscript{301} See Holmes and Gifford (1997), Richmond et al (1997).

\textsuperscript{301} For example, Blackmores, a company which sells various vitamin and mineral supplements, alternative remedies, face, body and hair products, regularly publishes material exclaiming the virtues of their products and how they will improve health status.
providing 'health information' in this way is to sell products, frequently marketed as containing some 'natural' ingredients (listed on the packaging) and subject to non-animal testing, a reference to animal rights groups' sensitivities. Some health food shops also have leaflets and business cards of alternative therapists working in the local area. Many health food shop owners make referrals to them or have a naturopath visiting on-site.

**Self-help Groups**

Self-help groups were a minor source of health knowledge for participants (cf. ABS 1997). The politics of lay healing or the 'self-care movement' has various agendas which underlie the concept of self-help: i) tradition or habit; ii) economic rationalism (the affordability of health care); and iii) ideological notions of body ownership and responsibility. Each one of these may become a reason for taking a political stance on health care, and a basis for lobbying and advocacy, by presenting and representing laypeople's 'voice' on the implications of health policy and programs to government and non-government organisations.\(^{562}\) The formation of self-help groups, such as COSHG and the Consumers' Health Forum in Australia, which lobby and advocate on behalf of their members, pose a challenge to medical dominance and other 'regimes of truth' (Smart 1985). Self-help groups also represent an increasing professionalisation of lay health knowledge (Baum 1990, Syme 1997).\(^{563}\)

Andrea, Jackie, Sian, Alice, Carrie and Mandy had personal experience of seeking further 'practical useful information' and instrumental support from self-help groups or 'local support groups' as Andrea called them. The women consulted and participated in regional self-help groups specialising in cancer, epilepsy, chronic illnesses, parenting and breastfeeding. Andrea surmised that medical consultations are becoming expensive and few people can afford medical care - despite Medicare rebates - particularly when they are faced with life crises or long-term low income, and 'if you need counselling of any sort to get you through the stresses of life'. She gave the example of someone in the family having arthritis and Alzheimer's disease, she 'would go to the people who have got it, self-help sort of people who would give you factual day-to-day coping advice' and were prepared to make referrals to alternative therapists in the Geelong Region as additional sources of health knowledge and support for the condition (cf. Kelleher 1994).

In Australia, self-help groups such as Nursing Mothers' Association (NMA) and playgroups provide parents of babies and young children with pragmatic advice and support on babysitting, breastfeeding and parenting. Local branches have regular meetings, which are also social occasions, and parents can obtain clothing, footwear

---

563 See the Consumers' Health Forum's journal: *Health Forum.*
and other items for their child. Some branches are considered more dogmatic than others in their approach: 'breastfeeding is best', rather than bottle feeding with milk formula (Carter 1995). Some women in the study did not find them helpful. 'Nursing Mothers' [Association] gave me a hard time, when I found out that I couldn't breastfeed' and their attitude towards bottle-feeding was 'that's bad', said Alice. Playgroups offer mothers (and fathers) of pre-school age children an opportunity to socialise, meet other parents in the same area, develop friendships outside of the group and provide mutual support with parenting. The sessions are of 30 minutes to two hours duration. The playgroups are also an inexpensive substitute for kindergartens and provide a service 'where parents and children live isolated together in the home, or because they live in rural districts' (Community Development Committee 1995:129-30).

Mass media

Participants reported that television, radio, films, books, magazines, newspapers, and other literature remain the most accessible and least costly forms of mass media for laypeople. They also constitute a significant source of health knowledge, provide dis-information and are part of 'consumer culture' (Featherstone 1991).

*Simone, Rachel and Teresa* Media ... Television and radio ... Even the newspaper. They have
a big section on health in the newspaper.

*Renata, Margot, Nancy and Barbara* Lots from TV ... Radio ... Magazines ... Multimedia.

The media of television, radio and film present images of health and well-being, and of illness and injury in auditory and visual forms. Individuals and communities of diverse gender, age, social class and ethnic backgrounds reveal the universality and the particularity of health and ill-health. 'Dozens of lifestyle programs': *Healthy, Wealthy and Wise, Good Medicine,* and medical melodramas: *ER, Medivac, A Country Practice, GP, Chicago Hope, Peak Practice* both popularise and democratise health knowledge, as well as support medical dominance (Turow 1989, Karpf 1988). A third format is the exposé of medical and health issues through the television documentary. It 'sets out to provide a challenge to powerful interests in an attempt to reveal alleged corruption or malpractice' (Bury and Gabe 1994:71) of a few individuals (patients and doctors) 'without questioning the general structures that make medical dominance possible' (1994:74).

Blair, Jennifer, Simone, Natalie, Helen, Ingrid, Kay, Rose and Felicity referred to television and radio as sources of health knowledge. Felicity spoke of children's programs on television:
I think that TV is an important influence on kids. They see on *Sesame Street* and *Playhouse*, they have those songs like *Brushing Your Teeth* and things like that. I know that my kids play more attention to those than I say, 'go and brush your teeth.'

Whilst Hazel, Jane, Mandy, Imogen, Nicole, Karen and Leah commented: '3LO ... The radio ... That's really very good as a source of information ... Oh different topics. I listen to it everyday.' In contemporary society, the media has a role in 'sharing knowledge'. Presenters invite 'experts' on radio talkback to convey their 'expertise' in a specialised area in plain English, and 'listen' to the voices of laypeople detailing their experiences. The women indicated listening to the following programs on ABC National Radio: *Life Matters* and *The Health Report*.

For Amalia, Fran, Belinda, Francesca, Libby, Ian, Owen, Ian, Tammy, Marcella, Dean, Scott and Natalie, books were a significant source of health knowledge. Together with their partners and children, they would frequently refer to their home library of books accumulated over the years. Belinda looked 'up a health book I have at home' whenever her children were sick or injured. Their libraries contained literature on parenting, baby care, first aid manuals, alternative therapies, home remedies, health and medical books and dictionary. Owen stated: 'We have a medical journal ... You know an encyclopedia on everything that opens and closes on your body.' Today, many best-selling books on health and medicine are written by biomedical health professionals, alternative therapists and folk healers specifically for laypeople explaining terms, and providing information and advice in plain English. They inspire confidence, encourage the lay individual to be pro-active, feel empowered, be agentic selves, foster self-help and facilitate self-care. The authors democratise knowledge in the spirit of making it accessible, understandable and useful to the lay person, that they may implement such information immediately.\(^{304}\)

Bunton's (1997) analysis of the British women's magazines reveals the extent of health products and services within a 'consumer culture' (Featherstone 1991). He argues that:

> Magazine knowledge is popular health knowledge that lies beyond the professional epicentre of medical authority, yet it reports and comments upon medical findings, extrapolates and interprets these findings for the general reader and makes judgements about the quality of that knowledge (1997:232).

Gillian, Dean, Caroline, Lewis and Valerie reported magazines and newspapers were additional sources of health knowledge, and on parenting and childcare (cf. Luke 1996).

Gillian and Lewis ... there's a lot of literature and even in women's magazines. There's always articles on health and children and everything ... But a lot of it just through general reading of newspapers.

Dean, Caroline and Valerie ... Lots of publications ... Go to the newsagent and buy Well-being ... New Idea ... Women's Weekly [magazines].

In Australia, popular magazines present a plurality of knowledge on health and illness (and other topics) that do not necessarily emanate from a biomedical paradigm. Their commercial interests include advertising and creating a 'market' for 'healthy' products. Health is more readily discussed in women's magazines than in men's magazines. Women's magazines are replete with laypeople's and 'famous people's' lived experiences of health and ill-health, as well as 'advice' to improve physical, mental and spiritual health status. In men's magazines, material related to men's health is discreetly found in the final pages, largely focuses on the physical body in relation to work, sex and sport, and provides little information on health promotion and illness-injury prevention strategies. Mental health and spirituality are overlooked, despite becoming issues for the men's movement. Magazines such as Nature and Health, Simply Living and Well-being are oriented towards alternative therapies and New Age interests; providing information on leading a healthy lifestyle and caring for one's environment. Recycling, aromatherapy, garden composting, vegetarian meals, vitamins and minerals, spirituality are popular issues in press. Weekly magazines such as: Time, The Bulletin and Newsweek often include articles on health upon the discovery of new developments in medicine and science, and on diseases affecting population health: AIDS, cancer, tuberculosis, plague (cf. Chapman and Lupton 1994).

Public Health Messages

Lupton (1995:106) asserts:

Media campaigns are directed at creating docile citizens, who accept the truths of public health authorities without question ... The primary goal is that of manipulation, often based on emotional appeals.

Rewards and punishments for behaviour are made explicit. For instance, use of condoms during 'safe sex' prevents contact with the diseases of 'sin' and 'immorality': AIDS and other STDs. Bike riding without a helmet may result in head injuries and disability. This is akin to a victim-blaming approach when few political, economic and

365 A full discussion is beyond the scope of this thesis.
social structural measures are implemented at the same time (Crawford 1977, Tesh 1989). How much attention do laypeople pay to public health messages? How relevant are these messages for laypeople's everyday lives (cf. Frankel et al 1991)?

Participants indicated their awareness of public health campaigns such as Drink but Don't Drive, Sunsmart, Walk for Life and regarded them with ambivalence. On the one hand, public health campaigns had increased their health knowledge insofar as they and their children, 'know' much more than their own parents. On the other hand, they considered public health campaigns as basic commonsense, which some of them were already implementing prior to such publicity. This raises the question of how public health campaigns are targeted at particular population groups, their presentation, content and uptake.366 Blaxter (1997) and Syme (1997) confirm the failure of public health strategies that take an 'educational intervention' approach. They tend to miss their target populations and have not significantly altered individual motivation to change risk behaviour. Syme highlights the trajectory of 'experts' and public health programs which adopt a top-down approach to public health without involving neighbourhoods and local communities in their design and content; thus excluding lay knowledge.

On a positive note, Christopher, Francesca, Edith and Helen commented that public 'awareness is much bigger now than it used to be' of breast cancer, prostate cancer, Hepatitis and AIDS. They perceived 'government initiated programs to try and get people aware of problems in the community' as 'quite good' because 'it makes you stop and think. Something comes along and you're informed.' Jennifer considered public health campaigns as persuasive for altering her eating patterns and making the connection between 'wrong foods', 'healthy foods' and cardiovascular disease. Kay, Ingrid, Jo, Nadia, Rose and Marcella collectively reflected that public health campaigns had not only meant that 'you're more aware these days' and 'you talk more freely about it', they considered generational differences in degree of awareness. As Rose stated: 'When we were kids we weren't taught anything like that [health promotion]'. Whilst their 'kids are growing up being more aware' today. The women noted pervasive success of some campaigns in promoting a healthy diet or a healthy lifestyle': 'everybody wears a hat these days. Everybody wears sunscreen ... the dairy foods one [advertisement] ... you need calcium ... Life Be In It.' Furthermore, they emphasised the impact of the public health campaigns upon their own children. Kay said, 'I think that those [television] programs help the parents because it's easier to tell your child who may disregard her/his parents' advice. She continued,

But if they've heard it on the television or at school, they then think, 'it's coming from this higher body and not just my mother. I'll do it, because it must be healthy because someone else said it was as well.'

The women in the group agreed with Kay's statement, having also experienced the same attitude with their own children. Not only are children being agentic selves, drawing upon sources of health knowledge other than their parents and being selective about the information, they are also active decision-makers about their own health status. Rose gave the example of 'my kids see someone with a can [of alcoholic drink] and say 'what a bloody idiot'." Nadia joked that her son asked:

if he was a 'bloody idiot' if he ate and drove, because he was eating an apple in the back of the car. [laughter] 'Are you allowed to eat and drive, or are you a bloody idiot?' [laughter]

[Gorgeous! So he has thought about the question?] Oh yes. He didn't realise at that stage ...

he was only five at the time ... he didn't realise that if they said, 'don't drink and drive' it wasn't just cordial.

The campaigns viewed on television by children become a talking point for parents to teach them about health promotion. 'They are asking questions, "what's that, what's that".' This made it easier for them to implement health promotion measures in the household (cf. Backett 1991).\textsuperscript{562}

In terms of the content of public health campaigns, Pam was critical of their 'over-emphasis' on the physical body with limited attention to mental health and no focus on spirituality. These have not yet become part of public health's agenda, neither at WHO nor at a national level. Even at the Jakarta Declaration conference, Indonesia (July 1997) there was greater recognition of demographic trends, social and behavioural factors, new and emerging diseases, transnational factors and mental illness as a 'problem' (Nutbeam 1997, WHO 1997). However, spirituality and its relationship to health promotion was not conceptualised let alone debated.

Dean, Eric, Francis, and Geoff questioned the effectiveness of public health campaigns. At the same time, they acknowledged the pervasiveness of the messages. Dean and Geoff agreed that 'you're getting it pretty constantly through your daily life ... you cannot help pay attention ... you're slowly getting educated whether you want to or not'.\textsuperscript{569} Eric asserted that occupational health and safety, for instance, was something that he believed he had always practised, having grown up on a farm. And it 'was

\textsuperscript{\textsuperscript{562} This is a reference to the television advertisement: \textit{if you drink then drive, you're a bloody idiot} produced to curb road fatalities and injuries in Australia.}
\textsuperscript{\textsuperscript{569} See Chapter 6 for further discussion.}
\textsuperscript{\textsuperscript{569} See also Blaxter (1997).}
keeping us healthy'. It did not become apparent to him that what he was doing coincided with the label: 'occupational health and safety'.

Now, I think to myself, 'well, why do we need all this sort of stuff, if you just do what you're supposed to do in the first place. There would be no need for it. For public health campaigns'.

Geoff's attitude was: 'it's like equal employment opportunity.' The four men considered it vital for laypeople to use their lay knowledge: commonsense. They argued that public health policies and campaigns are for people without commonsense. The implication here is that not everyone has or uses their commonsense, therefore some laypeople need public health 'experts' to develop campaigns based on commonsense to make good health practices more explicit. Geoff claimed: 'You probably sense that you don't need it. There's a lot of people out there and believe me, they need it.' He went on to give the ergonomic example of '120 people on computers all day' at his workplace and only '10% of the people know how to sit properly'.

In the above sections I established the pervasiveness of lay health knowledge, explored the content of this knowledge and identified the plural sources. This data confirms that parents of young children - as laypeople - have a significant store of lay knowledge on health which they acquire from a variety of sources. In the following section I discuss laypeople's information seeking, the flows of lay health knowledge and the implications for lay informed decision-making, by providing examples from participants' narratives. I asked participants: Where do you go to when you need information to look after someone who has become ill or injured?

**FLows of Health knowledge**

**Information Seeking**

When confronted with a hypothetical illness or injury - an unpredictable event - the responses of laypeople in this study were qualified by two factors: health status, and which household member (a child or an adult). Age of the person is a significant factor in deciding upon appropriate actions. Both criteria form the basis for laypeople seeking additional information, making decisions (lay diagnosis and treatment) and responding to the condition with action (Lauritzen 1997).

Firstly, Valerie, Kay, Tracey, Kirk, Sandra, Rose and Owen indicated that it 'depends on their illness or injury' to what extra information they would seek. Their lay assessment of the severity of the presenting condition - whether it was minor or major (ie. life-threatening, emergency) - has implications for whether they decide to manage the condition at home with confidence, or whether they seek outside help from other people (healers of distinct backgrounds) or institutions (Kleinman 1980, Frohock 1992).
Rose and Kay related their actions when faced with minor conditions 'or something that you're not quite sure is serious that you need to go to a doctor.'

So you look up an encyclopaedia. If not then you go to your chemist. Because obviously there is not a consultation fee there. You then get recommendations to go to your doctor.

Tracey, Valerie and Sandra would ask a doctor first 'to know more about the illness, the disease' before going on a 'book hunt'. They would then 'weigh it all up. What sounds right, what I can do. What I can't do' as a means to making informed decisions and implementing a plan of action. In contrast, Owen relied on his embodied knowledge - 'my knowledge of the body' - and the sick person telling him that their condition is serious to assess a condition as 'crikey, this needs attention, straight away'. He would also seek further information about the circumstances of illness or injury: 'I'd want to know why it happened. How it happened. When it happened.'

In addition to their health status, the second criterion for gathering further health knowledge is which family member is sick and their age: 'depends on who you are talking about'. Are they a child or an adult? Francesca indicated that 'if it's babies, I go to my [infant] health nurse.' Otherwise she would also consult a doctor. Kay and Jo determined that if their husbands were sick they would see a GP or specialist. If their children were ill or injured they would consult a GP but not a specialist, and they would also 'talk to other Mums whether their child had something similar'.

**Multiple Flows of Knowledge**

Participants' responses reveal the significant extent of laypeople’s information seeking process at times of illness and injury, but also to protect health within the household. Not only are their sources of information frequently multiple, as discussed above, but the flow of health knowledge is also diverse. It is multiple not singular. Health knowledge flows in many directions, and the flow of health knowledge continues in the context of laypeople’s everyday lives. There is no end point. The person seeking further information is an ‘agentic self’ situated at the centre of the multiple flows of knowledge. See Figure 5.1.\(^{370}\)

\(^{370}\) I realise Figure 5.1 is schematic and inadequate to fully describe the complexity of flows of knowledge, with the self located at the centre.
New information facilitates informed decision-making (Øvretveit 1996, Wood 1997), and may in some circumstances propel laypeople to seek further information from other sources, thus expanding their health knowledge base and transcending 'medical regimes of truth' (Peerson 1995a, S. Short 1996). This is indicative of their selectiveness of information and willingness to rely on 'trusted sources', evident in Scott's and Fran's narratives.

Scott Books I suppose, and friends who are in the medical profession. Other health professionals. I talk to neighbours and friends about childhood complaints, and that sort of thing.

Fran But if I wanted to know anything [else], I suppose I'd probably first go to books and then maybe, secondly to a doctor. Or maybe even ask someone who has had experience. If there's a particular illness, maybe even speak to friends or someone who has had a similar sort of problem.

Medical dominance theory argues the doctor-patient relationship rests upon unequal power relations, medical autonomy in decision-making vis-a-vis patient passivity and dependency, and an asymmetry of information. Ende et al.'s (1989) study of the doctor-patient relationship indicates many patients prefer their doctor to be the primary decision-maker of their health care but they also wished to be fully informed. However, doctors as health professional 'experts', as emphasised in the medical sociology literature, are not the principal source of laypeople's health knowledge. Laypeople also consult healers other than doctors, such as lay healers, naturopaths, nurses, pharmacists and folk healers. In all consultations, information, preferences,

---


ideas and explanations for cause and effect of health and ill-health are exchanged and recycled (Charles et al 1997). As Giddens (1990:145) remarks:

Modern social life is a complex affair, and there are many 'filter-back' processes whereby technical knowledge, in one shape or another, is reappropriated by lay persons and routinely applied in the course of their day-to-day activities.

Irene related:

If I was looking after somebody who had a lengthy illness, I would want to find out as much as I could from all different aspects. From those who had dealings with it ... individuals through doctors through naturopaths or whoever. And just sort of get an overall [picture] ... and probably even work out how I feel the best suits that particular person. Because I feel that not everything, not one particular thing suits one particular person.

Furthermore, Charles et al (1997) assert, the dyad relationship of patient and doctor may extend to a coalition of three or more parties with a vested interest in the patient's well-being. The third party may be their significant others, relatives, friends, members of their social networks or other healers who also play role in the healing process (Zola 1972, Kleinman 1980, Psicosolido 1992, Atkinson 1995).

Informed Decision-making: a process

Making an informed decision when confronted with illness or injury is crucial to restoring health status to an optimum and preventing an exacerbation, deterioration or additional complications. Participants' responses provide insights on lay health decision-making and non-decision-making. Firstly, the lay individual ideally remains at the centre of health information seeking and of decision-making, rather than a biomedical health professional acting as their 'agent' and making decisions for them (McGuire et al 1992). S/he is the principal social actor or agentic self (Foucault 1981).

Secondly, as noted in Chapter 2 and above in this chapter, to be fully informed is not always possible or to exchange information between patient and healer (Bernstein 1996, Charles et al 1997). This is most likely to occur when the patient is unconscious, traumatised, irrational, in shock, or their health status is life-threatening or requires emergency surgery. The patient is not always rational, alert or conscious and requires another person to act as their 'agent', 'advocate', 'guardian' or 'sentinel' on their behalf.373 At best, laypeople and healers of all modalities can only make decisions about a situation with available information - even if it is incomplete. Participants confirmed they have parental responsibility for health decision-making on behalf of their children,
whilst acknowledging that their own children - and children in general - are also agentic selves and health decision-makers (Mayall 1993b).

Thirdly, laypeople's information seeking is extensive, including lay and healer referrals (ABS 1997). Fourthly, the data reveal the initial steps laypeople take when teaching and promoting health and, preventing illness-injury in the household. They illuminate lay health decision-making in practice when parents of young children are diagnosing and treating illness and injury within the household, and their use of health care services outside the household.³⁷⁴

Laypeople's informed decision-making is a process consisting of four factors: knowledge, decision-making, action and evaluation. I suggest the process is circular: There is no end point.³⁷⁵ See Figure 5.2.

**Figure 5.2: The Process of Informed Decision-Making**

The process requires a lay person to be reflexive in the present: there is a looking back at past actions and a looking forward to the future. How could things be done differently (Beck et al 1994)? Jackie described the dilemma:

> It’s a constant sorting process for me ... I’ve got to find that middle ground. Am I making the right decisions at times or are they coloured too much by my past and my fear of failure ... I think a lot as to what is the best course of action of things to do.

Participants reflected upon various episodes of illness and injury within their households. They remarked upon the implications of limited health knowledge, weighed up the possible consequences of their (and other healers') decision-making and actions, and evaluated whether the resulting outcomes were positive or negative. Evaluation is integral to laypeople's informed decision-making. The context of each situation is considered in terms of how, when, where, why and who was involved. As laypeople, Jan, Rita, Kelly, Gillian, Heather, Irene, Belle, Eleanor, and Fran established

³⁷⁴ These three points will be discussed in greater detail in Chapters 6 and 7.
³⁷⁵ During my nursing hospital training (1979-82), I was taught the following model of clinical decision-making: assess, plan, implement and evaluate. The aim was to learn flexibility in providing nursing care with available resources in multiple public health settings and specialties: Aboriginal outstation in remote Australia, intensive care unit of a metropolitan hospital, urban community health centre, women's health service in rural town, refugee camp in South east Asia or Africa, war torn area in Central America.
the implications of absent knowledge as: risk, suffering, knowledge being 'discounted', maldagnosis, limited understanding of diagnosis and treatment, and the need to research alternatives. This in turn, became the basis for laypeople seeking further knowledge in other directions, and assisted them with decision-making in future scenarios (Pescosolido 1992).

The acquisition of health knowledge is only one part of laypeople's informed decision-making process. The concept of 'informed consent' dominates the literature on clinical decision-making and ethics from biomedical, philosophical, legal and consumer perspectives. Saks (1995) has explored the notion of responsibility and altruism of biomedical health professionals and alternative therapists towards their patients. Empirical research about health decision-making by both laypeople and folk healers is limited. More recently, consumers, researchers and policymakers are using the concept of 'informed' or 'shared' decision-making, and addressing the implications for 'informed consent', patient compliance and non-compliance with recommended treatment, and their satisfaction with 'quality of care' of health care services.

CONCLUSION

Laypeople's health knowledge provides public health professionals, researchers and policymakers with a better informed basis for healers' clinical practices, research agendas and policies and programs. This 'bottom-up' approach to lay knowledge has five consequences. Firstly, laypeople reflect upon, evaluate and filter 'trusted sources' from a variety of sources of health knowledge. They evaluate the factual content and commonsense value of knowledge, before determining its usefulness and applicability in their everyday lives.

Secondly, laypeople's sources of health knowledge are plural rather than singular. The principal source of laypeople's health knowledge is their family and community, closely followed by healers and the mass media. Lesser sources are themselves, education, institutions and organisations.

Thirdly, laypeople seek further information when someone is sick according to that person's health status (the severity of illness-injury) and their age (child or adult). The flow of laypeople's health knowledge is not one-way, that is from doctors to patients, but rather it flows in many directions. Whenever a layperson consults someone else, it is likely that they will also consult others about the cause and effects of ill-health. The lay individual is an 'agentic self' in determining both who to consult and the

information that is required. Parents on behalf of their children act as 'sentinels' and 'guardians' in their quest for health knowledge that is conducive to their well-being.

Fourthly, laypeople make informed decisions, and their decision-making is a process consisting of four factors: knowledge, decision-making, action and evaluation in a clockwise circular motion. There is no end point.

Finally, there are gender and age differences in laypeople's information seeking and decision-making about health issues. Their strategies depend on the sick person's gender, age and health status.
CHAPTER 6
HEALTH EDUCATION, HEALTH PROMOTION AND
ILLNESS-INJURY PREVENTION BY LAYPEOPLE

Public Health Discourses

During the 1970s there was much criticism of 'health education' and its singular emphasis on altering individual behaviour (Pederson et al 1994). Health professionals and educationists adopted formal and rigid pedagogic guidelines, and used a top-down approach to 'educate' laypeople about improving their health status with variable success. It was believed that providing 'expert' and 'professional' knowledge (biomedical scientific) to individuals and communities, would persuade laypeople to change their risk-taking behaviours. Little consideration was given to: i) the physical, cultural and social milieu of laypeople's lives; ii) their own plural sources of lay health knowledge; or, iii) their capacity for autonomous health decision-making.\textsuperscript{304} In this study I critique aspects of 'new' public health, in particular the over deterministic and oversocialized construction of 'consumers' (Petersen and Lupton 1996).

The global 'birth' of a 'new' social approach to health promotion stems from the Lalonde Report, \textit{A New Perspective on the Health of Canadians} (1974). The leading players, following the Lalonde example, were within the World Health Organisation and key personnel at the federal Department of Health and Welfare, Canada. Collaborative efforts led to the development of the \textit{Ottawa Charter for Health Promotion} (WHO 1986) which was 'committed to democracy and participation' (Kickbusch 1994:8) and which subsequently became part of national health policies worldwide (Pederson et al 1994). Health promotion heralded a paradigm shift (Kuhn 1979, Capra 1988) - which Kickbusch (1994) sees as positive - away from the biomedical model of disease and health care to a social model of health. Health promotion in some contexts tended to move away from 'blaming the victim' to a critical examination of the political and economic structures which impinged upon the health of individuals and population groups, and a redress of the social and environmental factors which determine health status.\textsuperscript{304} This was exemplified in the Healthy Cities projects initiated in a number of countries, including Australia (Ashton et al 1986, Baum 1993). The \textit{Jakarta Declaration} (WHO 1997) re-assesses the social conditions which impact upon people's health, and considers the need for more 'partners' in health. This WHO policy signifies a move away from individual agency and the lifestyle approach to health. However, it also runs the risk of being interpreted as advocating that individuals are 'victims' of their social circumstances.

Models and the rhetoric of health promotion abound, and yet, there is no agreed
definition in use.\textsuperscript{832} Health policies with a focus on health promotion (Kickbusch 1986),
have been developed by WHO such as Health for All (1985, Baum 1995a). Australia
through the health policy: Better Health Outcomes for Australia (1994), with an
emphasis on national health goals and targets, has identified population groups 'at risk'
of disease and/or death (Commonwealth Department of Human Services and Health
1994a, Nutbeam et al 1994). Current health promotion campaigns have an emphasis on
individuals making changes to their 'lifestyle' (cf. NHMRC 1995a, 1996b). The
dominant discourse of these policies is that of government policymakers and health
professionals. There is a presumption that laypeople do not know about nor do they
practise health promotion within their households. The lay discourses on health
promotion are not articulated (Peerson 1996a), nor in the Jakarta Declaration (WHO
1997).

From the mid 1980s, health education no longer assumed ascendency as a strategy
for reducing risk-taking. Instead, it was incorporated as a tool of 'biopower' (Foucault
1979) to be used by the 'new public health' professionals alongside 'regulation,
community action and basic changes in social structure' (Badgley 1994:27).\textsuperscript{833}
Public health professionals were also encouraged under international and national health
policies to expand their roles 'to include advocating, enabling and mediating' between
individuals and the state (Kickbusch 1994:8). From an analysis of interviews with 23
health promotion professionals, Grace (1994) concludes that they viewed health 'as a
concept cast fully in the positive.' She goes on to state:

to focus on health in the positive does not serve to redefine or reposition 'health'
with respect to the dualism [i.e. health-illness], but shifts the focus from curing or
treating the negative to producing or maintaining the positive (1994:275).

And, the key indicators used to measure health outcome are still disease oriented
(morbidity and mortality). This presents an ambiguous situation whereby, from a public
health standpoint, people exercise their right to health promotion but must take self-
responsibility (preferably without appeal to professional care) whilst at the same time,
they must necessarily rely on professional knowledge. It is a case of 'don't come to us
but use the information and be responsible about it'. 'Be healthy citizens'. 'Surveil and
regulate your bodies'.\textsuperscript{834}

Although a very small proportion of national health budgets are allocated to
health promotion, programs are steadily being implemented by policymakers who
perceive them as being a cheaper option to curative biomedical care, when individuals

\textsuperscript{833} See also Baum (1990), O'Neill and Pederson (1994), Petersen (1994), Gastaldo (1997).
can bear full costs for health care in the privacy of their homes, and hence are less taxing on the overall national accounting system (Waring 1988, 1996). Both these scenarios are largely attractive to middle class persons who can afford to take good care of their health, and have the social, political and economic means to do so. Despite innumerable studies linking socio-economic status with health, Aboriginals, migrants, disabled, unemployed and homeless persons are being overlooked in most mainstream health promotion programs. In an era of vast cost-cutting measures in health, education and welfare in Australia, disadvantaged groups are in no position to substantially improve the living and working conditions which have often given rise to disease in the first place.\textsuperscript{385}

**Laypeople and Others**

To date, biomedical health professionals, government policymakers (Baum 1990) and academics persist in maintaining health education, health promotion and illness-injury prevention as distinct categories within the broad field of public health. Indeed, each occupational group, within their own disciplines, has undertaken research, developed and implemented policies and programs, framed public health workforce pedagogy and practiced clinically. They have also asserted that their 'expert' knowledge is superior to lay health knowledge, and displayed arrogance in assuming that such scientific knowledge is not readily explicated nor understood by laypeople.\textsuperscript{386} These personnel have also supported and maintained their own occupational territory - with inherent power and privileges - amidst calls for intersectoral collaboration and partnerships *vis-a-vis* laypeople.\textsuperscript{387} Paradoxically, they also claim goodwill, altruism, humanitarianism, and profess health consumer empowerment, autonomy and partnership, whilst using the rhetoric of democracy and 'community participation' under the banner of the Ottawa Charter (WHO 1986).\textsuperscript{388}

I asked participants in the study questions related to health education, health promotion and illness-injury prevention as separate categories. I wanted to establish their lay views and practices within the household setting. The answers to these

---


\textsuperscript{388} See Baum (1990), Grace (1991), Petersen (1994), Anderson (1996), Dean and Hunter (1996), Bell (1996), Gastaldo (1997). More recently, the Jakarta Declaration for Health Promotion in the 21st Century, Indonesia (July 1997) confirms and moves beyond the Ottawa Charter (Nutbeam 1997). The following priorities for health promotion in the 21st century were established: i) promote social responsibility for health; ii) increase investments for health development; iii) consolidate and expand partnerships for health; iv) increase community capacity and empower the individual; and v) secure an infrastructure for health promotion (WHO 1997).
questions by 98 women and men in the sample crossed these boundaries. When I asked a specific question on health promotion, for example, the immediate response was clearly related to either health education or illness-injury prevention. The resulting data indicates that participants made no distinction between these professional, bureaucratic and academically defined categories. For laypeople - there is no succinct demarcation between health education, health promotion and illness-injury prevention. Rather, they perceive them as similar, seamless and inter-related. There is a blurring between these categories as the following participants' narratives show.

*Lewis* The only thing we do to try and promote it [health] is to try to foresee any dangers as you’re doing something and minimise the dangers.

*Sarah* Basics like hand washing after going to the toilet, eating as well as possible, and a variety of food to keep up as much in the way of vitamins. Try to get a reasonable amount of rest and sleep, and also physical activity.

*Jack* Well, just about everything you teach them is about health. To the degree that you generally encourage behaviours that are not likely to lead to ill-health and that can be accidental. [We] sort of encourage behaviours that avoid accidental injury ... transmission of infections, a development of degenerative diseases ... You’re teaching them [children] a lifestyle. Or you’re encouraging them to get exercise ... to eat well ... to wash their hands. All of those things are health education to me.

Furthermore, when asked: what issues they perceived as most relevant, participants indicated that these were not confined to just one category, but related to one or two out of three categories. See Table 6.1 for participants’ responses to this question. Table 6.2 presents another way of conceptualising participants’ categorisation of issues which they perceived as pertinent to health education, health promotion and illness-injury prevention within the household setting.

Kickbusch (1994:8) emphatically states: ‘Health promotion is not, and in my view, has never been a social movement’. Given her example, I interpreted the data as follows. Looking at participants’ responses in Tables 6.1 and 6.2, we can establish that firstly, their lay definition of what constitutes health education, health promotion and illness-injury prevention correlates closely with their lay conceptualisations of health and ill-health as discussed in Chapter 4. Secondly, it has implications for the success and failure of health promotion policies and programs (Frankel et al. 1991, Syme 1997). Thirdly, it also provides a framework for discussing the extent of these activities - as part of lay healing practices - within the household setting in reference to: 1) the nature

---

389 Rather, the discourse on health promotion is a professional and bureaucratic [and academic] response to the challenges put forward by other social movements including feminism and environmentalism (O’Neill 1994 et al :381, cf. Short 1997).
of the parent-child relationship; ii) 'ways of teaching'; and, iii) risk, accidents, risk-taking and safety.

| Table 6.1: Health Education, Promotion and Illness-Injury Prevention |
|---------------------------------------------|----------------|----------------|
|                                             | Health Education | Health Promotion | Illness/Injury Prevention |
| Healthy bodies                              | *               | *               | *                          |
| Healthy minds & attitudes                   | *               | *               | *                          |
| Hygiene                                     | *               | *               | *                          |
| Sleep & rest                                | *               | *               | *                          |
| Exercise & fresh air                        | *               | *               | *                          |
| Diet, food & nutrition                      | *               | *               | *                          |
| Clothing & footwear                         | *               | *               | *                          |
| Leisure, recreation & stress                | *               | *               | *                          |
| Relationships                               | *               | *               | *                          |
| Allergies                                   | *               | *               | *                          |
| Ongoing illnesses                           | *               | *               | *                          |
| Health checkups                              | *               | *               | *                          |
| Sexuality & STDs                            | *               | *               | *                          |
| Alcohol, drugs & medication                 | *               | *               | *                          |
| Smoking                                     | *               | *               | *                          |
| Social environment                          | *               | *               | *                          |
| Physical environment                        | *               | *               | *                          |

| Table 6.2: Regrouping of Issues              |
|---------------------------------------------|----------------|----------------|
| Health Education and Health Promotion       | * Healthy minds and attitudes|
|                                            | * Hygiene         |
|                                            | * Sleep and rest  |
|                                            | * Exercise and fresh air|
|                                            | * Diet, food and nutrition|
|                                            | * Relationships   |
| Health Promotion and Illness-Injury Prevention | * Clothing and footwear|
|                                              | * Leisure, recreation and stress|
|                                              | * Alcohol, drugs and medication|
|                                              | * Physical environment|
| Health Education and Illness-Injury Prevention | * Social environment|
| Health Education                            | * Healthy bodies  |
|                                            | * Sexuality and STDs|
| Health Promotion                            | * Health checkups |
| Illness-Injury Prevention                    | * Allergies        |
|                                              | * Ongoing illness  |
|                                              | * Smoking          |
PARENT-CHILD RELATIONSHIP

Setting the Context

There is little understanding from the literature on health promotion of how laypeople undertake health education, health promotion and illness-injury prevention within the household setting. This setting remains 'discounted' and unacknowledged, unlike the settings of schools, workplace, community and clinical. Yet, my research supports the argument that the majority of health care used by laypeople is provided within their own homes (Dean 1980, Kleinman 1980, Peerson 1996a, 1996b). The recently developed National Health Policy for Children and Young People (1995) acknowledges that:

Children and young people participate and learn from the behaviour patterns of their own family, of their peer groups, the school and the wider community in lifestyle matters such as eating and drinking habits. Within families, health and ill-health behaviours are modelled. The role of parents/carers as the primary source of health care and health education must be respected (Commonwealth Department of Human Services and Health 1995:11).

As parents, participants in this study are actively teaching their children (and other individuals) about health, promoting health and, preventing illness-injury as part of their lay healing practices in everyday life. Some participants acted as a team with their partners, others acted individually in taking responsibility for the household production of health. The parent-child relationship provides the context for participants' ability to protect health, maintain well-being and quality of life, and prevent morbidity and mortality on an individual and collective basis within the household. Factors influencing this relationship are: i) the age and gender of each generation; ii) the nature of the relationship and the value placed upon independence, responsibility, discipline, negotiation and respect; and, iii) teaching about health and illness versus parenting.

Age and Gender of a Generation

The participants have children who are infants and pre-school age (N=71), and older children attending primary school (N=122) and secondary school (31). (Some also have adult children older than 18 years of age [N=5]). There was a total of 221 children in the sample; excluding eight children who are not living in the same household as their parent(s) due to their age (ie. more than 18 years old and living away from home),

393 The Victorian Health Promotion Foundation asserts that, 'because the majority of health determinants fall outside the health sector, health promotion must be highly intersectoral. Five key settings cover the bulk of the population [health care, education, workplace, recreation, family]. These in turn fit within the wider settings of the city, district and village' (VicHealth 1997:5). However, again there is a dominant belief that professionals alone have expert knowledge and practice of health promotion, without any recognition for laypeople's activities in this area.

394 This issue is connected to household labour and will be fully discussed in a forthcoming paper. Participants' involvement was constrained by the household resources of time, money and energy, in addition to work, study and childcare commitments.
or living elsewhere with the other parent. The age and gender of both parents and children provides a context for the discussion of the self, body, health and illness in pragmatic terms within everyday life. These parents are 25-47 years old; they are not young adults or older persons. The relationships with their children are: mother-daughter, mother-son, father-daughter, father-son, indicating a confluence of age and gender. We can presuppose that with the birth and rearing of each child, a parent acquires additional experiential knowledge of parenting and health issues.\(^{302}\)

Parents agreed that the major foci for them were nutrition, hygiene and safety regardless of gender and age. Belinda was of the view that 'you teach them everyday, ever since they were born.' Whilst Tom said of his two daughters aged six and four years, 'that we've just started on the conventional ... you know washing of hands, cleaning of teeth, etc. The basic habits ...' He elaborated:

I think that we haven't been consciously explicit in other things such as exercise and so on. They tend to just happen. They are part of our general behaviour rather than something that's consciously taught. We teach by example.

And Peter indicated of his children - 'Kane is five years ... Julia is eight years and Douglas is 15 years':

Well basically I think I would like to teach them more about preventative matters. For example, you know how not to fall sick or what to do for that injured hand. That you have to wash it with water in the first instance.

For some participants, the gender of their children was an issue more so than for others. Geoff stated: 'We've got a son, so I've got to teach him how to clean his foreskin'. He saw it as his responsibility, as a father to teach his son about 'male' hygiene, rather than his wife doing it. Pam and Rachel debated whether small boys less than seven years of age actually clean their teeth by themselves or whether they prefer their mothers do it. Drawing upon her own experience of having two sons, Pam claimed: 'He's a he. He'll go through a stage of not cleaning his teeth. Don't you worry. Then you'll look at them one day and they'll be really grotty.' Rachel responded: 'He prefers doing it himself than having me do it.' Whilst Dean admitted, 'I'm teaching my daughters about hygiene'. For him, the gender of his children was not an important consideration.

For many parents, when to teach their children about health promotion and, illness-injury prevention (for example, exercise, sunscreen, bike-riding, road safety) was a qualifying factor. It was also a topical issue within focus group discussions whilst

in interviews parents presented their own singular views. Sian and Vicky considered their six, five and two year daughters as 'too little' and too young at the moment' to be taught 'anything about health.' Yolanda, Wendy and Elsa disagreed when it was possible to teach their children about safety. Yolanda believed 'You start right from when they are little', whilst Elsa argued that 'some you can teach. And some you can't.' Wendy claimed that 'they're all different.' The child's advancing age and independence meant parents no longer needed to remind them about hygiene and nutrition, and they were able to recognise the importance of paying attention to these issues.

_Sandra_ You can teach them to be independent of you and take control of their teeth brushing and fruit eating and their thirst. So that they drink water, and get outside in the sunshine and play.

_Yolanda_ You try to create a harmonious atmosphere. Yes. And have an appreciation for all those things. And for children to recognise that themselves, rather than you telling them. But to get them to try and appreciate how they feel.

Bianca disputed this assertion and argued that 'You can't get this age group [preschoolers]' to take notice of what their parents are teaching them about health promotion and illness-injury prevention. Whilst Yolanda responded that as a parent, 'that's the thing to aim for'. Rita assessed her nine year daughter and seven year old son as still requiring parental supervision and instruction on road safety, because 'they are young enough not to be able to judge cars well enough at this age ... and they do take a few risks.'

**Nature of the Parent-Child Relationship**

Numerous studies continue to demonstrate that men are involved in their children's lives to a lesser extent than women owing to employment and income constraints, and persistent notions of the gender division of labour, regardless of women's paid and unpaid work and contribution to the household (and national) economy. Nine women are sole parents in the study. They have the gendered dual roles of 'mothering' and 'fathering' their children in the absence of a male partner and a role model of masculinity. Amongst participants who were married or in defacto relationships, both women and men claimed their partners played an active parenting role in their children's lives.

Participants indicated that they value responsibility, negotiation, independence, discipline and respect - both of themselves and of their children. These were not age nor

---

gender exclusive. It was these inter-related qualities of human existence which parents endeavoured to teach their children for reasons of encouraging 'active' citizenship and making a contribution to civil society once they attain adulthood. They are also related to parental and children's awareness of risks which could compromise health status. These moral values which 'fit into contexts of cultural values that set the tone, taste and texture of whole societies' (Leach 1994:23), were also central to the parent-child relationship and considered important for health promotion and illness-injury prevention. They also involve an expenditure of time, energy and 'emotional labour' vital for the integrity and intimacy of social relationships. The literature suggests that in the 1990s, parents are exhorted through the 'ideology of motherhood' (Wearing 1984) and the 'ideology of fatherhood' (Edgar 1997) to spend both 'quantity time' and 'quality time' with their children. Leach (1994:23) argues that '[i]n order to absorb particular values at home, children need to model themselves on parents who live by them, or are seen to try' (cf. Clinton 1996). Participants also indicated whether these values were accepted or rejected by their children.

The importance participants placed upon responsibility appeared to be high. It was repeatedly referred to during interviews and focus group discussions. Parents made a distinction between 'self-responsibility' and parental responsibility for children's behaviour. Pam argued that 'self-responsibility where health's concerned' was also related to 'self-discipline'. She reasoned that children need to understand 'that it's their body, their life and that they're responsible for it'. Kirk remarked that 'ultimately you are responsible for yourself to make sure that the things you have some control over ... because the consequences can be really quite dramatic'. Connie and Tammy agreed that self-responsibility also means awareness and taking responsibility for 'the repercussions' of one's decision-making and actions. Tammy stressed, 'it's no use saying, "you're sorry if someone's dead"', although she acknowledged that guilt - a profound negative human feeling - is punishment in itself. Both women and men recognised their children as agentic selves and their own parental authority and responsibility to manage the consequences. 'Well to look after themselves and not do anything silly ... and if they have a problem, they just come to me and we deal with it', said Connie. Valerie and Tracey agreed that 'you actually try and teach them [children] to be responsible ... for themselves and others ... to look after their own things ... to have respect for other

---

395 They are also related to parental and children's awareness of risks which could compromise health status.
397 Following the Family Law Reform Act (1995), Funder and Smyth (1996) conducted a national study on perceptions of parental responsibility held by the Australian general community and by divorced parents. Approximately 95-85% of both groups overwhelmingly support parental responsibility for: i) providing love and emotional support; ii) teaching children what's right and wrong; iii) looking after children's education. Lesser but still important parental responsibilities are: providing contact with relatives and access to sports, clubs and hobbies.
people’s things’. An example, Valerie gave was: ‘you teach them not to run with knives and scissors, and how to handle electricity safely ...’

Parental responsibility for children included ensuring their homes are a safe environment: both physically and socially. Personal safety appeared to be a moral imperative (Roberts et al 1993, 1995). Wendy and Elsa remarked upon their homes:

Wendy I’d just be aware where they [the children] are at all times. Oh, most of the time ... Elsa A quiet lookout? Wendy Yes.

Elsa When something’s happening, we would listen. When they’re little you’ve got to listen and look out for them all the time. To see what is going on.

Eric, Dean, Geoff and Francis agreed their children’s ages was an important factor in determining the need for parental supervision of children at play. Eric asserted that below the age of ten, what parents inform their children ‘goes in one ear and out the other’. As children get older, parents’ remonstrations ‘finally sink in’ and ‘then the responsibility goes to them’. Eric extended the realm of parental responsibility for children’s well-being to also include discipline and the need to set boundaries or limits on behaviour (Leach 1994, Edgar 1997). He argued that lack of parental responsibility would be a risk to health; for example, allowing children to eat junk food instead of ‘healthy foods’, and watch television instead of playing outside in the garden. Jackie regarded it her responsibility to inform her children that the untidiness of their room was a health hazard - ‘sandwiches rotting’ - that could not be tolerated. In addition she pointed out that if her children wanted to play with others at their home, she is ‘providing care for children that aren’t mine’. Therefore, she explained to her children: ‘I’ve got a responsibility whether I like it or not to keep this house clean, and put decent meals on the table and have you dressed properly’. Jackie was also cognisant of social sanctions and stigma that if she didn’t fulfil her responsibility for her own (and other children’s) well-being, there is always the implicit threat of labelling and in the extreme case, of her children being removed from her care and their welfare assumed by state authorities (Hil 1996). She remarked other people ‘would say, “well where was the stupid bitch? Who was supposed to be looking after her?”’

No matter, could be in a meeting or the kid was doing risk-taking behaviour ... or because they had no fear. I would have been held up in my job.

Jack expanded his responsibility for personal well-being to include not only his family members (wife and three daughters) but also the patients attending his surgery: to ‘encourage healthy lifestyles and discourage illness behaviour’ amongst his patients.
McDonald (1996) argues that Australian families as a social institution mediating between the individual and society, are in the 1990s 'bifurcating' into the 'dysfunctional family' (whereby child abuse is pathologised) and the 'negotiating family' (whereby dialogue and negotiation are practised) (cf. Edgar 1997). This trend is linked to the following factors: i) a societal and personal preoccupation with personhood, self-esteem and vulnerability within social relationships, including parent-child and marital; ii) opportunities for and constraints upon 'individualization'; iii) the 'normal chaos of love'; and, iv) the transformation of intimacy.\(^{909}\) As a result, Edgar (1997:xv) surmises: 'Everything now is open to negotiation and nothing can be taken for granted'.

Negotiation between parent and child often involves not only a tussle of wills - 'testing one's power' - but also reaching a compromise between two or more options; resulting in a decision and action. Negotiation of an issue between two parties requires conversation, patience, and a willingness to hear another's viewpoint. Tammy remarked it was important to have a social conscience, and be 'able to see the other person's side, even if you don't agree with it', rather than one person claiming ultimate authority for decision-making. Each person's ability to negotiate depends also on their age and level of understanding. An adult negotiating with a two year old child is markedly different from negotiating with a ten year old. Neil noted the following aspects of his ongoing negotiation of issues with his eldest son, Ben.

I mean after dealing with business executives and hierarchy, like some fairly big-named people, in the advertising world ... that's nothing compared with trying to handle a three year old [child] and sorting out his negotiating skills. Just unbelievable. You can't walk away from the child and say, 'no look, we disagree'. Because you've got to come up with a result.

Neil endeavoured to introduce 'alternatives' into the discussion - 'not confrontation' - with his son. 'Already he's learnt that he has to give somewhere along the line', reach a compromise and 'accept the result'. He also acknowledged his son's agency and capacity for autonomous decision-making. Whilst Hugo and his wife 'encourage the kids to evaluate a situation before we send them out into it' such as running down a slippery ramp in wet weather. However,

you're pointing out to the kids that they are making a choice, and you're filtering out the extreme choices. Like if they decide to do something that really is 'beyond the pale', then you have to stop them.

Edgar (1997:ix-x) contends ‘[f]amilies are arenas of "cooperative conflict", a place of negotiation and compromise'. Participants indicated that certain issues were negotiable: cooking meals, pocket money, childcare, wearing clothes and shoes, personal space and 'time out', recreational activities. Each person's 'preferences' or likes and dislikes were recognised and considered integral to the negotiation process, as well as who does what and when (cf. Backett 1990a). For example:

*Donna* My six year old son - it was six degrees outside and he came home with a T-shirt on.  
But he doesn't feel the cold, so I can't really make him wear a jumper.

Safety in terms of children's activities and environment (physical and social) was an issue parents narrated they were not prepared to negotiate nor compromise (cf. Roberts et al 1993, 1995). For instance, sunscreen and a hat in the summer, playing with knives and other sharp objects, poisons, bike riding with a helmet, wearing a seatbelt in the car. This position is more likely to occur when a situation becomes dangerous and immediate action is vital for personal safety. There is no time for discussion or negotiation. Fran insisted that her six year old son Andrew not put any sort of plant in his mouth because it could be dangerous, nor sleep with the cat on his bed 'because he could breathe in his fur'.

Many parents agreed that being consistent was important. Not only to exert their authority and responsibility, but also as a preventative measure against illness and injury. Nicole related:

When you say 'no', you mean 'no'. You won't enter into any argument about it. And the kids know that Mum said, 'no'!... it takes more patience to say 'no'. And to keep on saying 'no' three times and then say, 'alright then'. [And give in].

Hugo gave the example of his five year old daughter and two year old son: 'You're not eating ice cream until you've had your broccoli'. Hugo explained there are 'two sides of the coin'.

The Yin and the Yang ... with everything there is a balance and there is a compromise ... and you do stray one way or another over the line.

Consequently, 'it's very challenging' to be consistent with one’s own children, when as adults, Hugo admitted, 'we're inconsistent. I'm inconsistent with myself' (cf. Backett 1990a, 1990b). Mandy asserted that it was more difficult to be consistent, patient and maintain parental authority, 'when we're all tired at the same time of the day. The kids are scratchy'. If negotiation of an issue was not possible or their children manifested
negative behaviour (shouting, rudeness, irresponsibility), many parents in the study indicated that they implemented disciplinary strategies before negotiation and dialogue about the contentious issue could proceed further. These disciplinary strategies included: 'grounding' their child, having some 'time out', and writing a letter. Participants did not express their views on nor indicate they used corporal punishment in the domestic sphere.\(^{400}\)

**Teaching versus Parenting**

A review of health education journals and consultations with health educationists - academics and clinical practitioners - reveals their tendency to view the pedagogy of health education as their exclusive prerogative; to take place within the confines of universities, schools and health care settings on a paid and formal basis. A plethora of policies and rules govern the structured teacher-student relationship. Little credence is given, firstly, to the pedagogy on health that laypeople provide to members of their family, neighbourhoods, social networks and local communities in an informal and voluntary capacity. Secondly, teaching occurs within the context of affective (emotional) relationships within the private and intimacy spheres. Again, there is an assumption that laypeople are not 'qualified' to teach, and do not possess the specialist skills and expert knowledge required of health education.

Are parents of young children - as laypeople - in this study health educationists? - albeit without the formal training and practice of 'teachers'. Out of 98 participants, nine parents had teaching qualifications (including one man completing a higher degree), of which three were currently employed in a formal teaching capacity. Or are they simply parents, with no significant teaching role about health in their children's lives? Tammy, a practising social worker with teaching qualifications and married to a teacher, succinctly expresses the paradox of these questions. 'You've got such an important job as a parent. Just like a teacher has too. In modelling and shaping, encouraging and disciplining and all that.' Rossmanith (1997:143) emphasises:

Parenting requires a great deal of teaching, but it is informal teaching. There is no formal curriculum. No lesson preparation. You learn early that there is no point in forcing very young children to do what they are not ready to do. Your teaching is paced by the individual child and by the situation itself (cf. Clinton 1996).

Functionalist views of the family assert that socialisation of the child by the parent(s) is vital for society's well-being (Parsons 1951). 'The ideological benchmark remains the patriarchal nuclear family' (Hill 1996:37), despite growing acknowledgment that other family structures exist and the diversity of relationships and forms of socialisation within them.\(^{401}\) Children can learn about health by parents encouraging them through

\(^{400}\) Only Jackie related her childhood and adolescent experiences of corporal punishment.

\(^{401}\) See UN (1993, 1996), IYF (1994), Commonwealth Department of Human Services and Health
play, fantasy, having quiet time, using their imagination, sensory stimuli, reading, art and music, free time and development of social skills (Rossmanith 1997).

Given the nature of the parent-child relationship, the data raise additional questions addressing health education within the household setting. These are: i) which parent teaches what to their children?; ii) when and where does the teaching take place?; iii) how is that teaching of health undertaken?; and, iv) do parents agree all the time about the content or is there a compromise?

Both women and men in the study talked about their role in health education in the household setting. It is not women alone who teach their children about health; men do also in their capacity as parents. The age of a child and their level of understanding were key criteria for parents assessing what health issue would be taught, how much information to be given, and when. In the following section, I explore the 'ways of teaching' to promote health and prevent illness-injury used by parents of young children - laypeople - in this study, by drawing upon qualitative data from interviews and focus group discussions.

WAYS OF TEACHING
Promoting Health and Preventing Illness-Injury

Since health promotion and illness-injury prevention are imperative for reducing the likelihood of individual and household morbidity and mortality, sustaining well-being and improving quality of life, how laypeople conduct health education within the household setting, is a critical factor. Table 6.3 presents lay 'ways of teaching' which participants in the study used and described. These 'ways of teaching' are: i) teach by example, ii) explanation, iii) learn by experience, iv) negative injunction, and v) raise awareness.

Participants strove to 'remove hazards' from the physical and social environment, and create conditions for producing health in their households. They indicated their preference for which 'way of teaching' their children about health when promoting health and preventing illness-injury, in order to 'avoid hazards'. And, at times they resorted to one or more ways of teaching as a means of furthering their children's knowledge of health and illness. Parents acknowledged their children being agentic selves, in terms of their emotional intelligence, reasoning, agency and capacity for autonomous decision-making.
Table 6.3: Ways of Teaching

| Teach by Example                       | • Role models  
|                                      | • Personal observation  
|                                      | • Others’ experiences |
| Explanation                           | • Give reasons  
|                                      | • Fables, metaphors, stories  
|                                      | • Make a connection between behaviour, environment and outcome |
| Learn by Experience                   | • Oneself |
| Negative Injunction                   | • Reverse psychology  
|                                      | • Homoeopathic approach |
| Raise Awareness                       | • Repetition, nagging  
|                                      | • Reminders of potential behaviour outcomes  
|                                      | • Know children’s limits |

Firstly, through daily living in the same household, parents are primary role models to their children because they ‘lead by example’ and indicate ‘how you behave at home’ (cf. Commonwealth Department of Human Services and Health 1995). Christopher believed that ‘parents’ habits rub off on their children’ (cf. Rossmanith 1997). Beth put it: ‘They see you eat or do certain things, they will try to do it themselves’. Therefore, ‘you play sport, they wish to play sport. You eat apples, they eat apples’. Francesca asserted her ‘philosophy’ that ‘by the time they’re eight [years old]’ the ‘ground rules’ have been set so that the child has a sense of responsibility towards her/himself and others; especially if they identify with their parents. In response to Francesca, and similar to Carrie, Helen’s concern was that as the child gets older, the issue is ‘how many friends will persuade them the other way. You hope that they are going to be strong and say, “well no”’. She feared that when her daughter and son are exposed to peer pressure during adolescence, their personal desire for ‘belonging’ to a group may influence them away from their parents’ values and behave in ways that could impair their well-being: fast foods, drugs, drunkenness, smoking. In contrast, Pam argued that ‘you can teach them one thing: that most of our behaviour is learnt. And because it is learnt you can change it.’ Olivia reasoned that regardless of gender stereotypes or a person’s age, children like her son Angus, can learn from their role models - in this instance, his father - not to make a mess vomiting ‘all over himself or the blankets’ and expect someone else to clean it up. Instead he could go to the bathroom. Natalie related that of a large family of ten children living overseas, two siblings and herself ‘were adopted out and the rest stayed with the parents’. Now in her early 40s, Natalie commented:
We've started looking at our lives. And I was not reared with any of these children. And the similarities of how we've been brought up, even with different parents.

In Natalie's situation, her biological parents were not her immediate role models during childhood, and yet, she perceived similarities between her nine siblings despite their different family environments and upbringing (Macbeth 1989).

Parents may also refer to other people (grandparents, relatives, friends, neighbours) as role models to their children who are personally known to them. They make explicit the connection between that person's behaviour and the visible outcome(s) (Rossmanith 1997). 'Look what happened to them!' 'So that they can see how it's affecting them', said Alice. She remarked:

My father-in-law is an asthmatic and he also suffers from asbestosis. So they [the children] know that smoking can affect his lungs, their lungs ... 'Grandad is having trouble breathing, cancer is worse.'

Other examples are asthma and cardio-vascular disease, food habits and dietary preferences. The children learn through direct participation in family life and others' experiences, of the relationship between health and lifestyle, and of risk factors which can impair their health status. Beth agreed that 'it is easier to see it than be told.' Kelly reasoned that 'sometimes you need a fright to make you do it', that is, to change your behaviour. When her daughter was admitted for surgery at a children's hospital in Melbourne, Sian observed at first hand young children being treated for severe burns and the emotional trauma suffered by their parents. She learnt how the burns were caused and how to prevent them. Sian related: 'we heard so many terrible stories' of 'many children in the burns unit [who] were scalded with a hot cup of tea or coffee.' Her direct observation subsequently led to personal behaviour modification at home and also advocating other parents (and her daughters' grandparents) to do likewise; by not holding a child whilst drinking tea or coffee.


I had been taught as a child to recognise story as quintessential medicine. I understood from years of being fed and groomed by the old women in my family that story in all its many variations can, in the right time and place, with proper application give help to the hurts and wounds of simply having lived life (in Thomas 1994:xvi).

Carrie stated: 'in our house we have an explanation for things'; giving the example of the comparative nutritional value of apples and biscuits. She indicated that her children did not always accept the explanation of the importance of having 'good teeth'. 'Sometimes you don't always win. Sometimes they win. But it's worth a try'; indicating that food intake in her household is negotiable between parents and children. Both Francis and Dean agreed that health promotion and illness-injury prevention requires 'talking about it', having a discussion, so 'that it's part of normal conversation'. The health issue may be recreation, exercise, or their partner coming home with 'a little dark cloud' (in a bad mood). If explanation didn't work they were then prepared to take direct action such as: 'pick up the remote control and turn the television off and go in and turn the computer off'. And suggest 'we're going over to the park' or the beach 'instead of sitting around'. Hugo indicated that when he and his wife observe their children to be 'reckless and running down the ramp when it's wet', they say:

'look that's slippery. Do you realise that you have to be careful when you're running down the ramp?' Toby says, 'no, I don't', and runs down. And manages to do it without slipping over.

Rachel believed it was essential to discuss 'things' with her children, 'because if you don't air things that are festering in their mind, they come out with illnesses.' Vicky indicated her unease in teaching her five year old son 'how you get babies in your stomach'. She was concerned that 'he's going to tell the whole class after I explain it to him'. Pam responded that children need 'facts rather than fiction' when they are given explanations about the human body, and in particular, sex education. She suggested to Vicky that her son 'may just want a simple answer and not ask anything further.'

You could say that 'Daddy puts it there' and he'll go 'oh, alright'. And he'll come back a year later and ask 'how? [Laughter]

Thirdly, experiential knowledge, as argued in Chapter 5, is a steady source of lay health knowledge that laypeople draw upon (Dean and Hunter 1996, Popay and Williams 1994, 1996). Some parents considered learning through personal experience as the key 'way of teaching' their children about health promotion and illness-injury prevention. Participants hoped that their children's exposure to certain situations in everyday life would enable them to: i) make decisions; ii) implement action; and, iii)
understand the consequences. Jane believed that children 'have to learn too. They have to experience things as well.' She reasoned that 'the more ... you say "no", the more that they are determined to go ahead and do it anyway'. Children as agentic selves are asserting their own independence. Francis pointed out that 'you are confronted with so many choices and you're confronted with so many situations' that as a parent 'what you're always trying to install is that degree of responsibility with the children to make the correct choice. [heads nodding] They learn as we do, by experience.' Dean and Eric perceived the need to balance freedom with responsibility, given the risks children (and adults) experience due to their lifestyles and environments.44 The experiences could be personal and/or familial. Examples given by participants of personal experiences were: falling off a bike, being bullied at school and of familial experiences: travelling overseas, camping in the bush.

Fourthly, related to the acquisition of experiential knowledge is 'negative injunction'. This 'way of teaching' consists of two approaches: i) 'reverse psychology' whereby something is treated with the opposite; and ii) the 'homeopathic approach' whereby like is treated by like. Parents reasoned that when explanation fails, they were unable to reach a compromise on a negotiable issue or safety was non-negotiable, they deemed it necessary for their children to learn 'by personal experience'. Gemma spoke of her son and daughter jumping off the couch.

It's making rules - they're not really allowed to do [something] [sic] but that doesn't stop them from doing that. They really have to find out the hard way themselves a lot of the time.

The outcomes may be minor injury - 'bumped their heads on the floor' - but the ultimate aim was for the child to learnt from this experience not to repeat her/his actions. Imogen gave an instance of 'reverse psychology'.

We never put a firescreen around the heater because we felt that the kids only had to touch it once and burn their fingers after being told, 'don't go near it, you might burn yourselves'. As if to say 'you will burn yourselves', they're more than likely going to burn themselves ... so if you warn them 'if you touch it, you will burn your fingers'. They only have to touch it once to know that Mum was right.

As an example of the 'homeopathic approach' Leah spoke of the time when her five year old son Ethan wanted to cut up vegetables using a sharp knife, and her fear of injuring himself even under her supervision. 'The more I say, "no, you can't do it", the more he is determined to do it. And he'll get up there by himself and find a knife.' She

not only disciplined him and taught him a skill, but also gave him responsibility by contributing to the family meal. Mandy responded:

You're better off to let them [children] experience it. You get chunky, mushy vegetables.
Blunt knives. [laughter] It takes two hours.

'He's happy' even if vegetable peelings end up on the floor and need to be cleaned up. In this way, the young boy learnt that doing something the same as his mother (Leah) has similar results. In contrast, Richard drew upon his working class upbringing as an explanation of 'negative injunction': 'it's the school of hard knocks'. Touching machinery could result in 'losing an arm', which cannot be easily replaced even with microsurgery. This perspective contrasted to his partner's middle class approach that 'the child's quite intelligent, just needs to have things explained clearly and patiently over a period of time and be protected [from harm]'. She reasoned, 'that the child isn't silly; the action of the child is silly'.

A fifth 'way of teaching' resorted to by parents was 'repetition' or 'nagging'. Giving children regular reminders of potential outcomes of their behaviour would raise their awareness: dental caries, wound infection or poor nutrition.

Fiona You have to nag them to brush their teeth.
Francesca I'm forever telling my daughter to wash her hands.
Blair 'Make sure you've got your fruit for kindergarten'.

In other instances, parents aimed to raise their children's awareness of the existence of 'potential danger' in their immediate environment. They also endeavoured to minimise the hazard whilst it might not be structurally possible to remove it. Imposing safety rules fulfilled parental responsibility for their children's well-being and was a strategy for preventing illnesses and injuries. Eleanor cautioned her children: 'Don't run on the roads' and to 'ride their bikes safely by staying in the lanes.' However in everyday life, parental vigilance, explanation and rules do not always function. Francis narrated the 'carrot and stick philosophy' tended to work in his household. Because when 'you yell and you scream and you jump up and down to get them [your children] to do things ... the softly, softly approach fails.' As a result of this strategy,

If the children can see something that they want, then they learn to do those particular jobs: make their bed, empty the dishwasher, feed the dog, feed the cat. If they're getting something out of it, they tend to play along with it. And that's fine. The next trick is to wean them off the carrot. [Laughter] So that it becomes second nature.
Caroline agreed that children 'either do things for their reasons or for your reasons'. Wendy claimed, 'the old saying: "You can't teach a pig to swim. You'll only waste your time and annoy the pig". 'They'll ultimately make a choice, regardless of what you do', said Elsa.

**DISCOURSES ON RISK, ACCIDENTS AND SAFETY**

'Risky' Discourses

In terms of health and ill-health, risk, risk-taking and being at-risk are of ontological and epistemological importance in the public health arena - theory and practice, policy and research. As discussed in Chapters 1 and 2, certain individuals and population groups living in particular social and physical environments are at-risk of ill-health. Indeed, authors of academic literature and policy documents articulate national and state health priority areas - diabetes, cardio-vascular disease, cancer, injury and mental health - consistently arguing who is at risk of what, where and when in the lifecourse. Following the Ottawa Charter (WHO 1986), national health goals and targets have been defined using the strategies of health education, health promotion and illness-injury prevention. What is missing from this 'expert' discourse on risk, are the lay discourses on risk (cf. Davison et al 1992, Brown 1995, Gabe 1995, Green 1997).

As noted in Chapter 5, laypeople are not immune from public health messages - informed by reductionist and value-free science - that they confront daily. Laypeople critically evaluate the deluge of information, and implement those messages which make 'commonsense' in their everyday lives. Pam observed on the inconsistency of science and paradigm shifts: 'science changes its ideas and concepts on things every couple of years' (cf. Kuhn 1962, Capra 1988, Latour 1987). She gave an example of the public health experts' current 'obsession' with blood serum cholesterol levels resulting in 'all of a sudden everyone stops eating eggs and then they do eat eggs' (cf. Skolbekken 1995:301-2). Pam contended public health attention would be better placed upon pleasure and quality of life: 'be happy and just live'. Since a person could 'reach really old age and do all the wrong health things but are "having a ball" with life'. Whilst Jack regarded 'poor lifestyles, excessive stress, dangerous behaviours ... drink-driving' posed known risks to health. He also believed an individual's 'excessive preoccupation with your health' - 'hypochondria' - was a middle class attitude towards health and well-being (cf. Cornwell 1984).

I contend that laypeople have their own unique conceptualisations of risk and the meanings attached to them. Participants narrated incidents of risk-taking behaviour of

---

themselves, their children and others, and what they 'know' are risk factors affecting individual and household health status. Margot, Kate, Barbara, Tina, Nancy, Renata, Veronica, Jackie, Laura, Whitney and Peggy considered the following factors as a 'risk to health':

Smoking ... Drinking. Drugs ... Pollution ... Alcohol ... Sweet drinks ... Too much sugar ...
Too much Coke ... Too much processed food ... Caffeine.

Sellerberg (1991:197) argues while

experts place fat, sugar and salt at the top of their list of hazards, followed by food poisoning, natural poisons, residual substances, and additives ... [c]onsumers reverse the ranking order, viewing poisons as the greatest risk.

Frankel et al (1991) note that laypeople may render some of these 'risky' items and behaviours as 'bad/desirable' or 'bad/poisonous'. Their notion of what constitutes a 'risk' to health is markedly different to that of public health 'experts', and hence may constitute a reason for the failure of health education programs (cf. Davison et al 1991, Syme 1997).

Risks in Everyday Life

Participants indicated firstly, that risks are multiple, ubiquitous and ever-present. Everyday life is fraught with risk. For example, Sarah stated: 'that you have got risks just about anywhere, walking across the roads and things like that, [even] other people's actions.' They perceived multi-causes of ill-health (Tesh 1989), and are daily confronted with the visible effects such as depression, anxiety, infection, injury, despair and a sense of disconnectedness. Single factors are not readily identifiable, but are contextualised in terms of individual and household activities and events, and the external world.⁴⁹⁹ Hugo and Peter gave the following responses:

_Hugo_ Well I think that the first thing is the risk of accidents. So basically any environment in our modern world has got risks, because there are pots and pans and cars and strangers and things.

_Peter_ ... there are several risks, physical diseases ... accidental [such as] falling down and injuring yourself or bruising yourself. Breaking an ankle. I suppose a more serious one would be through accidentally jabbing yourself with a needle which may be contaminated. So I guess there are some other risks around. In terms of pollution: the air, water.

Secondly, amongst participants - most noticeable during focus group discussions - there were disagreements and contradictions about risk. Risk, it seems, lies along a continuum, with 'control' at one end and 'random' at the other. See Figure 6.1.

**Figure 6.1: A Continuum of Risk**

```
control ←———→ random
```

Control infers known risk factors and responsibility for individual behaviour and structural factors. Random refers to risk being uncontrollable, unknown, and occurring due to chance, fate or 'luck'.

Ian noted the paradox of risks being both control and random in everyday life:

> To some degree you have a certain control over them. But it's also random and everything in life is random ... [due to] certain things you don't know which you can pick up or be made unwell from.

Furthermore, Ian argued, 'I think disease from external sources is the probably biggest [risk] apart from accidents you might sustain in a motor car.' Both of these latter types of risk are simultaneously at the control of the individual but they also occur at random. Elsa reasoned that 'breathing in dirty air' is random 'because that's something we do all the time, because we don't have any control over. Everything else we have.'

Vicky related control over risk factors to the importance of having quality of life: 'You get people who do all the right things and they still die at a young age anyway.'

Pam emphasised the axiom of human mortality: 'you've got to die of something. That's a fact.'

Ian made the following comments about risk factors causing disease which appear to occur at random.

Contamination from food and water sources. That's one of those things you can't control. Epidemics. ![Such as?] Nasty things you see on TV, videos. Infestations from exotic countries that come into our nation on foreign fishing boats and go through quarantine or miss quarantine. [They] land in our country. Our research institutes ... animal research institutes will have a cock up with handling of quite deadly bugs that can escape, be they rabbit viruses or whatever bugs within different animals ... horses ... we've seen a few pig quarantine diseases lately ... bugs like that I see as a threat to health.

---

409 See Davison et al (1992), Kagawa-Singer (1993), Blaxter (1997). In contrast, Evans-Pritchard (1937) notes the Azande consider risks to themselves in everyday life as misfortune, due to witchcraft, sorcery, and 'incompetence or failure to observe a moral rule' (Morris 1987:191).


411 See Garrett (1995), de Silva (1996), Ryan (1997) and Sellenberg (1991) for further comments on disease and threats to individual and public health which are within human control and occur at random.
And thirdly, we can therefore establish laypeople's responses when faced with the dilemma of a (imperfect) knowledge of risk: i) how to avoid known risks?; and, ii) what are the unknown risks? The lay decision-making process as argued in Chapter 5, includes action and evaluation. Unlike the 'experts' on risk in hypothetical situations, laypeople are also confronted with knowledge of risk, decision-making, taking action and evaluation in everyday life (Brown 1995, Gabe 1995). In a coastal area, Irene, Gillian and Heather remarked: 'Smoking, excessive drinking ... over-indulgence in really anything' is risky. However, 'anything is fine as long as it's moderate.' Whilst Olivia argued that the public health imperative of 'everything in moderation' meant that 'you [could] still die of something' (cf. Skolbekken 1995). For what constitutes risk - then and now - has (sometimes unintended) consequences for the future; such as weight gain, infertility, cancer, broken wrist, emergency surgery and accidents (McKie 1993).

Accidents

Accidents are 'unforeseen events', 'unintentional acts' or 'mishaps' that occur due to chance (Collins 1981:8), and therefore are 'blameless'. Many participants reiterated the importance of parental responsibility for their children's welfare, including illness-injury prevention, and therefore, reducing the probability of accidents. They considered both perspectives. Participants were also divided over: i) the degree of parental influence (role modelling); ii) the need for constant parental vigilance of their children; and, iii) trusting their children to be responsible (increasing with age and level of understanding, independence, and learnt through socialisation) (Rossmanith 1997). Not all children are like their parents - despite their genetic inheritance and upbringing in a similar environment (Macbeth 1989). Moreover, children's rights to a safe physical and social environment that contributes to their health and well-being are enshrined within the UN Children's Convention (1989), and in Australia's National Health Policy for Children and Young People (1995).

"As I discussed in Chapter 4, adults' and children's bodily responses to illness and injury are variable by age and gender, family history, and by individual differences. Blair suggested 'perhaps you're reducing the injury rather the risk.' He explained, that children are 'still going to fall and hurt themselves but they're not hurting their feet because they're got boots on or something like that.'

Healthwise, I think it's just a good diet, making sure they're physically fit in themselves because they're eating well and I guess most illnesses and any sort of abrasion or anything is going to heal quicker if the body is in good condition.

---

Ian believed:

You have an inward health that prepares you to be better able to respond to something around you. Whether it be some bug in the air. You create good health within yourself, whatever comes along ... I contacted whatever bug. My body wasn't the best it could have been probably, and to fight it off.

Pam defined accidents as 'explosions of energy': a metaphor for something sitting still and suddenly exploding, like dynamite or a volcano. There was general consensus amongst women and men in the study that some accidents are preventable, but occur as a result of human error, poor supervision, negligence and carelessness (cf. Green 1995, 1997, Roberts et al 1995). Natalie gave the following example:

I had a young boy up at my place recently and he cut himself with my circular saw. I wasn't at home thankfully, and someone else took him up [to the public hospital] and to get attended to and everything. But again, it was lack of concentration. Somebody took his concentration away as he did it.

Pam suggested that 'he was also doing something that he wasn't supposed to be doing.' Other participants asserted that accidents are not preventable, despite precautions and minimising risks, and hence were due to fate, chance or bad luck. The person was in the wrong place at the wrong time (Evans-Pritchard 1937), therefore the accident was unpredictable and blameless (Green 1995). Sarah argued that 'you can be as careful as possible, but if somebody else is being an idiot then you can suffer from their actions.'

I assume in a lot of cases that most of life is like that ... you have got to assume that you are being sensible and that you treat it as if just about everybody else around you is an idiot, so you have to take full responsibility for what you do and take full care as well. You have got to trust somebody sometimes.

Sarah is referring to the issue of trust and distrust of others, and their actions, within civil society and the potential intrusions into ontological security and intimacy.413 The issue here is whether an accident occurs as a result of: i) individual behaviour; or ii) structural impediments; or iii) a combination of both factors (Tesh 1989). Therefore, whether it was possible to 'avoid hazards' or 'remove' them. People attribute blame to the incident (it happened!) and ask questions about the individual(s) involved. What were they doing at the time? When, how and where did the accident occur (Douglas

1992, Green 1995, Roberts et al 1995)? Lewis asserted accidents result from 'stupidity' - a conscious act - not human error or something occurring at random. He maintained that 'human error is to me just saying, "oh well, I've done something but it was an accident".'

To establish the cause of accidents, participants indicated they investigated the circumstances. In the interest of health and well-being, the question is raised: whose responsibility was it to ensure that the accident did not/should not occur? Identification of the locus of responsibility - individual/structural, material/behavioural, parent/child - within the context of everyday life makes it easy to attach blame to someone, something, somewhere and the outcome of such an accident (cf. Gabe 1995, Green 1995, Roberts et al 1995). Rachel asserted: 'You've got to look for what you think caused that problem', which could be 'a lack of balance'. Whilst Vicky agreed, that 'if we can find the cause then we can blame. Put blame. You would then accept that' (cf. Douglas 1992, Finerman and Bennett 1995).

Parents revealed their emotions on discovering accidents within their households.414 Despite their carefulness and vigilance of their children, accidents happen. In Tammy's two-story home, there are 'stairs' and 'balconies'. She described her sons, aged five and eight years, as 'little terrors' who are 'very energetic' and 'very inquisitive'.

You've got to be forever watchful ... because they're so young still. I can't let them be outside playing without me knowing where they are all the time and what they're doing ... you can never relax really.

Whilst Libby spoke of her four and seven year old sons, 'I'm really careful with what they do but sometimes they have an injury that is unbelievable. It's sometimes scary.' Furthermore, 'it can make you angry because you've been so careful.'

Risk-taking Behaviour

Participants asserted that firstly, some (not all) children are like their parents in personality, behaviour and attitudes towards life. That is, parents are role models for children in some instances and not in others. Lewis claimed 'it all starts, I honestly believe, it stems from the parents. You learn your manners and you learn what is a good thing and what is a bad thing from your parents.' Christopher argued:

414 See also Chapter 7: lay diagnosis and treatment of illness and injury, for further discussion of parents' emotions and tendency to blame when ill-health occurs.
I think that parents can prevent injuries. Parent's habits rub off on their children ... if the parents are reckless then that's a generational thing that continues down. Those sorts of habits. So very careful parents tend to have children who are also very careful. On an individual basis ... some just don't take any care at all. And so they're climbing trees and all that sort of thing ... but risk-takers in parents I think produce risk-takers in children.

Jo contradicted Christopher and asserted:

You can be a really careful parent and overdo it. Make your child so cautious that they'll miss out on a lot of things in life ... by missing out on the ferris wheel isn't going to upset his life but it could rub off onto his personality and he could miss out.

Secondly, children are also agentic selves and capable of autonomous decision-making, separate from and in conjunction with their parents (and others). With increasing age and development, their understanding of risks develops. They are also asserting their independence and a unique personhood (sense of self) that is distinct from their parents (and other siblings). In the late 1990s, many parents are working, studying or involved in other community activities outside the household. Therefore, it is not always possible for parents to monitor their children's behaviour at all times in all places; because they might be 'on the phone' or 'in the shower', said Tammy.

Risk-taking behaviour, participants agreed, depended on whether a person was 'cautious' or a 'risk-taker'. Parents used these terms. 'Some people are daredevils', said Marcella. It is not an either/or factor. Rather, being labelled as cautious or likely to take risks, rests upon a dialectical relationship of human behaviour. Pam indicated that her twelve year old son 'would average at least one or two [accidents] a year': for example, 'he sliced his feet open and put a cigarette lighter 'to his lips to see whether it was hot'.

He is extremely coordinated and therefore a rather gifted sportsperson ... he's a risk-taker ...
he's not into jumping out of parachutes ... but nevertheless he seems to push himself a bit further than he should all the time. And then we have to pick up the broken pieces.

Hugo explained he and his wife applauded and fostered their children's curiosity, whilst they also encouraged self-responsibility. He also noted personality differences between them. Five year old Ruth will show an interest in an object and then move on to something else. Whereas three year old Toby will 'definitely' try something and 'then

---

416 See ABS (1994a, 1994b), Clinton (1996), Edgar (1997), Maushart (1997), McKenna (1997). A parent's presence or absence when their child became ill or injured is a factor in their lay diagnosis. See Chapter 7 for further discussion.
decide [sic] he didn’t like that. Neil described his propensity towards being ‘cautious’ and the imperative for ‘pre-planning’.

I’m a very conservative person, so I don’t jump out of trees with a parachute ... Hopefully you think things through before you do most things ... I’m quite happy to try. I’ve done some dangerous things ... Well I’ve built shearing sheds and hay sheds for three years, and I mean you’d be up a ladder, and hanging off roofs ... But you made sure you had somewhere to jump ... I won’t go out and jump in an ultra light plane.

Being cautious could save a person’s life, whilst risk-taking could represent taking advantage of life opportunities as they present themselves (Modjeska 1994, Dattner 1996). These descriptions are not related to gender or age.⁴¹⁷ See Table 6.4.

<table>
<thead>
<tr>
<th>Table 6.4: Being ‘Cautious’ and Being a ‘Risk-taker’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cautious</strong></td>
</tr>
<tr>
<td>• conservative, careful, thoughtful, pre-planning, commonsense, moderation, scared, nervous, lack confidence, level-headed, mature, watchful</td>
</tr>
<tr>
<td><strong>Risk-taker</strong></td>
</tr>
<tr>
<td>• challenges, hyperactive, energetic, fun, stupidity, ‘pushing oneself a bit further’, peer pressure, inquisitive, curiosity, irresponsible, over-indulgence, ‘going beyond one’s limits’, excessive, exploring, active, reckless, dare devil, ‘going out on a limb’, well-co-ordinated, rebellious, ‘taking the next step’</td>
</tr>
</tbody>
</table>

Furthermore, what one lay person may consider a risk or risk factors is relative (not absolute) to another. Different individuals are ‘comfortable’ with different risks. Participants gave examples of different risks that they perceived themselves, their partners, their children and others are prepared to take. See Table 6.5.

⁴¹⁷ Lewis reflected upon his adolescent risk-taking behaviour and contended there are gender differences in risk-taking behaviour. ‘As a male, I know that from what I’ve seen of my “girlfriends” [during adolescence], my boyfriends were mates ... is that we tend to take more risks’, resulting in negative outcomes.
### Table 6.5: Different Risks for Different People

- Alcohol
- Illicit drugs (*marijuana, heroin, speed*)
- Smoking
- Climbing trees
- Martial Arts (*Tai Kwando, Shoot Fighting, Karate*)
- Riding Harley Davidson motorbikes
- Hot air-ballooning
- Eating unripe berries and fruit
- Swings
- Certain foods
- Roads
- Poisons
- Ultra-light planes
- Sky-diving
- Bungee-jumping
- Ferris wheel
- Boogie-boarding
- Climbing roofs

On a scale of what constitutes high to medium to low risk (with degrees of variation in between), participants indicated that this is an intangible, often non-quantifiable and personal estimation. There are several mitigating factors affecting this scale and whether a person is likely to take risks in everyday life. See Table 6.6.

### Table 6.6: Factors Affecting Laypeople’s Perceptions of Low to High Risk

- ‘Knowing’ one’s limits
- Self-esteem
- Risk changing in time and place
- Peer pressure
- Having fun
- Childhood memories
- Participant-observation in risk-taking behaviour
- Experience of outcomes

Firstly, ‘knowing’ one’s personal limits. As a parent this also means ‘knowing your child’ and *their* limits. Fran spoke of her sons aged six and three years:

[They] will climb and leap off tables and stuff. I know that they won’t hurt themselves. I hope they won’t, but because they’re both active children and they’re fairly well co-ordinated. If it was another child who wasn’t that way inclined, I would be saying, ‘don’t do it, you will hurt yourself’ ... as long as I’m sort of keeping an eye on them, then I think they’re fairly safe.

---

[218] ‘Knowing your child’ was frequently reported by parents as a way of diagnosing an illness or injury. See Chapter 7 for further discussion.
In contrast, Scott's five year old daughter has cerebral palsy and 'some balance problems'. His concern was 'about trying to anticipate dangerous things like sharp corners, slippery rugs, obstacles on the floor.'

A second factor is self-esteem: personal confidence, security, lack of fear and self-assurance. Jo related that her son Connor will:

climb the highest tree and wouldn't think that, that was dangerous to him because he has climbed trees before. But there's a lot of other things. Because we've said, 'be careful'. He becomes a real wimp and won't try things that I say, I wouldn't let you do this if I didn't feel ... He wouldn't go on the Ferris wheel for example. He won't go on the Ferris wheel, but Georgie [my daughter] will ... because 'it's all too high and it's too scary'. So you worry whether you're over [protective].

Nadia, Kay and Rose reasoned:

_Nadia_ But if your children want to do something ...

_Kay_ ... there are challenges.

_Nadia_ And then maybe they won't want to take the risk to do it. They won't do it, but they want to. They're too nervous, with a lack of confidence.

_Rose_ Because they [the children] don't perceive that as a risk. If they've got tree-climbing down to a pat, that's not dangerous for them.

A third factor affecting laypeople's scale of risk is the nature of risk changes in time and place (playground, beach, garden, farm, workplace) and activity (fixing the car, mending a fence, playing on the monkey bars, or in the swimming pool) (Beck 1992, Bunton et al 1995).

Fourthly, the impact of peer pressure is more likely as a child grows older and has friends. Adolescence - ages 10-19 years - is the 'age of exploring and trying new things out', said Beth. It is also a time in the life course, 'when friendships between children change all over the place', affirmed Carrie. Given a paternal history of cardio-vascular disease (manifested by hypertension and high serum cholesterol levels) exacerbated by smoking, Carrie was concerned about her six year old son also developing cardio-vascular disease. 'We'll have to watch him during his teenage years' owing to the imputed tendency of adolescents to eat 'fast foods' and be rebellious against their parents' wishes, whilst asserting their independence and developing personhood. Helen readily expressed her fears of her adolescent son being exposed to smoking, alcohol and drugs by his peers at 'wild parties'. Lewis recalled participating in criminal activities

---

*See Brandon (1994), Steinem (1994), Rossmanith (1997).*
such as shoplifting, robbing money - 'burgs' (burglaries) - and ingesting illicit drugs as an adolescent due to peer pressure. As an Anglo-Australian, he 'wanted to impress' and fit in with a group of adolescent boys of other ethnic backgrounds in his neighbourhood (Russian, Croatian, Scrbian, Macedonian).

They thought it was great Lewis [was] coming back with all this 'dough' [money] and all that.
They didn't really care where he was getting it from. They knew it wasn't legal, but it kept them on the 'pinnies' [with money in their pockets], kept smokes in their mouths [cigarettes].

This behaviour continued until he presented in court, accompanied by his parents, and faced the possibility of being sent to a youth rehabilitation centre in Melbourne. It was at that point, Lewis recalled that it was not in his best interests to continue this type of risk-taking behaviour.

Fifthly, wanting to have fun is a positive inducement to taking risks and advantage of life's opportunities.60 Neil regarded his wife, Margaret as a risk-taker. In celebration of her '40th birthday' - she wanted to 'go for a ride in a hot-air balloon ... or ride down the Great Ocean Road on a Harley Davidson [motorbike].' His concern for her well-being was the risk of an accident as a result of these activities, regardless of her pregnancy at the same time. 'I am old-fashioned. I don't want my kids to have a motorbike ... I just think they're too dangerous. I've seen too many people killed or injured.'

A sixth factor, 'childhood memories' - what they did or didn't do - may be an impetus for risk-taking. Now in their mid 20s to late 40s, many women and men in the study admitted and reflected upon their regrets on 'missing out' on certain life experiences (cf. Beck et al 1994). They wished they had, had more courage and less fear to have taken up opportunities and 'follow their bliss' (Campbell 1988, Jones 1998). As parents, participants wanted their own children to not also 'miss out'. Jo remembered:

when I was a kid we went water-skiing. The whole family. I would never do it because I was too scared. So I feel now that I missed out on that and I wish that I hadn't. So I want to be careful that you don't make them [my children] too cautious and make them not take any [risks] ...

Finally, laypeople's first-hand participant-observation in risk-taking behaviour and/or personal experience of outcomes of risk-taking behaviour - injuries or fatalities - may act as deterrents to risk-taking. Lewis recalled two friends from his adolescence

who currently have an intellectual disability and display anti-social behaviour resulting from alcohol abuse and drug overdoses. He now considers this behaviour as 'stupidity'.

The Importance of Being Safe

If there are unknown risks, some risk factors are within control, and risk-taking behaviour can lead to illness and injury, then the importance of health education is to instigate measures of safety, thereby reducing morbidity and mortality. Laypeople have their own conceptualisations of safety. Whilst they recognised the unpredictability or randomness of illness and injury, parents imposed ‘safety rules’ based on ‘commonsense’ upon children, and their activities both within and outside the household: as a means of exerting some control over risks and risk-taking behaviour (cf. Roberts et al 1993, 1995). These safety rules also indicate lay assessment of risk (Frankel et al 1991). Within their households, women and men in the study hoped to avoid extreme risk-taking behaviour, accidents and the outcomes: loss of limbs, broken bones, burns, electric shocks, gastro-intestinal or respiratory infections. ‘Safety behaviours [are] behavioural responses to risk mediated by cognitive, affective and structural factors’ (Kronenfeld et al 1997:206). Table 6.7 provides examples of safety rules indicated by parents that they reinforced in their households, often through explanation and raising awareness (nagging and repetition).

<table>
<thead>
<tr>
<th>Table 6.7: Parents’ Safety Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Not to touch the heater’</td>
</tr>
<tr>
<td>‘Push the pot with the handle to the side’</td>
</tr>
<tr>
<td>‘Not playing with matches’</td>
</tr>
<tr>
<td>‘You don’t let your child play on the road’</td>
</tr>
<tr>
<td>‘Don’t go on the swings so high’</td>
</tr>
<tr>
<td>‘It is naughty to break property’</td>
</tr>
<tr>
<td>‘Tell me if one of the children does anything, if they’ve been naughty or doing anything dangerous’</td>
</tr>
<tr>
<td>‘Be careful. Look out for Sally when you’re on the swings’</td>
</tr>
<tr>
<td>‘You don’t run on roads’</td>
</tr>
<tr>
<td>‘Don’t touch dangerous things’</td>
</tr>
<tr>
<td>‘No running’</td>
</tr>
<tr>
<td>‘Don’t touch that. It will make you sick’</td>
</tr>
<tr>
<td>‘You’ve got to wash your hands’</td>
</tr>
<tr>
<td>‘Look to the left and then look to the right’</td>
</tr>
<tr>
<td>‘Use the stairs’</td>
</tr>
<tr>
<td>‘Don’t climb over the balcony’</td>
</tr>
<tr>
<td>‘No silly manners at the table’</td>
</tr>
<tr>
<td>‘Everything in moderation’</td>
</tr>
<tr>
<td>‘Get out of that tree’</td>
</tr>
<tr>
<td>‘No bare feet’</td>
</tr>
</tbody>
</table>

Research on child health, illness and injury emphasises that the locus of responsibility for well-being lies with children themselves, parents, health professionals and
governments. In this context, the family serves as a microcosm of public health surveillance. Parents are 'watching over' their children with marked panoptic tendencies (Foucault 1973, Armstrong 1983). Parental (especially women's) surveillance of children is encouraged by the architectural design of contemporary housing. Open plan living with a centrally located kitchen enables adults to watch children in the family room whilst cooking meals.

Apart from implementing safety rules, participants resorted to two safety measures to minimise the incidence of accidents and the severity of illness and injury in the household setting. Firstly, they endeavoured to 'remove the hazard'. This involved a radical structural change or physical modification to a building or living abode to ensure a 'safe environment'. Having a fence around the backyard swimming pool, stair-rails, electricity safety switches, 'earth protection on the power points', smoke detectors, safety locks on cupboards, a locked garage meant that their children had somewhere to live and play 'safely'. Secondly, by encouraging individual behavioural change, coupled with self-responsibility, parents hoped their children would 'avoid hazards'. For example, bike-riding with helmets, minimal household use of chemicals, appropriate clothing and footwear for weather and activity, swimming lessons. And if, despite these precautions, accidents still happened, then at least parents could feel secure that the resulting illness or injury was more likely to be minor and heal quickly, rather than be major and require both emergency and prolonged treatment.

CONCLUSION

Missing from the public health discourses on health education, health promotion and illness-injury prevention - including the Jakarta Declaration (WHO 1997) - are laypeople's discourses and practices. Whilst public health professionals make a distinction between health education, health promotion and illness-injury prevention, for laypeople there is no clear demarcation between these categories. Rather, the fine line between them is blurred, nebulous and continuous. Furthermore, the majority of health promotion policies and programs have focussed upon schools, the workplace, community and clinical settings. There has been scant attention to how laypeople undertake health promotion, as part of their lay healing practices, in the household setting. Most of the health promotion activities that the participants in this study discussed, relate to 'educating children' about nutrition, hygiene and safety.

The age and gender of each generation - of parents and children - in the household provides a context for health education, health promotion and illness-injury prevention in everyday life. The major foci, participants agreed, were food, hygiene and safety.

Some parents decided to commence practising health promotion and illness-injury prevention from the time their children were born, whilst others considered their child's advancing age and independence, before introducing a particular issue (bike-riding, sunscreen). Participants asserted that the nature of the parent-child relationship and the value placed upon independence, responsibility, discipline, negotiation and respect, provided a context for these activities. Parents stated that they invested considerable time, energy and emotional labour to maintain these social relationships.

Both women and men in the sample indicated they teach their children about health as part of incidental learning in the context of everyday life: practices, values and activities. The data confirms Freire's (1992) argument that: i) education is a means of overcoming oppression; ii) knowledge flows in several directions; and, iii) education is not restricted to the classroom of schools or universities but may occur in numerous settings, including the family home. To promote health and prevent illness-injury in the household setting, laypeople resort to five 'ways of teaching': i) teach by example; ii) 'explanation'; iii) 'learning from experience'; iv) 'negative injunction' entailed both 'reverse psychology' (treat with the opposite) and the 'homoeopathic approach' (treat like with like); and, v) 'raise awareness'.

Laypeople's discourses on risk, accidents and safety reveal numerous tensions between: agency and structure, control and random, individual and collective interests, and, rights and responsibilities. These are not perceived in an either/or position but rather as and/or. Firstly, risk can be conceived as both controllable and occurring at random. Secondly, knowledge of risk is imperfect. Therefore lay assessment of risk is based on what is known, making it difficult to evaluate and prevent unknown risks in everyday life. In addition, what constitutes risk for laypeople is markedly distinct from that of public health experts. Thirdly, when accidents occur, laypeople consider the locus of responsibility (individual, structural or both factors), and whether they could have been prevented. They also investigate the causes and effects of the circumstances which led to accidents, whilst identifying the source of blame. Fourthly, participants agreed that: i) not all children are like their parents; and, ii) children are 'agentic selves', capable of autonomous decision-making. However, parents rely on their children to be responsible and minimise their risk-taking behaviour in situations where parental supervision is absent (crossing the road, bike-riding). Fifthly, laypeople define themselves and others as 'cautious' or as 'risk-taker' in both positive and negative terms. The labelling of a person and their behaviour is independent of gender and age, but includes the individual's personality. Sixthly, there are different risks for different people, and 'lay assessments of risk' vary according to a subjective and relative scale: from high to medium to low. Finally, laypeople impose 'safety rules' (based on commonsense) in their households, and expect their children to follow them both within and outside the household. At the same time, laypeople also minimise the incidence of
accidents and the severity of illness-injury within the household, by 'removing hazards' (structural change) and 'avoiding hazards' (altering personal behaviour). They are thus fulfilling their unofficial public health role of surveilling and sustaining children's well-being in the household setting.
CHAPTER 7
LAY DIAGNOSIS AND TREATMENT OF ILLNESS AND INJURY

Lay Healing Practices in the Household

Dean (1980, 1981) and Kleinman (1980, 1995b) argue that the amount of 'self-care' instigated in the popular sector of the health care system is extensive, but assert there is little empirical evidence to support this view. There remains limited recognition and attention to the internal workings of the household as a setting for laypeople's healing activities, nor their importance for public health.\textsuperscript{422} Furthermore, the household is an example of a 'therapeutic landscape' (A. Williams 1998): \textsuperscript{423} the site of healing undertaken by laypeople, employing their physical and emotional capital (Bourdieu 1977, Illouz 1997). The majority of health care studies, as I argued in the introduction of this thesis, have concentrated upon 'modern medicine' and other forms of healing - 'expert' and 'specialist' diagnosis and treatment - which exist outside the household.\textsuperscript{424} This study affirms the presence of medical pluralism in Australian society.

The UN Children's Convention (1989), to which Australia is signatory, acknowledges that children have a right to health and health care. Article 24 states:

States Parties recognise the right of the child to the enjoyment of the highest attainable standard of treatment and to facilitate for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services (in Alston and Brennan 1991:118).

The Convention does not specify whether such health care services should be formal (provided by the state) or informal (provided by parents within the household); merely that children have a right to good health and to accessible health care. Australian health authorities recognise that social and economic factors have an impact upon children's health.\textsuperscript{425} Family size and structure, and parental education, employment status and income levels have differential influences upon women's and men's capacity to provide essential material conditions for life: food, shelter, heating, sanitation, transport and recreation. In turn, parents' ability to ensure a reasonable standard of living and a healthy, safe and supportive environment for their dependent children - with or without


\textsuperscript{423} 'Therapeutic landscapes are those changing places, settings, situations, locales, and milieus that encompass both the physical and psychological environments associated with treatment or healing' (A. Williams 1998:1193, cf. Gesler 1992). Other therapeutic landscapes could be: hospitals, community health centres, women's refuges, naturopath's clinic, folk healer's community, a church, a sacred site.


government and community assistance - is directly related to child morbidity, mortality, quality of life and well-being.\textsuperscript{426} These structural factors have implications for laypeople's healing practices in the household, in terms of lay diagnosis and treatment.

Given this scenario, I wanted to ascertain how much healing laypeople provide in their households: before and instead of pursuing other healing options outside the household. Mayall (1986:139) reports that out of 135 mothers, 59% 'cared for the child without consulting a health professional. Many of these episodes were of symptoms or conditions familiar to the mother and she knew how to deal with them' (my emphasis), and did so within the household. In the current study, both mothers and fathers reported extensive lay healing practices to manage ill-health within the household. For example, Beth stated:

\begin{quote}
I'm not a great one for medicine proper, for myself or my children ... we usually cope with things at home. Keeping them in bed. Drinks and just keeping their heads down ... you can usually cope at home if it's something simple.
\end{quote}

Blair admitted, 'I tend not to like to be too quick to go to the doctor and give it time to settle, 'cause there's a lot of 24 hour things [flus] around.' Sarah made a distinction between lay and biomedical healing practices.

\begin{quote}
Even with my sons; if they have what is obviously a virus, it is useless taking them to the doctor, because the doctor would just say, 'put them to bed and rest.' So if it is something that is obviously an infection, like if they have got an earache or something like that I will take them to the doctor. I know that if it is just a cough then the doctor won't be able to do anything about it except just general treatment that I could do at home, then what is the use of doing that? So I am not one of those who run off to the doctor for any little thing, but if I feel that it is warranted then I will take advantage of the services that are available.
\end{quote}

The context for these practices entails oneself and significant others, the parent-child relationship, and lay health knowledge and decision-making within the household setting.

Using examples of illness and injury of themselves, their children and others, participants' narratives present 'lived experiences' of lay diagnosis and treatment, and clinical encounters with other healers (cf. Murphy 1987, Duff 1993, Frank 1995). They also reveal laypeople's 'voices', emotions, dilemmas, insights, conflicts and regrets resulting from their decision-making and course of action taken, in the interest of healing. In this chapter, I discuss the following issues as they pertain to laypeople as lay

healers - in this instance, parents of young children - producing health in the household: i) lay health knowledge of the body and of children; ii) lay diagnosis; iii) lay treatment; iv) the patient-healer relationship in terms of 'the affective partiality of lay healing'; and, v) 'decision-making when lay healing is not enough'.

LAY HEALTH KNOWLEDGE

Knowledge of What is Normal and Abnormal

'Normal' is something that is self-evident, taken-for-granted, the usual, to be expected, includes the majority and is the average. The range of normality includes degrees of sameness and differences. In contrast, what is 'abnormal' lies outside of this range. It implies deviance, pathology, disorder, non-conformity, defectiveness, the extreme and the marginal (Canguilhem 1989). What constitutes normality and abnormality rests upon both natural (biological, physical) and cultural (social) givens. We take-for-granted that our bodies communicate, ingest, excrete, copulate and sleep. We also assume that it is normal for people to have parents, are able to independently dress and feed themselves, and can socially interact with others. These bodily and social activities are normalised and shaped by historical and cross-cultural notions of what constitutes normal human bodies and behaviour.\(^{427}\)

Knowledge of what is normal and abnormal enables a healer to distinguish between 'embodied norms' and 'bodily alterations', and to make a tentative diagnosis.\(^{428}\) The healer 'reads' the signs (observable indications) and symptoms (complaints), and interprets them (Kleinman 1995b:73).\(^{429}\) The questions are: how to make sense of these? What do they mean? It is only by being aware of what is normal (from a baseline), that a healer can establish what is abnormal. Backett (1990a:61) remarks:

Family members have potential insights into one another's health in several ways. They have access to a rich fund of genetic, biological, and contextual knowledge about one another's health. Also, there is particularly high visibility of the individual's health and illness, whether or not any 'problems' are deemed to be occurring (author's emphasis).

In this study, participants (as lay healers) considered the following multiple factors: i) age and gender of the person; ii) their physical, mental and spiritual health status; and iii) behaviour in determining what is normal or abnormal.\(^{430}\) Similar to Kai (1996b:987), parents in this study 'used combinations of behavioural and symptomatic clues assessed against any deviation from what was normal for their particular child'. Excerpts from


the focus group discussions and interviews provide examples of participants' discourses and knowledge of what is normal and abnormal, and distinctions between illness and injury:

They look different when they're seriously injured ... they usually do something different to normal. (urban)
Any tell-tale signs. (coastal)
Any unusual behaviour. (rural)
Not their normal selves ... there is a change in their personality. (urban)
Abnormal behaviour. (urban)

Parents were concerned about physical illness and injury, as well as mental illness, stress, bullying and child abuse. These conditions visibly manifested as: 'withdrawal', 'behaviour pattern changes', 'social interaction changes', 'not their normal personality', 'excessively lethargic', 'yelling at me a lot' and 'putting on an act' indicated Edith, Francesca, Dean, Francis, Jack and Gillian. Other signs of emotional distress were: 'whingeing', 'crying', 'screams', 'sadness' and 'irritability'.

If parents 'know' that their children are not conforming to a picture of good health and well-being, how is it that they know? Participants relied on a variety of sources of knowledge: from intuition to their mothers to scientific knowledge in medical journals (cf. Cunningham-Burley 1990, Lauritzen 1997).

**Embodied Knowledge**

Participants in the study displayed ample knowledge of the human body's anatomy and physiology, and which stemmed from both allopathic and alternative perspectives (such as traditional Chinese medicine, energy flows and acupressure points). They were able to describe and locate body organs and systems, and changes to normal bodily structure and function. However, this lay knowledge is not as specialised as that knowledge held by biomedical and alternative therapists whose tertiary education and training includes substantial study of human anatomy and physiology, and disease process.401 Participants drew heavily upon their embodied knowledge to: i) assess the meaning of the presenting signs and symptoms of ill-health (tachycardia, skin rash, intractable pain); ii) determine what was normal and abnormal to facilitate making an initial tentative diagnosis and a subsequent more concrete one (heart attack, asthma, haemorrhage); iii) which further influences their decision-making on the most appropriate form(s) of treatment (neck collar, dietary changes, analgesia); and, iv) evaluate therapeutic outcomes (scars, hospital admission, plaster cast).

'Knowing Your Child'

Not only do parents of young children have ample knowledge of the body's anatomy and physiology, their knowledge of their children is also extensive. 'You know your child' was frequently remarked upon by participants. 'Well you're with them from day one. I mean no-one knows your child better than yourself, I think', emphasised Connie. 'Knowing what is normal behaviour' enables laypeople - parents of young children, in this instance - to make an assessment of what is abnormal, and when their undivided attention is warranted when someone becomes ill or injured. Any behaviour that their children manifested as 'out of the ordinary', unusual or 'totally out of character' was immediately taken seriously by parents. Jackie asserted, 'if it's real to the child ... you have to examine them and assess that situation.' Parents noted sudden changes in their children's behaviour: lethargy, becoming 'distressed', unhappy, 'whingeing', 'grizzly', 'wanting a cuddle and affection', 'not eating', being 'off their food', crying or (keeping) quiet, being irritable or 'not wanting to go to school' (cf. Irvine and Cunningham-Burley 1991). For Gemma, a child screaming meant the injury is not serious, whereas no screams meant it's serious and it was vital 'to sit up and take notice'.

Participants could make a distinction between something that is 'really wrong' with their child and 'an attention seeking thing'. Jo, Patricia, Libby, Christopher, Marcella, Ingrid, Nadia, Rose and Kay related their responses to their children complaining of 'feeling sick'. Christopher indicated that he and his wife (both health professionals) tend to '[ignore] the minor illnesses. In the family, they get no sympathy for minor coughs and colds, unless it's a major illness.' Ingrid, Jo, Kay, Belle, Libby and Patricia responded in different ways to their children's well-being, in establishing a genuine case of illness or injury: 'trying to work out how sick they are', as opposed to 'any attention is better than no attention'. 'But all that comes with knowing your child too. You know when they're putting it on.' When the latter occurred the parent would give their child:

A pat on the shoulder. 'You'll be right. Come on. You're still walking. You don't need to go to the doctor's' ... 'You could be wasting his time if you're only taking it. And you get medication that is no good for you because you're not really sick. So if you're really sick we might just have to take you to hospital'.

---

432 See Backett (1990a, 1990b), Cunningham-Burley (1990), Lauritzen (1997). See also section: the negative consequences of 'knowing your child' in this chapter. Macleod (1993) and Radwin (1996) comment on the importance of nurses and doctors 'knowing the patient' to aid healing.
LAY DIAGNOSIS

National and international indicators of morbidity and mortality rely on data collected by health professionals, statisticians and government policymakers, although laypeople's self-reports of health status have been found to be reliable. Johannesson (1991) claims that morbidity statistics are often 'inflated'. Rather,

the study of morbidity levels during the world's health transition should start at the micro level, with how ordinary people are taught to recognise sickness, and what they should do about their perceptions (1991:59).

In previous studies the term 'lay diagnosis' has not been used. Instead, lay diagnosis is called 'recognition of illness and symptoms' and 'threats to health' (Irvine and Cunningham-Burley 1991, Lauritzen 1997). This study affirms laypeople are capable of diagnosing and treating ill-health in the household. Participants' narratives contain references to their own experiences or that of significant others within the household setting, contrasted with incidents of diagnosis and treatment of ill-health by diverse healers. Since the majority of their experiences with other healers were with health professionals, comparisons are made between lay and biomedical diagnosis and treatment. Factors crucial to lay diagnosis are: i) presenting signs and symptoms; ii) physical examination; iii) investigating the circumstances; and, iv) assessing severity of the condition.

Presenting Signs and Symptoms

Biomedical assessment consists of, firstly, observation using sight, and then physical examination using the other senses to inspect, palpate, auscultate and percuss a person's body (Foucault 1973). Laypeople are more likely to use their sight (observation), before touch (wound, sprain, fever) and hearing (breathing). Neil admitted, 'I'm not medically minded but visually, you can say "OK. This looks bad or it's not bad or whatever".' Jackie stated: 'if a child fell out of a tree ... obviously you would look at the physical signs and watch them' closely. When I asked participants: how would they know someone was ill or injured?, they spontaneously recited a litany of specific signs and symptoms.

Caroline, Elsa, Wendy, Bianca and Amalia Blood ... how loud they yell ... silence ... they cry when in real pain ... or they don't cry ... vomit ... they go blue ... they change colour.

Margot, Renata, Laura, Jackie, Barbara and Whitney Pain ... blood ... whingeing ... crying ... screams ... sadness ... irritability.

---

Mandy, Imogen and Nicole Screams from the backyard ... oozing blood ... unconscious ... bones protruding through skin.
Carmel, Valerie, Tracey and Sandra Blood ... bits and pieces hanging down ... crying ... pitch of cry ... they’re lying around ... they’re hot ... they’re throwing up or going to the toilet.
Francesca and Edith Pain ... totally unresponsive to stimuli ... lack of mobility ... lethargic.

Participants reported the following 'collection' of signs and symptoms related to body systems that they would observe when someone became ill or injured, and which they recognised as deviations from the norm (cf. Cunningham-Burley 1990, Irvine and Cunningham-Burley 1991). See Table 7.1.

<table>
<thead>
<tr>
<th>Table 7.1: Signs and Symptoms of Ill-health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>body temperature</strong></td>
</tr>
<tr>
<td><strong>pain</strong></td>
</tr>
<tr>
<td><strong>blood</strong></td>
</tr>
<tr>
<td><strong>breathing</strong></td>
</tr>
<tr>
<td><strong>state of consciousness</strong></td>
</tr>
<tr>
<td><strong>gastro-intestinal disturbances</strong></td>
</tr>
<tr>
<td><strong>skin colour</strong></td>
</tr>
<tr>
<td><strong>eyes</strong></td>
</tr>
<tr>
<td><strong>degree of mobility</strong></td>
</tr>
</tbody>
</table>

Rita emphasised the importance of 'being aware of each of the [signs and] symptoms that come with injury' and illness. Participants noted whether these occurred singularly or together with others. The presence or absence of particular signs and symptoms for certain conditions was crucial in their ability to make a 'correct' diagnosis with confidence. For examples of parents’ responses, see Table 7.2, with their initial diagnosis placed in italics.
Table 7.2: Bodily Signs and Symptoms

<table>
<thead>
<tr>
<th>Name</th>
<th>Symptom Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter</td>
<td>it may be sweating, perspiring ... redness around the cheeks... shivering, fever.</td>
</tr>
<tr>
<td>Richard</td>
<td>children having fever or they go into spasms or convulsions.</td>
</tr>
<tr>
<td>Ian</td>
<td>Going white in the face. shock.</td>
</tr>
<tr>
<td>Kelly</td>
<td>She had blisters on her feet ... spots on her hands and ulcers in her mouth. hand, foot and mouth disease.</td>
</tr>
<tr>
<td>Tammy</td>
<td>Blood. It was like a waterfall. haemorrhage.</td>
</tr>
<tr>
<td>Rita</td>
<td>Pupils whether they are dilated or not. Whether they have a headache, feeling a bit dizzy. concussion.</td>
</tr>
</tbody>
</table>

Signs and symptoms of ill-health may be firstly, physical, external and visible of bleeding, hot skin, respiratory distress, vomiting, discoloured urinc or faeces. 'Visibly ... that could be one of the cues. If they're bleeding or non-responsive or they can't move. You know there's something wrong because it's not the norm', stated Frances. A person's 'behavioural pattern' or 'social interaction' changes. 'I can just look at the kids' heads and I know that there is something coming. They get a look', responded Natalie.

Secondly, internal and invisible signs and symptoms may indicate malabsorption syndrome, liver dysfunction, septicaemia, kidney failure (Foucault 1973). It is more difficult for a lay healer to discern the severity of an ailment when s/he cannot see it, and requires high technology to establish a diagnosis: to 'visualise the invisible' (Sachs 1995, cf. Atkinson 1995). For example, unless there is a bone visibly protruding through the skin surface, it is often difficult to ascertain whether a limb is sprained or fractured. Xrays of the limb facilitate a doctor's diagnosis, and hence the appropriate treatment. The 'technological imperative' of biomedicine provides solutions to bodily alterations as well as fosters dependence upon high technology, whilst overlooking social relations (Bates and Lapsley 1985, Barger-Lux and Heaney 1986, Konner 1993, Willis 1997).

The severity of pain is a subjective experience and difficult to assess objectively - both by laypeople and other healers. Adults' and children's pain thresholds vary on an individual basis and relate to cultural differences, gender and age.444 Participants noted differences in pain thresholds between their sons and daughters, and adults and children. Patricia related:

Jeremy will complain about the slightest pain, whereas as Robyn tells me she's in pain, I know she's in pain. Because she never complains. So we always treat her as serious, whereas with Jeremy we'll say, 'you'll be alright'.

A child's pain threshold is a factor influencing parents' assessment of the condition's severity and determining the appropriate remedy to relieve it. Peggy believed it was 'a matter of judgement', whilst Nancy stated that 'it's not good judgement all the time.' Speaking from personal experience, she related the incident of her son having broken his ankle. On initial assessment it was swollen, and he was not complaining of pain. 'We took him in the next day and it was a green stick fracture'. Barbara narrated a similar incident when her daughter sustained a fractured arm. In other instances, some individuals appear to have a high tolerance of pain and can cope with painful procedures, illnesses or injuries without minimal analgesia or anaesthesia: for dental fillings, wound suturing, amputee phantom pains, bone marrow biopsy. Other individuals, for instance, suffering migraines, cancer or backpain, may need regular, increasing or stronger doses of analgesia to alleviate the pain (Sacks 1981, Morris 1991). Ian kept a supply of doctor prescribed analgesics to relieve referred pain from benign spinal tumours.

**Physical Examination**

In order to reach a 'lay diagnosis', laypeople check the sick person for further injuries and symptoms of ill-health. Following their observation that 'something was wrong' with their child, partner or another person, participants narrated that they would physically examine them.\(^435\) Their actions varied according to the condition and actions included: i) taking a temperature with a thermometer, feeling the person's forehead or 'check their neck';\(^436\) ii) cleaning an injury of blood and debris to ascertain the extent of blood loss and severity of the wound;\(^437\) iii) checking a person's mouth (teeth and tongue) if a head injury, fitting or facial wound; iv) checking for swellings, lumps, bumps and whether these are fixed or mobile, large or small. Also noting any inflammation, infection or bruising around the area the patient complains is sore or achcs, and noting any exudate (pus, blood, lymph), the amount and colour; and v) examining the patient's chest, abdomen, back and limbs to determine possible fractures, internal bleeding, paralysis that are usually accompanied by other signs and symptoms relative to the condition. For instance, Francesca would ask herself, 'is the person immobile because they're unconscious or have just fainted due to heat stroke?'

\(^435\) See below discussion on 'first aid' as a form of lay treatment.
\(^437\) Peter indicated 'the first thing ... would be to make sure the injury is fairly clean ... so wash it out with water. Perhaps put a bit of antiseptic on it, and if it is fairly large I would have to dress it with a bandage. Now if it was a more serious wound that may need to be stitched, then I would ... take her to the hospital, or to the doctor.'
Investigating the Circumstances

In Victoria (1994), the major categories of injury related hospitalisation of children aged 0-4 years were falls (22.8%), iatrogenic (19.6%) and poisoning (14.9%). Children aged 5-12 years were hospitalised as a result of falls (45.5%), transportation (14.3%) and iatrogenic (11.3%) (Department of Human Services 1997:5-6, cf. ABS 1995, 1997). The state health department's priority areas to address child injuries are: burns and scalds, falls in the home and playground, poisoning, drowning and dog-bites.

Besides 'knowing their child', and awareness of normal and abnormal anatomy and physiology, parents' knowledge of the child's (or adult's) circumstances and activity when an illness or injury occurs is an important factor for making a tentative diagnosis. This lay health knowledge relates to parents' constant surveillance of children's physical and social environment, and their adherence to safety rules; as discussed in Chapter 6. Using commonsense knowledge, participants reported that they sought to eliminate possibilities of causes of the condition: 'how did it happen?', 'where were they and what were they doing at the time?' and 'why did it happened?'. Francesca questioned:

If they were riding a bike or climbing a tree ... and if they did fall, the distance from where they fell from or ... something on the road or in the driveway.

Kelly reflected: 'We sit back and think, "where have we been and what have we eaten? What have you been doing?"' Brody (1987), Kleinman (1988a), and Frank (1995), discuss the importance of obtaining a 'story' from the ill and injured for diagnosis and therapeutic intervention. If the sick person is an adult, 'they would tell you what was wrong, what was hurting'. Blair stated:

My wife gives a grizzle too when she hurts herself because having worked in offices and things she's not used to physically injuring herself. I've always been a tradesman so I'm used to cutting myself and banging my fingers and things like that. I don't feel it much anymore.

Parents stressed the importance of 'talking to your child' to facilitate assessment of the condition. 'I would question them' said Donna. Sometimes, Neil noted, 'with the children, someone comes and tells you ... and would say 'oh such and such has done this.' Sarah argued the importance of knowing your child and taking them seriously, especially when two children indicate different responses to pain. She responded:
... my youngest son is a real ham and the slightest little thing ... I am worried that I am going to miss something real because he acts up so much for the smallest things; whereas my eldest son won’t say something unless I specifically question him about it ... I have to almost prise the information out of him. “Where does it hurt? How much does it hurt?”

Tammy explained that when ingestion of poisons was suspected, ‘you’ve just got to “hammer” the child with how much they’ve taken. You’ve got to work out how much they’ve actually taken’, before being able to taken any action. This requires knowledge of the poison, the amount ingested, and how to rapidly detoxify the body. Irene and Heather indicated they immediately called the Poisons Information Bureau for advice in treating their child, for example, for ingestion of cedar wood polish and Antrid solution. The family, as an informal agent of public health, is required by the State (via health and welfare institutions and policies) to surveil and ensure the health and well-being of children at the micro level, and to seek medical attention when an illness or injury occurs (Foucault 1973, Reiger 1985, Frohock 1992).

Furthermore, owing to a child’s age, when they are quite young, ‘they can’t really tell you so easily’. Blair noted of his youngest child, ‘the little one, the two year old, of course, won’t tell us but you’ll notice the difference in the behaviour.’ Whilst Gemma observed that when a child is one or two years old ‘they’re starting to tell you, but they can’t tell you sufficiently’, it is as they grow older that they can more fully describe their ill-health. A second reason for a child’s (and adult’s) inability to tell someone may be due to the severity of their condition: ‘shock’, haemorrhage, ‘pain’, ‘coma’, ‘deafness’. Sarah asserted ‘that it is obvious that something has happened to them - whether it scared them or hurt them.’

However, children may not always tell their parents that they’re injured - not because they may be unconscious and therefore unable to speak - but for their own reasons. Eleanor recalled having to rely on her own observation, as her son didn’t tell her what was wrong. She felt guilt and remorse that she did not realise his injury at the time.

Last night I pulled his hat up, because he had it over his head, and here he is with this whopping big cut across his eye. And I said, ‘what happened?’ And I’m yelling at him all the way home, ‘hurry up, hurry up’. He walked on a stick and it whacked him in the eye. And he had all this blood on his face ... He was running with the dog. And he put his hat over his head to not show it. I pulled up his head with this blood all over his head. And his eye was all cut. ‘Davis why didn’t you tell me? I’m yelling at you all the way home to hurry up.’ He burst into tears then ... He would never say he was hurt or anything. I only find injuries on him later ... So that’s observation. He wouldn’t have told me.
Natalie recalled her daughter falling off a horse and hurting her head, as she wasn't wearing a helmet at the time. She was afraid of her mother finding out the truth and forbidding horse-riding in the future. 'But she was sitting there and I was watching her and she was going white and passing out, and doing all sorts of strange things.' The lay diagnosis was concussion. Natalie rang the doctor who advised her to keep observing her. When her daughter started vomiting, Natalie related she panicked and took her to the doctor.

Parents consider their own presence or absence at the onset of symptoms. Blake, Jane, Karen, Hazel, Mandy, Imogen, Nicole and Leah indicated that 'witnessing' an accident - being present at the time - as well as 'someone has told you what's happened, like another sibling or other adults', gave them 'some sort of sense of something that's not quite right' and they could respond quickly (Roberts et al 1995). Hannah, Donna, Isabel and Gail remarked upon being absent when their child was injured, and their different responses to a hypothetical situation; loss of consciousness:

> If your child wasn't at home at the time, you don't know whether they're conscious or not. And if they come in like they've got a really bad headache or not quite themselves, they're a bit vague, 'hang on I'd better see whether it's a head injury or how bad it was' ... I observe their pupils and everything, but I'm more likely to take them to casualty to observe for 24 hours.

These women recognise the situation as life-threatening, are able to make a tentative diagnosis and recognise the need for immediate hospital care. Questions parents ask to ascertain the context of an illness-injury include: i) What was the location/setting of the incident?; ii) If at home, were they in the same room or in another room?; iii) Were they inside and the child was outside?; iv) What activity was s/he doing at the time?; v) What food and fluids were ingested?; vi) How did they realise something was wrong? Did the child cry, scream, become silent, or disappear (cf. Roberts et al at 1995)?

Assessing Severity of the Condition

There is historical and cultural variability on which signs and symptoms of a condition are considered more serious than others, and the meanings attached to these (Sontag 1991, Conrad et al 1995). Laypeople's 'emic' assessment of severity of a condition, decision-making and actions, are different to the 'etic' criteria used in hospital and clinic settings (Kai 1996a, 1996b, Lauritzen 1997).

Firstly, the imperative is to make a distinction between different conditions: emergency, life-threatening, and a condition that is chronic and requires long-term care. Secondly, the severity of the condition must be established. Thirdly, the necessity of imposing a time limit; that is, how long a lay person (parents in this instance) is prepared to provide self-care at home before seeking other therapeutic options:
immediately, two, four, twelve or more hours? Participants indicated that 'observation' was pivotal to assessing severity of condition.

*Eleanor* You observe them. You get a fair idea of when something is serious or is just superficial.

*Connie* You can tell just by looking at them. If they're pale or they look like they're going to pass out.

*Deidre* If the whinge goes on for too long ... for more than 30 seconds ...

After establishing the signs and symptoms, taking actions to confirm or disprove the initial diagnosis, investigating the circumstance that led to the condition, and establishing the severity, laypeople reach a lay diagnosis 'almost immediately' before deciding upon therapeutic intervention. Nadia responded:

With a child you've got to look at the situation and sum it all up in a split couple of seconds to work out, 'yes, I've got to take them into town to the doctor. Or no, I'll put a Bandaid on it.'

Heather said, 'I think with injury it's assessment before action. You assess the situation first and then only take action if you know what action to take.'

**LAY TREATMENT**

Empirical evidence of laypeople's treatment of illness and injury in the household setting is limited. Firstly, the majority of research examines self-care and mothers' - not fathers' - responses to their children's illnesses or injuries.\(^{43}\) The term 'lay treatment' is rarely used in the literature, but 'illness behaviour', 'illness management' and 'health-related actions' (Calnan 1987, Irvine and Cunningham-Burley 1991, ABS 1997).

Secondly, medical anthropology and sociology literature has used the term 'hierarchy of resort' (Romanucci-Ross 1977) to explain how laypeople seek treatment of illness and injury. Romanucci-Ross uses this term to describe the linear progression of healers and healing laypeople resort to when sick, in an hierarchical order; commencing with lay treatment and moving to 'traditional medicine' of indigenous peoples and subsequently to allopathic medicine. My data questions this concept. I contend that lay treatment is the 'primary resort' of healing that laypeople refer to instead of and in addition to other healing options. Laypeople are at the centre of various healing options, assessing and deciding which one(s) would be most appropriate. B. Wellman (1995:230) concludes from her study of persons with backpain:

Pathways to care were not necessarily linear progression from self-care through informal to formal care. There were multiple pathways - two or more sources of care being used at once - and many interludes in which clients [sic] used only self-care.

There is no 'hierarchy of resort'. Rather, therapeutic options for laypeople occur in different directions and overlapping concentric circles of healing. The use of one or more healing modalities may occur singularly or concurrently. This study confirms an absence of a hierarchy of resort: participants sought further information from diverse sources when someone is ill or injured (as discussed in Chapter 5), and multiple factors influenced their decision-making when lay healing was not enough (discussed later in this chapter).

Participants' narratives contain details of their lay treatment and therapeutic decision-making both within and outside the household. The term 'self-care' has been used as an umbrella term for a variety of lay healing practices, as 'self-treatment' or as 'self-medication'. The qualitative data confirms that laypeople's treatment of ill-health is much broader than 'self-care'. Rather, lay treatment consists of: i) first aid; ii) self-care; and, iii) self-medication. It is the culmination of laypeople - as parents in this study - knowing what is normal and abnormal (changes in the body's anatomy and physiology, and their children's behaviour), their actions taken to confirm or disprove a tentative diagnosis, their investigation of the circumstances of the condition (possible causes) and assessment of the severity of the ailment, that they make decision(s) about appropriate treatment. Therapeutic intervention may entail: administering first aid, providing self-care or self-medication at home, or resorting to medical attention, hospital care, or consulting an allied health professional, alternative therapist or folk healer. Essentially, laypeople exercise agency as the primary decision-makers of treatment within medical pluralism.

The following section addresses in detail three lay treatment options: i) first aid; ii) self-care; and, iii) self-medication. The data reveal the 'emic' meanings of lay treatment for participants in the study. Where appropriate, comparisons are made with 'etic' or specialist biomedical notions of lay treatment.

**Administering First Aid**

First aid is the immediate response to an emergency situation. First aid is a historical and universal practice; it is not new. Many laypeople respond to emergency situations with knowledge and confidence on what to do to save someone's life.

In Australia, laypeople are continually confronted by public health messages in the mass media on the importance of: i) subscribing to the ambulance service, to reduce

---

costs of transport to a hospital in the event of an emergency; and, ii) improve their knowledge of first aid measures in order to save lives. In addition, laypeople (including children) and emergency services personnel who save others' lives (sometimes at risk to themselves) are considered 'heroes'. They attain notoriety and public esteem, and may be awarded medals of bravery for their actions; epitomising social capital (Featherstone 1992, Cox 1995, Rayner 1997). However, despite the graphic portrayal of emergency and life-threatening situations by mass media, there appears to be little research on laypeople's responses when they are first on the scene and are faced with the moral imperative to 'do something' to help another person.

Irene was fatalistic about accidents; they 'happen so quickly'. She continued: 'it could be something that they've [children] done a hundred times before, and nothing's happened. But this one time, something happens'.440 Francesca affirmed that she felt confident in administering first aid, especially 'if it is within my capabilities' as she would not wait for an ambulance to arrive before a patient received treatment. In two coastal areas, Natalie, Pam, Marcia, Teresa, Vicky, Rachel, Olivia, Simone, Irene, Heather and Gillian discussed the importance of having first aid knowledge to save someone's life and deal with wounds, and their concern that few people in their coastal communities were 'known' to have first aid knowledge. Irene gave the example of her husband's knowledge and confidence in administering first aid, and distinguishing between a broken arm and a sprained arm sustained by their son.

When I reflect back ... he [my husband] never said anything. He just disappeared and came back with two rolled up newspapers and a gauze bandage ... and just splinted it [the arm and put] it in a sling.

The saliency of his actions was confirmed by a GP who 'didn't bother to take the sling off. He just looked at it' and recommended hospital treatment: xrays, plaster cast, analgesia, sling and rest.

Parents may feel uncertain or be doubtful of their diagnosis, lacking confidence in their own abilities at times. Eleanor stated: 'I think that your first aid is usually pretty well spot on. When I hum and ha a bit, it's when I lose my confidence.' However, there was consensus amongst participants that if first aid was necessary and if 'you don't have any idea what to do, you should get expert help'. Heather was of the opinion that 'a lot of people cause more damage than good ... Unless you've done first aid and you can hold things up until you get to the hospital.' However, 'if it's something that you can't handle ... you should just call an ambulance', to prevent further 'damage'. Andrea admitted that she 'would probably take them elsewhere a little too often. Things that I

could probably deal with at home'. However, 'sometimes it is not clear' what the full extent of the injury is, and so she 'would probably take them to the emergency department or a specialist.' The uncertainty of, for instance, a fractured limb, head injury or concussion is a prompt for this parent to seek further assistance and another healing option. Whilst Rita indicated that she would 'look back on my experience' as a registered nurse to establish whether it was serious enough to visit a doctor. 'And if I am not sure then I would always seek expert help.'

Self-care at Home

Dean (1983:20) emphasises that 'self-care is neither a new or fringe phenomenon. It is the basic health behaviour in all societies'. Furthermore, laypeople exercise agency in providing self-care for themselves and others. They are determining which form of lay treatment would be most appropriate for the presenting condition, and the household resources required to improve health status (cf. Mokyr 1996a, 1996b). More recent studies examining lay knowledge and self-care for their babies and young children focus on women† - not mcn - and on 'families'.‡

Laypeople are active not passive healers (Worsley 1982). They have control over their health and well-being to the extent that only they can decide what is appropriate for them as individuals, their bodies and lives (Dean 1990), and what resources to access and use in self-care (Peerson 1991). Some examples of self-care include: religious rituals, prayers, rest, massage, special foods and herbs, ice packs, friends and family for support (Chrisman and Kleinman 1983). These activities are closely aligned with individuals' concepts of health and causation of illness, and build upon lay knowledge and experiences which may be transferred across generations, but are greatly undervalued by biomedical health professionals as unreal or illegitimate. These activities are positive and therapeutic with the aim of preventing and overcoming ill health (Peerson 1990).

The common remedies used by both laypeople (including parents) and health professionals for treating fever are: giving the person some Panadol to lower their temperature, keeping them cool by bathing or sponging with lukewarm water, and encouraging a lot of oral fluids, whilst watching their urine output.† Participants gave a rationale for these practices as: 'You don't want them to dehydrate', or have a febrile convulsion. Peter indicated his actions when one of his three children became feverish. His 'first priority' is:

---

to try to reduce the temperature ... perhaps [with] a cold face flannel ... On the forehead. Or a cold bath ... Then the second thing would be to look for the Panadol ... Just to make the patient a bit better.

Blair indicated how he took care of his sick children at home, using 'infant pain relievers' and encouraging bed rest.

Quite often they don’t want to go to sleep. So I put a few cushions on the couch, making up a bed basically. They lay back there and watch some videos or read some books with their Teddy, and sooner or later they drop off to sleep anyway. So just keeping them quiet, warm, comfortable. All the time, I’m offering them drinks to make sure that they’re getting plenty of fluid ...

If the fever persists for 24-48 hours, dehydration has occurred or other symptoms co-exist (profuse sweating, nausea, vomiting, diarrhoea), participants reported they would take the sick person to a doctor.

Ochiltree and Greenblat (1991) report that when Australian working mothers have a sick child, they or their partners take time off from their paid work (often as personal 'sick leave') or they use their flexible working hours, or rely on relatives, friends and neighbours. Parental leave is a recent phenomena in the Australian workplace. Fifty-two women in the sample indicated they did home duties and were the primary caregivers in their households. They described their occupation as: 'home duties', 'housewife', 'home management', 'Mum' and 'mother' (Oakley 1985). Some women worked full-time or part-time, others did some voluntary work in their local communities or cared for their sick parents (cf. ABS 1994a, 1994b, 1998b). In this study, in order to ascertain the extent of self-care laypeople undertake as a form of lay treatment, I asked participants the following question: who takes care of someone when they are sick? Their responses listed in Table 7.3, indicate both a mix of household labour by members (who does the minding and who gets time off work most readily) as well as calling on 'outside' help.

In the majority of instances, participants reported that it was 'themselves' (N=50) who took care of the sick. Donna, Adrian, Kelly, Connie, Blair, Deidre, Eleanor, Ian, Valerie, Christopher, Tracey and Debbie are primary caregivers and healers in their households. As Fiona and Hannah reported:

---

444 The question of who works in the household, whether they work full-time or part-time, and the number of hours they worked during the week was not specifically asked in the questionnaire. Some details are evident in the qualitative data, but are not available for all participants.
Fiona My husband dry retches if he sees the children get sick. [Laughter] That could be worse, because I [would] then have his mess [ie. vomit] to clean up too ...

Hannah My daughter gets a lot of blood noses, and I know I'm the one that gets to clean up all the mess when that happens. Change the sheets, etc.

<table>
<thead>
<tr>
<th>Table 7.3: Household Labour when Member is Sick (N=98)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
</tr>
<tr>
<td>Self and Partner</td>
</tr>
<tr>
<td>Self or Partner</td>
</tr>
<tr>
<td>Partner</td>
</tr>
<tr>
<td>All other household members</td>
</tr>
<tr>
<td>Grandparents</td>
</tr>
<tr>
<td>Family doctor</td>
</tr>
<tr>
<td>Specialist</td>
</tr>
<tr>
<td>Professional Nanny</td>
</tr>
</tbody>
</table>

* Missing cases (1)

Twenty-four participants revealed that both 'themselves and their partners' attended the sick. It was a joint activity and responsibility, regardless of gender. Elizabeth, Belinda and Sarah agreed: 'my husband and I, 'we both do it', 'we work together as much as possible'. Both partners either take time off paid work (as part of their sick leave, annual leave or parental leave) or work flexible hours so there is someone at home at all times to be with the sick child. Andrea stated, 'even if Callum was there I would probably intervene'.

Twelve participants responded that either 'themselves or their partners' took care of the sick: 'whoever is at home', 'the person at home'. Both Imogen and Owen agreed 'which ever parent was available' as 'the kids go to either of us. No set person'. Irene narrated,

My husband is wonderful. So if I have a sick child, I do it during the day. And then when he's around, when he's available, when he's home, he has no qualms, no hesitation to just take over and look after this person.

Richard was adamant that his 'partner' - a health professional - have primary healing responsibilities for care of their two children when sick. 'You're the doctor. I know how to fix cars, and build rooms. You know how to make bodies healthy. You do it'. Richard considered this division of labour as equitable given his lack of prior experiential knowledge of ill-health. In other instances, 'all other household members' will unite their efforts to care for the sick: 'we all try to take care of each other'.

Marcia's husband had, had a back injury for 'five years' and 'has been unable to work for 12 months'. Consequently, she and her children assisted her husband with his daily activities, despite his chronic pain and frustration at being dependent and his difficulty in maintaining his masculine identity as 'head of the household' (cf. Eccleston et al 1997). Marcia asserted she now had major responsibility for the family's health and welfare.

In terms of 'outside help' when someone is sick, participants drew upon a range of people to assist them. When Ian or his sons are sick, going to the 'family doctor' was the most feasible option. It meant having 'someone to take care of us'. He rationalised his actions for consulting the doctor as: 'I quite often go there because we need putting and nurturing. He's love and reassurance whatever. Someone taking care of you.' Patricia's husband has a kidney disorder. When he is acutely ill, they would consult a 'specialist' for his treatment. If his daughters are sick during the week, Michael indicated that he and his wife would first take them to the doctor, 'to get something to work for improving it [the condition]'. Since they were both self-employed and needed to keep working in order to maintain their income levels, neither partner felt they could take any time off work to be at home with their sick children. Rather, they would phone a nanny agency in Melbourne for a 'professional nanny' to look after their child for the length of time she was ill. Four participants responded they would ask their children's 'grandparents' who lived in Geelong to help them when sick.

**Self-medication**

Helman (1981), Montagne (1988), van der Geest and Whyte (1988), and Nichter and Vuckovic (1994), have explored meanings, symbols, images, metaphors and ideologies of drugs as factors influencing laypeople's consumption of medicines. Van der Geest et al (1996) examine the 'lifecycle' of pharmaceuticals from production, marketing, prescription, distribution, purchasing, consumption to efficacy (cf. Nichter and Vuckovic 1994) Various stakeholders in the pharmaceutical industry (pharmacists, doctors, government policymakers and consumers) have expressed concerns about laypeople 'hoarding' drugs and medication at home, and the risk of such drugs becoming 'out-of-date'. Additional concerns are: 'rational' drug use, 'drug monitoring', drug-related admissions to hospital, morbidity and mortality (accidental poisoning, overdoses), problems with particular drugs, compliance and drug/drug interactions.445

The National Health Survey (1995) indicates approximately 70% of persons reported using medications, as the most common health-related action, while 23% of

445 The qualitative data on self-medication from interviews and focus group discussions was voluminous. A full discussion on self-medication will be in a forthcoming paper.
persons consulted a doctor (GP or specialist) (ABS 1997:6). We could call self-medication by laypeople, 'lay pharmacotherapy'. Laypeople administer both doctor-prescribed drugs and over-the-counter medicines (OTCs), as well as self-prescribed medicines and home remedies. Laypeople often determine and self-select medicines they consider 'suitable' for their households, when ill-health occurs. It is possible that some of these products may be 'recommended' by doctors and alternative therapists, but which do not formally require a prescription for state authorities purposes (National Health Strategy 1992b). Participants readily indicated their own self-medication to themselves and significant others. They were aware of the following factors concerning OTCs: i) adult versus child doses; ii) side-effects; iii) use-by-dates; the cost of drugs impacting on the household budget (despite the PBS); iv) placebo effects; and, v) substitution (cf. Brody 1986, PHARM 1995, Vuckovic and Nichter 1997).

'Home remedies' are those practices and resources from the kitchen, bathroom or garden used by laypeople to treat minor illnesses and injuries. The sources of knowledge of these remedies may stem from: 'old wives' tales', lay empiricism, mothers, family tradition and friends (Chamberlain 1981, Hayes 1996). During both focus group discussions and interviews, there was an exchange of 'home remedies' - that is, knowledge and practices - between the participants and myself, and between participants. Sometimes there was a difference of opinion as to what works and what doesn't owing to an individual's previous experience with a particular product, and also when something was 'fashionable' to use and when it was no longer, for instance, coloured ointments such as Mecurochrome and gentian violet. In addition, brand names rather than generic names of medicines were referred to by participants. This is quite common amongst laypeople despite campaigns by health consumer groups to 'educate' the lay public that their bodies are unable to distinguish between brand and generic names (PHARM 1995).

To self-prescribe, self-administer and self-regulate drugs and remedies, laypeople require knowledge of their use, administration, dosage, preparation, side-effects and storage. Their lay pharmaceutical knowledge is not as specialised as a pharmacist, nurse, doctor or healers specialising in herbal medicines and homeopathic remedies. Participants reported that this knowledge came from varied sources: prior experience, trial and error, pharmacists, doctors, nurses, family, friends, alternative therapists, folk healers, books, medical and health books which encourage self-help. As noted above,

---

418 The Pharmaceutical Benefits Scheme (PBS) subsidises the cost of a wide range of necessary and cost-effective medications. Its aim is to ensure that individuals are not financially precluded from access to these items. The items that attract benefits are reviewed frequently, and the price of every item covered is negotiated with the supplier [pharmaceutical company]. Patients are grouped into two classes: concessional beneficiaries (pay a set contribution of $3.20 per item from January 1998), and general beneficiaries (pay a 'higher contribution for each item') (AHW 1998:223).
419 See also Dunnell and Cartwright (1972), Beckham (1996), Hayes (1996), Allardice (1997), Vuckovic.
in the event of poisoning, participants indicated that they contacted the Poisons Information Bureau for further advice on treatment.

I asked participants where they obtained their remedies. 'Chemist. Supermarket and the health food shop' were the common responses. The majority of products participants used were bought from the chemist (pharmacy) or supermarket, based on convenience, cost and 'what is available' at home. Neil responded, 'since I'm unemployed we actually buy most of our things wherever we can get it cheapest. I mean, we're very price conscious.'

In 1995, the most commonly used medications by Australians were vitamins or minerals (26%), pain relievers (24%), medications for heart problems/blood pressure (11%), skin ointments and creams (10%), and natural or herbal medicines (9%) (ABS 1997:7). In establishing drugs and medicines participants as laypeople retained in their households, the qualitative data reveals: i) commonly held substances; ii) those products which are kept for specific purposes; and, iii) maintenance and location of a first aid kit (including medicines) at home. Firstly, the most 'common medicines' mentioned by participants were: 'Bandages. Panadol and pain relief stuff. Antiseptics', Dettol, Bandaids, bandages and throat lozenges. 'Everybody tends to have them', said Gillian. Other common medicines were: cough mixtures, nasal decongestants, anti-histamines, 'cold and flu capsules', 'eye wash' saline solution, and gripe water for children's 'tummy pains'.

Secondly, certain medicines are held by laypeople for 'specific purposes'. Jack kept Ipecac 40 at home. Since Rita's and her husband's experience with gastric illnesses in Central Australia, they kept Gastrolyte as a home remedy for oral rehydration, in the event that their two children might become ill with digestive problems. Kelly indicated the public hospital's pharmacy provided her son's medication for treating his epilepsy on an outpatients basis; therefore his drugs were publicly funded. Other participants listed doctor-prescribed medications required by particular household members for chronic conditions: epilepsy, depression, chronic pain, diabetes, asthma, hayfever. The presence of these medications and their comments about obtaining these drugs on a regular basis suggests patient compliance with medically recommended treatments (Trostle 1988, Nichter and Vuckovic 1994).

During their patient consultations, naturopaths and other alternative therapists prescribe essential oils, homoeopathic and herbal remedies, and Bach flower remedies for particular conditions. Similar to the situation in Britain, Europe, United States and

40 It is a poison antidote given to children and adults to induce vomiting when poisoning or drug overdoses are suspected, thus purging the body of toxic substances.

41 The National Health Survey 1995 indicates that 'the estimated 10.7 million people who used medications other than vitamins or minerals, approximately 62% did so on medical advice, and 51% required a prescription to obtain the medication' (AIHW 1998:222). More women (74%) reported taking medications than men (63.4%).
Canada.452 approximately 50% of Australians are willing to purchase alternative medicines containing various herbs and other nutritional components (MacLennan et al 1996).

The $AU621 million estimated for alternative medicines alone in Australia far exceeds the $AU360 million of patient contributions for all pharmaceutical drugs purchased in Australia in 1992/93 (MacLennan et al 1996:572).

Participants in this study also kept naturopath-prescribed medicines in their households such as: witch hazel tablets, Vitamin C powder, multi-vitamins, herbal hayfever tablets, Evening Primrose Oil tablets, acanthi tablets, essential oils, Bach flower remedies and homoeopathic remedies. Pharmacologists have questioned 'polypharmacy' when laypeople take herbal remedies concurrently with doctor-prescribed drugs, and warn of the potential for side-effects, toxicity and fatalities. It is alleged that in many instances, laypeople do not readily admit to their doctors that they are also using alternative therapies because of 'the perception that doctors would probably reject the therapies, and a belief that individuals were "in charge of their health"' (Shenfield et al 1997:516). Laypeople are 'discerning consumers'.453 The pharmacological and medical professions are concerned about quality and safety of these substances when so few have been funded for testing (Saks 1994, MacLennan et al 1996, Shenfield et al 1997).

Thirdly, apart from keeping 'common' and 'specific' medicines, some participants also maintained various forms of equipment and medical supplies. These included: thermometers, tweezers, cold-hot packs, hot water bottle, vaporisers and nebulisers. Kay ensured her household had pressure bandages, essential for treating 'snake bites, because I'm a bit worried about that. Living in the bush with kids walking around'.454

Laypeople may also refer to their collection of over-the-counter and left-over medicines, prescribed drugs and medications, disinfectant and antiseptic creams and solutions, medical supplies, equipment and other items as a 'first aid kit'. Gillian joked: 'we've got just about everything. It's a matter of finding it when something happens. [Laughter] This not a highly organised household'. Other participants indicated that their first aid kit was usually placed in a container like a bin, box or picnic basket in a cupboard or on a shelf (usually out of reach of children): situated for easy adult access in the bathroom, laundry, kitchen or car. We 'have a box full of whatever is left over from the last time we needed to buy something', reported Tom. Lewis admitted jokingly to having an abundant supply as an 'insurance' measure to treat injuries at home. 'We've got a large Bandaid bin ... we've got all brands ... [and] 15 bowls of bandages ... like when the pharmacy's run out they come here.'

454 Kay lives in a rural area 20 minutes drive from Geelong, where many middle class families live on properties outside of town.
THE AFFECTIVE PARTIALITY OF LAY HEALING

Above I discussed the extent of physical labour undertaken by laypeople to take care of their embodied selves and provide lay healing. Thomas (1995) and Korten (1997) assert it is vital to conceptualise laypeople's 'domestic labour', in terms of health, as including both physical and emotional labour in the social economy. For when a person is sick, not only does s/he require the physical assistance, but the emotional or affective relationship they have with the healer contributes to their healing within the private sphere (Giddens 1992).

In this section I discuss the centrality of emotional labour in lay healing, in terms of the parent-child relationship, and the potential negative consequences of 'knowing your child'.

Parents and Children

The context of the parent-child relationship is an affective relationship involving adult(s) and child(ren), and their 'knowledge' of significant others, in contrast to the 'affective neutrality' which defines professional relationships with clients. The parent-child relationship (as discussed in Chapter 6) requires substantial emotional labour in addition to the values of trust, honesty, independence, responsibility, respect and communication skills for its validation and continuation. As lay healers, parents make a subjective response to their ill or injured child in the private sphere; unlike the objective, clinical and emotional detachment of biomedical personnel in the public sphere. At such times, parents' emotions are complex, overwhelming and everpresent.

Participants reported their feelings when confronted with a sick child: fear, panic, guilt, blame, disbelief and 'nearly passing out'. They prefer to hide or not disclose their true feelings to their sick child. They endeavour to maintain a demeanour of 'being cool, calm and collected' so as not to 'add' to their child's distress. And they 'try' to appear supportive, strong and in control of the situation. Parents strove to make rational decisions on their children's behalf (as sentinels or guardians, responsible for their well-being), by providing and ensuring the best health care is made available to their child, so that there is a return to healthiness (Saiki-Craighill 1997, McMurray et al 1998). Irene emphasised the importance of 'needing to keep calm'; because if 'they see you getting upset, distraught and anxious ... it makes them that way too'. Not only is there a transfer and abundance of emotion in times of crisis, role modelling of parent to child also occurs.

Having someone else to call on - a friends, a neighbour, a partner, or other member of social network - and ask for extra help with an emergency such as a fracture or head injury, provides laypeople with emotional and physical support, reassurance,

and sharing of the decision making of establishing a diagnosis and appropriate treatment. The importance of acting quickly in an emergency or life-threatening situation was stressed by participants, as it is sometimes difficult to keep calm and administer first aid, and take the sick person to a GP or hospital for urgent medical attention. At the time, a parent may be unable to function or cope emotionally. S/he may need or allow someone else to 'take charge'; both with decision-making and implementing action. The other person is in a lot calmer position than the person involved' said Pam, and thus can remain more objective and emotionally detached.

Irene admitted: 'I'm not a very calm person' when injuries occur. She related her response when her husband 'chopped his fingers on a chainsaw': 'I walked around in circles literally looking for the first aid kit.' The coincidental arrival of a friend 'for a visit' - given her 'mental blank' - helped her to administer first aid by applying a bandage to his hand and taking him to the public hospital in Geelong. However, Irene reflected that 'in other instances, I've been quite calm about the whole thing.' Heather responded:

Just hearing that story makes me feel sick. I mean I'm hopeless with blood. And I know my first aid. I know how to react and how to do it. But I think that if someone else was there, I would pass out on the floor.

However, she acknowledged that 'if I was the only one' available, she would feel the moral responsibility to 'help someone' and 'do something'. 'You wouldn't have had a choice about passing out ... Even if you'd had passed out you would have got back up again.'

Blair would give his wife 'a ring to let her know what was going on and then getting a second opinion.' Pam spoke of her relationship with her husband and how they 'work' together to make a diagnosis, manage the situation, administer first aid, and seek medical attention or hospital care.

I used to pass out when I was a child. And as an adult, as soon as we're in a crisis situation, especially where there is blood involved, the adrenalin just goes haywire in me. And I have so much trouble just collecting my thoughts to do the immediate right thing. My husband, on the other hand, is just brilliant. He can just move in and do whatever is necessary, and then somewhere along the track we reverse. And I become the one that is really strong. So I'm the one that nurses them at the hospital and holds the injury together while it's being stitched. And he passes out. And all I can say, is that I'm glad that we've got this complimentary thing. Because we would be in trouble otherwise. [Laughter]

Pam stressed the importance of lay referrals and the frequency of receiving phone calls from friends, relatives and other community members asking her 'what shall I do?' (cf. Israel 1985, Moyal 1989). When her girlfriend called to say her two year old daughter had a facial wound which had been bleeding for an hour, Renata was adamant on getting her to medical attention immediately. She took charge of the situation and exuded confidence to her friend who did not know what to do, and was not aware of local health care services, given that she had recently moved to the rural area. Renata explained her confidence in knowing what to do resulted from a time, when she had injured herself 'in the middle of the desert in Western Australia', a few years ago. She sutured her head wound with a needle and cotton, without any anaesthetic, antiseptic or pain relief, apart from 'bourbon'. 'Well, it had to be done' and 'there were others around but they were a bit under the weather at the time. And no doctor available.'

Children, if present at the time of an injury or illness, may also assist in the care of the 'sick' person, and may be supportive and have input into the diagnostic and therapeutic decision-making, assisting their parents (or other adults) (Christensen 1993, Mayall 1993b, UNICEF 1994). Pam says of her three children (aged 10-14 years), when an emergency occurred at home: 'they just somehow seem to fit in. They have a role in it' and 'you don't have to ask them anything twice.' Her 'youngest daughter very much sees herself as nurse' and will 'hold the other person's hand.' Whilst her eldest daughter 'will automatically take the role of notifying people.'

Participants indicated there may be conflict between competing responsibilities or priorities. Making a decision in an emergency requires being calm or going onto 'automatic pilot': by doing just what needs to be done. However, it is not always possible to be rational: one's feelings rather than thinking may be supreme in the moment (Bernstein 1996). In such a situation the question arises: Are we making decisions on a rational or irrational basis, that is based on our emotions? Sandra remembered her mother dying from a terminal illness at home, and needing her presence. 'My father rang and said "Mum will go apparently at any time". And I said, "do you want me to come around?" And he said, "yes, please".' At the same time Sandra had responsibility for her three children (aged 3-8 years) and the difficulty of finding someone to care for them in her absence. She was unable to contact her husband, and so she rang a friend in a rural town (40-50 minutes drive away) to borrow her car, even though her parents lived in the next suburb. 'Not thinking, "stuff it. We'll get a taxi. Who cares? She's not going to be here soon".' Or 'this could be the last time that my children would see her alive.' Sandra felt a conflict of interests in meeting her parents' needs, her children's needs and her own need to be available for everyone.
I didn't know what to do with them [the children] ... I was trying to get somebody to watch them while I went there ... To me, my mother was my number one priority.

Like many women belonging to the 'sandwich generation', Sandra was juggling her life between two generations: younger and older than herself with little time for 'herself' (Summers 1994, Mackay 1997).

Other parents reported their disbelief and sense of panic when their children were injured. Andrea conceded that her son is 'accident prone': 'bumps into things and never sort of hurts himself'. Consequently, 'it took me ages before I actually believed him' when he broke his elbow after falling off a slide and required hospital care. Belinda and Tracey indicated that 'if it's someone in the family' or 'the neighbour's kid' they tend to 'panic' and then 'try to resolve it.' Alice admitted that she panicked when her son 'insisted on running around the loungeroom and smashed into the television. The lump on his head expanded before our eyes to the size of a golf ball.'

The Negative Consequences of 'Knowing your Child'

Earlier I discussed the importance for parents of 'knowing their child' when diagnosing and treating ill-health. 'Knowing your child' may have two negative consequences. Firstly, in some instances, the parents may not believe something is 'wrong', because of past experiences, the child is accident prone or the 'crying wolf syndrome'. So if their child fractures his ankle instead of spraining it, a parent may not take her/his condition seriously, initially.

Yolanda related two instances whereby her son had a severe ear infection and didn't complain of any pain,

and the only way I could pick it up was that he couldn't hear me ... The doctor said he could not believe it. 'This child should be screaming in agony.'

On another occasion, her son came home from playing hockey with a sore hand, and she sent him off to bed.

And the next morning he got up and sat on the bottom of the stairs and he said, 'Mum, you're going to have to do something. I've really done it this time.' And he had a broken hand ... the pain wasn't severe ... he'd been hit with a hockey ball and it really hurt. It wasn't that excruciating broken hand pain ... The next morning when he came [downstairs] ... when it was all mangled and nasty, I thought, 'this is serious.'

This situation may also arise as a result of a parent having no previous experience of dealing with a broken hand. The parent may lack confidence or have limited knowledge
to make the distinction between a fractured hand and a sprained hand. Lack of change in their child’s behaviour may lead to the perception by parents that no serious injury is present. That is, the child’s behaviour appears ‘normal’ rather than ‘abnormal’, and their child is not complaining of pain relative to the severity of the injury (Cunningham-Burley and MacLean 1991). ‘It’s not good judgement all the time.’ Elsa believed that sometimes, ‘in order for you to know how serious it was, you really need signals from them [children], don’t you? You couldn’t have evaluated that by looking at it.’

It may only be later that the parents realise that there is something ‘wrong’, and seek immediate medical attention or hospital care for the fractured hand, confirmed by xray. Parents’ immediate emotional response is often immense guilt, self-blame; for not having recognised the signs and symptoms sooner, that the situation was an emergency one, and the need for a healer other than themselves was urgent. This is particularly the case when they were not present at the time of the incident. The parent in this instance, tends to berate her/himself for not having taken their child seriously, and feels immensely personally responsible for the compromise to their child’s well-being. This is paradoxical when teaching children self-responsibility and independence, is part of health education, health promotion and, illness-injury prevention, as argued in Chapter 6. In addition, a child’s age is a factor in parents’ knowing their child. ‘I think you have to be on the ball ... from birth to say 12 ... I think from 12 upwards children are pretty much independent’. Margot argued that the older a child is, the more likely she is to believe them: ‘I wouldn’t query it’.

Secondly, knowing your child is an impetus for a parent taking their sick child to another healer for diagnosis and treatment. However, parents (especially mothers) appeared to be ‘severely criticised’ and labelled ‘neurotic’, ‘hysterical’ or ‘over-reacting’. Biomedical health professionals assume that parents bringing in their sick child(ren) for medical or hospital care are ignorant of health issues (Irvine and Cunningham-Burley 1991).

Yolanda recalled asking a doctor to give her ‘a clue’ of the symptoms for scarlet fever which she ‘knew’ - and was later confirmed - to be the correct diagnosis for her daughter’s condition rather than German measles. Parents may be berated for not having taken in their sick child into hospital sooner. Some participants commented upon their frustration when they had repeatedly requested and been refused GP referrals to a specialist. The parents’ intuitive knowledge and experiential knowledge of knowing their child and what is abnormal, and previous experience with emergency situations may be readily dismissed. Roberts (1996) asserts the imperative of ‘health professionals’ to ‘listen to the parents: [since] they know best’. Sian emphasised,

457 See Finerman and Bennett (1995).
you've got a 'ballpark' idea of what's going wrong and the doctor's the last resort. So you must have felt that there was something really serious for you to have gone there anyway.

Medical practitioners and other health professionals are often incredulous and disbelieving of the parent's fears and concerns about the severity of their child's condition, which may lead to delayed investigation of the presenting ailment. Elsa remembered taking her young daughter to three different doctors in Melbourne over a 18 month period for treatment of diarrhoea. She was repeatedly told that her child had gastroenteritis, despite her knowledge that it was not this condition.

And the fourth time, I had, had enough ... I'd burst into tears, and said, 'you've got to do something.' 'Oh, if you feel that way I'll do a stool test.'

The ultimate diagnosis was Golden Staph - a virulent bacterial infection - for which her daughter was immediately treated. Meanwhile, Elsa felt that upon her insistence on getting help, 'you really have to resort to hysterics' and then you're labelled as a 'hysterical mother' (Kai 1996b).

The consequences of this situation are multiple. Maldiagnosis and therefore incorrect treatment of the condition may occur. Wendy and Yolanda gave examples of their children being treated for diarrhoea instead of constipation, and of being given an enema for 'stomach cramps'. Laypeople's criticisms also reveal the 'vulnerability' of biomedical healers in not having all the answers to health and illness, despite their claims to do so and which hinge upon rational, positivist, clinical-based evidence. There is a need for diverse healers to retain a focus on the 'personal significance' of health and ill-health for laypeople (Sweeney et al 1998). In both situations Yolanda and Wendy indicated that 'they knew' something was wrong. There was considerable patient dissatisfaction amongst the participants with the diagnosis, treatment and therapeutic outcomes. Wendy said:

I thought I was a bad Mum, because I was giving him the wrong foods and you know, all those things you associate with guilt ... yes, and it was just the doctors treating him for the wrong thing. Unbelievable.

A further implication is that parents - both for themselves and on behalf of their children - will shop around for another doctor or healer: for someone who will listen to them. They may resort to consulting an alternative therapist who takes a holistic approach to healing the patient and usually provides longer consultations than the

---

standard 10 minutes consultation by a GP (Sharma 1992). The belief that seeing a doctor is not value for money because of the poor quality of care delivered and the short consultations was widespread amongst participants.

DECISION-MAKING WHEN LAY TREATMENT IS NOT ENOUGH

Elsewhere, I have argued that given medical pluralism, other healing options not just biomedicine are available to laypeople. Laypeople's health knowledge and decision-making not only determines their lay healing practices in the household, but also has implications for their use and purchase of health care services outside the household. In this study I wanted to establish the range of health care services used by participants' household consultation of healers and use of health care services in the previous 12 months. For this purpose, the questionnaire contains a series of closed and open-ended questions administered to each participant. See Table 7.4.

<table>
<thead>
<tr>
<th>Health Care Services</th>
<th>Utilisation in Previous 12 months (N=98)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP services</td>
<td>96</td>
</tr>
<tr>
<td>Hospital services</td>
<td>44</td>
</tr>
<tr>
<td>Dental care</td>
<td>77*</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>95</td>
</tr>
<tr>
<td>Diagnostic services</td>
<td>65</td>
</tr>
<tr>
<td>Specialist care</td>
<td>54*</td>
</tr>
<tr>
<td>Allied health services</td>
<td>32**</td>
</tr>
<tr>
<td>Aids and appliances</td>
<td>6*</td>
</tr>
<tr>
<td>Alternative therapies</td>
<td>31</td>
</tr>
<tr>
<td>Folk healer</td>
<td>9**</td>
</tr>
<tr>
<td>Other</td>
<td>3**:**</td>
</tr>
</tbody>
</table>

* Missing cases (1) ** Missing cases (2) *** Missing cases (6)

Of 98 participants, the majority of their households had sought biomedical care from general practitioners (96), diagnostic services (65), specialists (54), hospital services (44) and allied health services (32). Dental care was utilised by 77 households. In addition, participants' households had also used pharmaceutical services (95), aids and appliances (6), and consulted an alternative therapist (31) or folk healer (9). Three participants had used 'other' health care services; respite care, in particular.

Upon closer examination of the quantitative data from the questionnaire, participants indicated that they had consulted healers and attended health care services in their local suburb, in the City of Greater Geelong, in other suburbs, and in Melbourne where there are numerous specialist services. Their reasons for consulting healers ranged from specific illness or injury, to a checkup and diagnosis, to treatment, medication, advice or other (including Workcover, Transport Accident Commission,

Whilst the empirical data affirms that lay treatment consists of first aid, self-care and self-medication, I wanted to establish: at what point do laypeople decide that their management of a condition (illness or injury) is no longer enough and they seek healing from another healer? Participants' narratives contains details of three factors related to their decision-making: increasing severity of the condition; the extent of confidence in their own diagnostic and therapeutic skills; and, awareness the condition required specialist care. In all instances, parents provided a rationale for their decision-making and actions. They considered the affective relationships of adults and children within the household, the degree of external social support, their work and community commitments, and the availability of friends and relatives to assist them in times of ill-health.460 Fran for instance, took into account her sole parenthood and therefore, her singular responsibility for lay diagnosis and treatment in her household. She indicated her actions when she felt she couldn't manage the condition by herself when sick:

If I was sick and I was getting treatment from a doctor ... say if I had to stay in bed ... then I would call on my family to help look after the children.

However, if her two sons were sick,

after I'd taken them to the doctor, if they had required ongoing treatment from ... like at home, then it would be me. Again, if I needed any help with doing anything, I'd probably ask my family.

Parents of young children tend to take a conservative approach to managing minor illnesses and injuries at home, rather than immediately taking a sick child to the doctor or hospital. Blair described parental vigilance as 'observation and commonsense', or what Cunningham-Burley (1990:93) calls an 'active monitoring process'. Laypeople seek another healing option when they believe the condition is worsening, that is, the signs and symptoms are becoming more severe, there is an altered state of consciousness, or there is no improvement in the condition - after a period of time or 4-24 hours.461 This may be arbitrarily specified by individual parents as 'no changes in their responses'. Table 7.5 provides a list of other responses given by participants.

'Children dehydrate so quickly ... so you've got to act quickly', responded Jackie. Elizabeth replied: 'If they're so dehydrated that you can't treat them with a home remedy, I might use other therapies.' Alice stated: 'I watch them [my kids] like hawks and after 12 hours ... if that doesn't work I seek medical treatment.'

Biomedical Health Professionals

As discussed in Chapter 5, biomedical health professionals increasingly rely on best evidence to guide their clinical diagnosis and treatment, especially where there is doubt. Laypeople draw upon their substantial health knowledge - its multiple sources - to assist with their lay diagnosis and treatment. However, healers of all modalities may admit to uncertainty, and sometimes must take a 'risk' when knowledge is imperfect to reach a diagnosis and implement treatment, and achieve healing.

Peggy and Veronica stressed the importance of 'seeing the chemist' or ringing 'your local doctor or your local clinic, to tell them what's happened. And nine times out of ten, they'll tell you to come in and see them. They'll advise you to seek further help'. Other participants responded:

*I think they need more ... seek a second opinion or alternative method of treatment ... not at ease with the way I was handling it ... would go to the local GP ... go back to the same doctor or if not happy see someone else.*

This study supports Sharma's (1992) assertion that laypeople's decision-making process about the choice of healers involves pragmatic factors (cost, location, barriers of accessibility) and ideological factors (perceived benefits of therapies). Furthermore, the data indicates that when laypeople seek other healing options, the pathway of their decision-making process about diagnosis and treatment depends upon: i) the condition; ii) uncertainty and the need for reassurance; iii) time and distance from other healers; iv) the need to confirm a lay diagnosis; or v) establish a diagnosis from an unknown.

---

They are also related to laypeople's seeking of further knowledge at times of ill-health, as discussed in Chapter 5.

Firstly, as Fran reported, a 'health professional would be my first choice', however, 'I wouldn't have any hesitation about changing doctors or seeing someone else.' Blair indicated, 'I would still be going to a doctor or a dentist' but if it was 'a fall that had caused it [the condition] then we see our chiropractor.' He would also phone his mother - 'Dr. Mum' - who would question him about a child's signs and symptoms: 'are there spots on the back? Is there anything in their ears or in their hair?' She provided advice on what to do next (Blaxter and Paterson 1982). Peter adhered to 'lay referrals' by consulting his partner 'to find out what she thinks' and 'if she doesn't know, perhaps the next point of call would be to call the doctor ... or my partner's parents or someone else who is close by.' Gemma related that '[lay]people will advise you' of remedies and specialists for treating minor ailments such as eczema (cf. Zola 1972, McKinlay 1973, Kleinman 1980).

Secondly, parents admitted their uncertainties, which prompted them to consult other healers. Their lack of confidence about what to do next or 'you can't manage by yourself', whilst at the same time, they 'know' there is a need to consult other forms of healing. 'I have to be really confident that I have got the situation in hand. If there is any doubt, I'll always ask for a second opinion', usually medical, indicated Owen. Other responses were: 'something I couldn't cope with'; 'err on the side of caution rather than think, "I know what this is"'; 'better to over-react'; and, 'you seek professional help when you're unsure'. Blake and Michael were likely to take a child straight to the doctor or hospital. At times, they expressed limited confidence in their own ability to diagnose and treat the condition, despite their knowledge on how to do so. Elsa indicated: 'if you're unsure ... the next best thing is to take them to the doctor or naturopath or whoever you want to go to ... to have them checked out. To go seek help' (Cunningham-Burley 1990).

Thirdly, time and distance to the nearest doctor or hospital was a major consideration for participants living in rural and coastal areas of the Geelong Region (cf. Taylor 1994). Their concerns are legitimate given the importance of the 'golden hour' to provide emergency care following an acute illness or injury. In two coastal communities where few community members are known to have first aid knowledge and experience, the nearest ambulance service is 10-20 minutes away and the nearest public teaching hospital is 30 minutes away. Thus, there is still a time lag for the ambulance officers to arrive at the scene, 'take over' management of the situation, and pick up the sick person to transport them to the public hospital in Geelong, for emergency care. Simone, Vicky, Irene, Olivia, Marcia, Heather, Rachel, Natalie, Teresa

---

At the time of interview - mid 1995 - the ambulance service in this area had only been in operation for six months. The nearest ambulance service was previously located near the public hospital in Geelong.
and Gillian explained at length that laypeople in these communities must make the critical decision of meeting the ambulance officers halfway or going straight into hospital. Pam's personal criteria for calling an ambulance revolved around: extensive blood loss, shock, 'any suspected spinal injury', or she was 'on my own and the injury was of a nature where it needed a lot of pressure ... put onto it, and I wouldn't be able to do that and drive' at the same time. She expressed her desire to learn 'how to stitch people up. In my household that would be an advantage', as she described her children and husband as 'accident-prone'. 'If I could stitch, I would stitch. Who knows, it would be a lot more convenient.' Natalie, Vicky, Simone, Olivia, Rachel and Teresa jokingly responded:

Your children probably wouldn't let you anyway. [Laughter] They have trouble letting a doctor near them ... It's always better to let a stranger do it. [Laughter] Then they can go to their Mum for comfort.

Similarly, Gemma, living in a rural area '40 minutes' from Geelong and the public hospital, related the 'risk' of relative isolation and receiving medical treatment on time. The nearest GP surgery is ten minutes from her home and only open during business hours. Time and distance is thus of 'concern' to Gemma, particularly if her children were 'bitten by a snake or a spider'.

When seeking other healing options, laypeople also consider: i) the day of the week (Monday to Friday, or the weekend); ii) the time of day (day or night, during business hours or after-hours); and, iii) being a public holiday when the incident occurred. Hazel, Leah, Nicole, Imogen, Karen and Jane live in a coastal town, with limited health care services, 30 minutes drive from Geelong. They agreed 'night-time is a pretty crucial time ... It's sort of scarier at night ... you feel like you're on your own'; isolated and having to cope with a sick child or adult. Consequently, as parents they 'tend to have some interesting times with showers ... steam for croup ... lukewarm bath to try to cool a fever' in the 'middle of the night'. This contrasts to their lay healing practices 'in the daylight' when someone is sick: 'oh well, he's not so bad' and their relief that other healers are more readily available and accessible.

A fourth factor influencing laypeople's health decision-making is their need (and desire) to confirm their own lay diagnosis. They seek reassurance (Cunningham-Burley 1990). Participants considered that their lay health knowledge, decision-making and confidence in doing 'the right thing' will then legitimated by another healer (Kai 1996b). 'Connie admitted her tendency to 'go to the doctor too late. I've already diagnosed it at home and then doing all the right things but I'll just better check it out'. Her doctor 'always says, "you're doing alright" which boosts her confidence in her experiential knowledge even further (cf. Irvine and Cunningham-Burley 1991). Tammy noticed her
eldest son at three years of age 'that when he had his back to me, he'd ignore me when I called him.' She surmised there were 'things he was missing and so I took him off [to the doctor's] and had his hearing assessed, and yes, that confirmed that he had a problem.' As a result of her intuitive knowledge that 'something was wrong' her son had tiny tubes (grommets) inserted in his ears by an ENT specialist, and she also ceased his swimming lessons to prevent ear infections.

Finally, not knowing what could be wrong but being aware that 'something's not right' makes it difficult for laypeople (and often other healers) to establish a definitive diagnosis. A label for the condition in the interim is 'unknown' and warrants substantive investigation prior to healing. Carmel spoke of her son having a iron-deficiency disorder and (possible) immune-suppressed condition since birth. 'I knew something was wrong but I couldn't pinpoint what it was'. Her son 'was always sick ... with fevers and tonsillitis' and 'constantly at the doctors'. It took over a year for paediatricians to establish a diagnosis and treat him with an 'iron tonic' to boost and maintain his haemoglobin levels. Carmel indicated there was no family history for his condition.

**Alternative Therapists and Folk Healers**

A. Williams (1998) discusses 'holistic medicine' (constituting other forms of healing that are not biomedicine) as another therapeutic landscape where healing is performed. Sharma (1992:24) ponders the question: "why do people use non-orthodox medicine?" [as it] generally implies the unspoken subordinate clause "when they could use the services of an orthodox doctor for nothing" (cf. Easthope 1998). She found from her study of laypeople using alternative medicines and seeing alternative therapists in Britain, that they seek healing

chiefly for conditions which can be described as chronic rather than life-threatening ... for problems which orthodox medicine currently finds it difficult to cure, such as musculo-skeletal disorders, chronic pain, allergic conditions, stress-related and psychosomatic problems (Sharma 1992:24, cf. Eisenberg et al 1993, MacLennan et al 1996).

Furthermore, Sharma (1992:23) asks: 'on the basis of what advice or information do individuals resort to non-orthodox practitioners? What - or who - encourages them to sample complementary medicine, or on the other hand to rule it out as an option?' In addition, 'what happened next?'

Do patients continue to use the practitioner they first consult? Did they sample other types of non-orthodox medicine and do any of these experiences have enduring consequences for their own or their families' health care practices? (Sharma 1992:23, cf. Frohock 1992).

Included in the questionnaire and schedule for interviews and focus group discussions were questions on alternative therapists and folk healers. I wanted to
ascertain whether participants considered and used these healing options. In the anthropological and religious studies literature there is increasing evidence of folk healers practising their esoteric knowledge and healing rituals within small scale societies, Third World countries and, within ethnic communities and mainstream society in western countries. Historically and cross-culturally, religion and medicine have co-existed, and are often inter-twined, incorporating both the sacred and the profane.⁴⁴ Many authors continue to define a folk healer as being similar to an alternative therapist or a 'New Age' healer; owing to their epistemological distinction from allopathic healers who practise a form of biomedicine, and their emphasis upon 'holistic health'.⁴⁵ However, for the purposes of this study, I wish to retain Kleinman’s (1980) useful definition of a folk healer in terms of demarcating her/his role and responsibilities from other healers.

The National Health Survey (1995) indicates that in the two weeks prior to interview, 1,792,600 Australians consulted 'other health professionals' including acupuncturists (54,200), chiropractors (286,300), herbalists (41,300), hypnotherapists (4,800), naturopaths (112,900) and osteopaths (32,100) (ABS 1997:40).⁴⁶ The remaining other health professionals were nurses and allied health professionals. Common to the lived experience of laypeople in Britain, Europe, Canada, the United States, and elsewhere in Australia,⁴⁷ participants readily reported consultations with alternative therapists (N=31) and folk healers (N=9) as other types of healers whose advice and treatment they would actively seek.

Participants’ questionnaire responses indicate they consulted alternative therapists for the following conditions: back, neck and muscular pain, injuries, pre-menstrual tension, headaches, child behaviour (bedwetting), allergies, and well-being. Their reasons were: remedies, massage, relaxation, topical treatments, stress management, pain relief and general checkup. Some participants related they were 'disgruntled with western medicine' and they had 'tried alternatives to usual medical care for allergies and behaviour' of their children. The National Health Survey (1995) indicates persons aged 25-54 years were most likely to consult an alternative therapist, than persons of other age groups, including children (ABS 1997). Participants related they were more likely to take their sick child (younger than 12 years) to a doctor for treatment with 'orthodox'

⁴⁶ The ABS (1997:40) indicates that in 1995, women more so than men were significantly higher users of the following alternative therapies: acupuncturists, herbalist, naturopath and osteopath. Both women and men used chiropractor services in similar proportions.
medicine, rather than consult an alternative therapist. However, they themselves or an older child (12+ years) would see an alternative therapist.

Wendy reported she had taken her ten year old son to 'a naturopath a couple of times', but as he - similar to other children - does not like the 'bitter homoeopathic remedies ... at the moment he just goes to the doctor'. Meanwhile, despite her extensive interest in alternative medicines and personal consultation of alternative therapists, Wendy hoped when her son 'grows up' he will 'make up his own mind' about healing options other than biomedicine. Owen and his wife had consulted a kinesiologist after exhausting biomedical options to treat their six year old daughter. Her signs and symptoms were: 'a fiery temper', 'lack of sleep', 'colds', 'tantrums, restless, hot', found to be due to an allergy to certain foods (including chocolate) and colourings. The recommended treatment was a change of diet, which upon implementing, Owen and his wife found to be successful in improving their daughter's well-being.

Nine participants stated they had consulted folk healers for 'help', well-being, advice, 'personal matters', esoteric/spiritual healing, and herbalism. Natalie is known in her local community as an esoteric healer and mystic. She regularly receives people in her home for healing matters of the spirit; working as a medium for spiritual guides whom she referred to as 'the team'. 'I put out a call two weeks ago that I'm back into doing some serious healing work.' Consequently,

I raise the light right up above my house and Soul sees it ... not the human, but the Soul sees it. And all of a sudden you get an influx of new souls that are looking ... I don't advertise, I don't really think that's how I work. I send my light up or send the call out. And they just come.

Natalie's patients are of diverse backgrounds: they may be friends and members of her social networks or 'strangers' to her local community such as 'Jehovah's Witnesses' who seek healing. She 'explained to everybody, it is not me who does it. I am but a channel for them to allow energies to flow through'. Natalie's outlook on life was one of simplicity. Reading widely on spirituality, religion, mysticism and philosophy had been a lifelong interest to her, to advance her understanding of the human soul and spirituality. She became aware of her 'calling' to spiritual healing when she was nine years old, following the death of her father, and several 'psychic experiences throughout my marriage breakup'. The soul became more important to her. Natalie had trained and continued her study with other spiritual healers, and took an active part in folk healer networks in the Geelong Region and elsewhere.

Folk healers are often part of a network, personally known to each other, sometimes working together. They are considered 'masters' in their fields. Those

---

persons who profess to be folk healers without specialist training under a master over many years, and stand outside of a network of recognised folk healers, are regarded as 'quacks' or 'fringe prophets', and discounted as reputable. These 'persons' may have done weekend or short-term courses in a particular field: psychotherapy, pop psychology, counselling, past lives, crystal gazing, astrology and have then set themselves up as a private business, advertising and charging fees for their services and products. Levin and Coreil (1986), and A. Williams (1998), are concerned that many of these 'healers' are espousing a 'New Age' philosophy with claims to 'heal', practise in an 'unregulated' environment, and misrepresenting 'holistic medicine'.

Vicky expressed her fears and anxieties about faith healers (folk healer) and their 'claims' to cure sickness. She had read newspaper reports (late 1995) of parents who had taken their daughter (sick with stomach cancer) to a faith healer, rather than a doctor. The tumour grew. State authorities intervened in the case by taking the girl away from the parents, charging them, and putting her in hospital for chemotherapy which reduced the tumour size. Vicky admitted that 'some doctors are good and some are bad. I suppose so are some faith healers' (cf. Frohock 1992). A folk healer in the traditional sense, relies on her/his reputation for healing on a word-of-mouth basis, through personal recommendation. Payment for services is usually in kind or as a donation. In a population such as the Geelong Region with diverse healing modalities available, who is a reputable folk healer and who is quack is known within the networks.

I asked Natalie, Olivia, Pam, Nicole, Rachel, Teresa, Vicky and Simone: would you consider seeing a biomedical health professional, an alternative therapist or a folk healer when confronted with a certain condition? I did not specify the condition, and explained that folk healers often have intensive specialist training. They may be known as herbalists, shamans, 'energy therapists' or spiritualists and are usually considered special people within their own communities. The conversation focussed upon the variety of therapies available within the Australian health care system. It would depend on what you had wrong with you and how far you had gone through the system.' Pam questioned the status quo:

Does that still reflect that old thing that alternative medicine is only viable if it's not serious?
That the medical profession is the one that you eventually turn to if it's in the serious category
Because it may in actual fact be the other way around.

Olivia responded: 'That's what I was thinking in reverse. If you go to the doctor and don't get any assistance then you would turn to an alternative [therapist].' Natalie mused: '[hopefully] the future of medicine will be a combination of all [therapies].'

---

other focus group discussions, Heather agreed that for some people, 'it's the other way around, and they prefer to see their naturopath rather than a doctor.' Edith revealed her 'father is a naturopath' in Germany, where it has long been an accepted healing tradition (WHO 1983). Whilst Mandy - a hairdresser - was regarded by fellow members of a focus group discussion as the local 'folk healer' in a coastal town, owing to her propensity to listen and empathise with her clients.

Kleinman (1980, 1995) has theorised the interface between professional and folk health sectors of the health care system; although he regards alternative therapists as health professionals (cf. Kleinman and Gale 1982, Frohock 1992). In this study, participants debated what constitutes 'orthodox medicine' and 'alternative medicine'. Participants referred to women's historical healing of others and questioned whether that form of therapy could be considered orthodox or alternative (Chamberlain 1981, Achterberg 1990). Imogen stated: 'I'm open-minded about that. Even though I'm a nurse I don't really think conventional medicine is the be-all.' Given her biomedical clinical practice, education and training as a registered nurse, she questioned: 'what's alternative? Naturopaths? Homoeopaths?' Imogen pondered:

Is that an alternative to modern medicine? Or is it what we call modern [medicine] the alternative? ... It's hypothetical isn't it ... if you're talking about old medicines and remedies that were around that the women mainly did.

Rather, Imogen considered that 'we [ie. laypeople] are conditioned to accept as mainstream' what is orthodox medicine, although hypothetically 'what is and what's not real' has been historically legitimised and credited by state authorities (Porter 1989, Frohock 1992, Conrad et al 1995, Weatherall 1998).

Gemma was more sceptical. 'I think it's really six of one and half-a-dozen of the other'. She explained: 'a doctor doesn't have all the answers, but a natural therapist doesn't have all the answers either.' Sarah highlighted the difficulty of 'finding somebody' suitable - an alternative therapist - as she could not be sure of their training and the lack of registration, and therefore their legitimacy.²² In contrast, Gillian, Irene, Heather, Belle, Connie and Deidre discussed the pathways of healing between alternative therapists and doctors. Irene's criteria for preferred choice of healer 'depended on the illness'. Belle and Connie agreed that 'if one of the kids got a virus' or 'a cold' it might be better to first 'go to a naturopath' or 'to a chemist ... instead of rushing to the doctor'. Gillian asserted 'a lot of people don't believe in naturopaths ... so it's entirely up to the individual.' Heather argued, 'if you started off with naturopathy, you then go medical. If you started off with medical and it wasn't heading anywhere

---

CONCLUSION
Laypeople provide extensive lay healing in the household setting. Previous studies on laypeople's diagnosis and treatment of illness and injury within the household setting have often been limited to looking at mothers of small children, and not fathers, or both genders in a family situation. This research considers lay diagnosis and treatment by both women and men in the household setting.

Laypeople are capable of diagnosing of illness and injury. To do so, they consider four factors: assess the sick person's presenting signs and symptoms; physical examination; investigate the circumstances of illness and injury by asking questions to establish activities, time and place, cause and effect of ill-health, and their own absence or presence at the onset of symptoms; and, assess severity of the condition. Unlike the assertion of previous studies that laypeople provide self-care and/or self-medication, I propose that laypeople provide 'lay treatment' and that this entails: administering first aid; self-care at home; and, self-medication.

Within the household setting, affective relationships (parent-child and marital) involve 'knowledge' of significant others, and extensive physical and emotional capital and labour. Parents of young children - as lay healers - make a subjective response to their ill or injured child or partner, unlike the clinical detachment of biomedical personnel. Participants reflected that having social, emotional and physical support of other people, to assist with lay diagnosis and treatment, boosted their confidence to manage an emergency or life-threatening situation, and enabled them to present a 'picture' of being in control at times of great stress. When confronted with an ill or injured child, parents reported a range of emotions. It was often difficult for them to sustain rationality when faced with ill-health, whilst at the same time 'knowing' they had responsibility for making decisions; acting as 'sentinels' and 'guardians' for their children's well-being to ensure they had the best of care. The data highlights the negative consequences of 'knowing your child' are twofold: parental disbelief that 'something is wrong' with their child; and, parents being labelled, and their health knowledge and decision-making being 'discounted' by health professionals. Consequently, maldagnosis and inappropriate treatment occurs, often prompting parents to seeking therapeutic solutions from alternative therapists or folk healers through their lay referral networks.

Laypeople consult other healers when they assess that lay treatment is no longer adequate to deal with a health compromising event. The pathway of the lay health decision-making process about diagnosis and treatment depends on the severity of the
condition, uncertainty and the need for reassurance, time and distance from other healers, the need to confirm or disprove a diagnosis, or to establish a diagnosis from an unknown. When laypeople decide to consult another healer they consider two factors. Firstly, the health status of the individual and the household as a unit: minor episodes of illness or injury versus major conditions that are acute, life-threatening, chronic or potentially disabling have implications for the choice of healer and cost of care. Secondly, the frequency of seeing a healer for acute or ongoing care entails the following questions: which one (who), how often (when), for what condition (why), period of the relationship (how long), availability and accessibility (where), other healers (why). Participants reported external social support, work and community commitments, and affective relationships within the household are other factors influencing their lay health decision-making.
CONCLUSION

Medical pluralism is clearly evident in the Geelong Region, as demonstrated by participants' responses to the questionnaire, and in interviews and focus group discussions. The issues raised by my research provide a basis for a comprehensive study of medical pluralism in wider Australian society, similar to those undertaken by Kleinman (1980) in Taiwan and Frohock (1992) in the United States. Diverse healing options are demonstrably available to laypeople; other than their lay healing practices in the household, and instead of or in addition to biomedical care, as proclaimed by medical dominance theorists.

Laypeople's expansive health knowledge emanates from diverse sources, not just biomedicine or personal experience. This lay knowledge is a legitimate type of knowledge and should not be readily discounted or ignored by government policymakers, academics or biomedical health professionals and other healers (Popay and Williams 1996). Laypeople use their health knowledge to make informed decisions about lay healing within the household, and about their use of health care services outside the household. Their decision-making process is circular involving factors of knowledge, decision-making, action and evaluation. Their aim is to produce and protect health (Berman et al 1994) in terms of morbidity, mortality, well-being and quality of life.

My research indicates a significant proportion of lay healing practices occurs within the household. Laypeople's healing practices are extensive, and include: health education, health promotion and illness-injury prevention, as well as lay diagnosis and lay treatment. These lay healing practices are differentiated by gender, age/generation and health status (individual and household). Participants expressed contradictory perspectives on gender: they pronounced the need for gender neutrality, yet noted marked gender differences in experiences of health and ill-health, and in health seeking approaches.

Lay conceptualisations of health and ill-health, as indicated by participants, include physical, mental and spiritual dimensions. Embodiment, whilst gendered, incorporates these three dimensions. This is also evident in laypeople's approaches to healing themselves and to healing their significant others. Previous studies on laypeople's consultation of alternative therapies and folk healers indicate they seek a 'holistic' approach to health and ill-health (McGuire 1988, Frohock 1992, Sharma 1992, Easthope 1998). In contrast, the emphasis in public health remains on the physical, material, visceral body, whilst the Cartesian mind-body split continues to dominate biomedical care.

Mental health continues to be labelled as 'problematic', whilst individuals suffering a mental disorder are also afflicted by stigma (Goffman 1963). Rather than the
tendency to label an individual's difficulties with coping with life as a 'mental disorder', according to an international psychiatric nosology, it may be better to acknowledge laypeople's experiences of 'life crises'. These life crises may be mitigated by cultural factors, the absence of social support and other factors. Mental disorders perceived in this way may encourage healers of diverse modalities, to creatively re-consider the isolation, exclusion and suffering these individuals undergo. Tudor (1996) and Orley (1997) advocate a 'new' approach: 'mental health promotion' as a way of sustaining and improving health and well-being, and to prevent mental disorders.

As a third dimension of health and ill-health, spirituality remains poorly conceptualised let alone debated within public health. Nor is there evidence of a public health understanding of laypeople's spirituality and its relationship to health and well-being in their everyday lives. Theoretical and methodological questions remain to be asked. The most notable public health interest in spirituality is by the WHOQOL Group (1995). In constructing their cross-cultural instrument to measure health from six dimensions, they also include the 'religion-spirituality-personal beliefs' dimension, but acknowledge that further work is required to develop it. My research contributes to the WHOQOL project by providing an understanding of laypeople's spirituality in relation to embodiment, health and ill-health.

Laypeople make no distinction between the categories of health education, health promotion and illness-injury prevention, unlike health professionals, policymakers and academics with vested occupational interests in the public health field. Laypeople in their capacity as parents are health educationists in the household setting. They employ a set of 'ways of teaching' about health and ill-health, whilst they also endeavour to 'avoid hazards' and 'remove hazards'. Laypeople's discourses on risk are dissimilar to public health, and have implications for their 'lay assessment of risk' (Frankel et al 1991, Sellerberg 1991, Brown 1995), conceptualisations of accidents, risk-taking behaviour and implementation of 'safety rules' (Green 1995, Roberts et al 1995). A further implication is how much attention laypeople pay to public health messages which continue to: take a top-down approach to design, implementation and evaluation; target specific 'population groups'; and, blame individuals for their lifestyle, whilst rarely overcoming structural inequalities which impair health, such as socio-economic status.

Lay diagnosis refers to laypeople's knowledge of 'normality and abnormality'; that is, 'embodied knowledge' and 'knowing your child' or another person (Cunningham-Burley 1990, Lauritzen 1997). When diagnosing ill-health, laypeople consider the presenting signs and symptoms of illness and injury, they physically examine the sick person, investigate the circumstances and assess severity of the condition. Unlike the assertion of previous studies that laypeople provide only self-care and/or self-medicate themselves, the data indicate that self-care is only one form of lay treatment (Dean
Laypeople also administer first aid according to their knowledge and confidence in their own abilities, they provide extensive self-care, and tend to self-medicate with patent and non-proprietary medicines (including OTCs and home remedies of their own devising).

How laypeople manage their household economy - in terms of their time, labour, budget and resources - has implications for their capacity to provide health care within the household, and their use and purchase of health care services outside the household. In addition, the decreasing membership of private health insurance reveals laypeople's limited willingness to access 'private' health care (in public hospitals as a 'private patient', and in private hospitals) (Productivity Commission 1996, 1997). Laypeople's perceptions of barriers to health care are social, political and economic; suggesting inequities between Australians and their accessibility to health care, despite Medicare. Whilst the household economy was researched, word space constraints do not allow a full discussion of the data on the issues raised in the project.

My research analyses laypeople's health knowledge, decision-making and healing practices within the context of their everyday lives. The quantitative and qualitative data of this study confirms national data (ABS 1997, AIHW 1996, 1998) and other studies on health, ill-health and health care services (for instance, self-medication and consultations with alternative therapists), despite the small and non-random sample (of more women than men). Previous research has concentrated on women as mothers, in particular, young mothers with their first child or young children (pre-school age). There has been less attention to both women and men as parents of primary school children (aged 5-12 years) or adolescents (10-17 years). Each participant in the sample had at least one child under the age of 12 years, of which a large proportion of all children in the sample (N=221) attended primary school (N=122). Many participants also spoke of their children of other age groups.

Women's extensive lay healing practices in the household are manifested in the fragmentary historical evidence to date as well as in contemporary studies. Women continue, however, as Hochschild (1989) argues, to work a 'double shift'. They are nurturing and caring for the family as well as being employed in the paid workforce, studying or undertaking voluntary community work (Bittman 1991, ABS 1998b). Female participants admitted they are confronted with competing and often conflicting roles and responsibilities. These have implications for their conformity with stereotypes of femininity and womanliness, dealing with changing gender relations, family structure and the family-work relationship, as well as their health status, lay healing practices in the household and use of other healing options (Research Institute on Gender and Health 1996).

Men's 'voices', perspectives and experiences of masculinity, health, ill-health, partnering, parenting and healing that are documented in this thesis, contribute to the
growing literature on the men's movement and the men's health movement. Given the 'absence' of men in health care studies, how men (and women) perceive their roles as parents and as lay healers in the household is given importance. Men also provide lay healing practices in the household. The data reveal that men play a significant role in diagnosing and treating illness and injury, and decision-making about appropriate healing options. Female participants spoke of their partner's level of involvement in lay healing. Seven men in the sample reported both advantages and disadvantages of their experiences of 'role reversal' or being a 'primary caregiver' (Gribich 1994, 1995), and the effects upon their lives and relationships with their partners and children, and their capacity to implement lay healing practices (popularly viewed as 'women's work') in their households.

The issues raised by the twenty male participants suggest the need for further research to establish how widespread these concerns are amongst Australian men, by taking into account both diversity and specificity (Broom 1998a, 1998b). That is, by exploring social class, ethnicity, sexuality, religious belief and age among men residing in urban, rural, coastal and remote areas of Australia. As Connell (1995) argues, 'masculinities' are plural and are shaped by individual as well as socio-cultural constructions. These in turn affect men in their roles as partners, parents and lay healers in the household, their lay health knowledge and decision-making, and the extent of lay healing practices they undertake for themselves and their significant others. This study clearly indicates that men's embodied knowledge and their language to describe male embodiment, health and ill-health are limited; having implications for their self-evaluation of health status, provision of lay treatment, and search for other healing options.

This project was undertaken at a specific historical and cultural junction in Geelong, Victoria, Australia (1994-98). By taking a multi-theoretical approach and drawing upon various disciplines within the social sciences and humanities, it was possible to provide an explanatory framework for data analysis at different levels - following Turner (1987) and using my 'sociological imagination' (Mills 1959) - of the power-knowledge relationship underlying lay healing practices in the household. This framework reveals various factors at the both the micro and macro levels, and enables an examination of the link between them and how they impact upon each other. Internal factors affecting lay healing practices in the household are: family structure, gender and age of each generation, the affectivity and intimacy of partnering and parent-child relationships, and individual and household health status, as well as lay health knowledge, decision-making and management of the household economy. The external factors are structural; social, cultural, political, economic and environmental, exemplified by policies and programs, which impose constraints on laypeople's households and their everyday lives. In between these two levels, tensions exist
between individuals and society, agency and structure, micro and macro, rights and responsibilities (Giddens 1984, Beck et al 1994). Laypeople respond to these tensions, by using their 'sociological imagination', or arguing 'the personal is political' as many feminists assert, through lay activism. Their responses are relative to their lived experiences of gender and age, and their roles as partners, parents and lay healers. Thus in Foucault's (1979) terms, laypeople exercise 'power' as a strategy, that is found everywhere and to which there is also resistance. They are 'agency selves' and 'reflexive subjects' (Giddens 1984, Beck et al 1994), with 'gendered embodiment' (Turner 1992), but their healing choices may be circumscribed by structural factors.

In 1998, the parallel discourses of 'economic rationalism' and 'social capital' in Australia highlight the disparaging effects of economic and social practices upon the health of this society (Cox 1995, 1997b, Baum 1997, Rayner 1997). Proponents of economic rationalism continue to implement significant reduction of funds, resources and personnel to health care (and other) services, at a time of continuing unemployment (nationally 8.1% in June 1998 [ABS 1998b]). Increasing numbers of public services are becoming curtailed and privatised, with implications for availability, content and quality of delivery of services, as well as accountability. Public hospitals, for example, struggle to retain their existence and prevent closure, or seek privatisation of many services in order to provide health care to large catchment areas (Collyer and White 1997). In contrast, the discourse of social capital continues to emphasise trust, reciprocity and 'acts of kindness' of people towards one another. Human beings are privileged over machines, and healthy social relationships are idealised. Within the health care system, laypeople as patients seek listening, communication, care, compassion and empathy from other healers (Kleinman 1998b). The human condition affects us all; regardless of whether we are laypeople or experts, rich or poor, alone or living in the company of our significant others. Health and illness as an axiom of the human condition constitutes a great leveller. No human being is immune to the vagaries of life; to pain and suffering, love and joy (Campbell 1988, Kubler-Ross 1997).

During the project, I engaged with health and social policy, noting the 'expert' discourses and the marked absences of lay knowledge and discourses. This study has implications for: assessing healers' clinical practices; establishing questions in health research; and, analysing and developing health policies as well as designing, implementing and evaluating health programs.

Healers’ Clinical Practice

Healers of various healing modalities - from biomedical health professionals, to lay healers to alternative therapists to folk healers - are concerned with improving the health and well-being of individuals and populations in various settings. My research confirms laypeople can readily describe the meanings of their embodied selves, health
and ill-health, which cannot be reduced to a sum of parts nor are they disconnected from everyday life. Laypeople when sick, endeavour to retain their integrity and subjectivity amidst an often confusing and distressing experience of health care services utilisation. Moreover, lay knowledge represents a challenge to the 'expert' and specialist knowledge of healers (Williams and Popay 1994a, Williams and Calnan 1996b).

It is imperative for healers to listen and heed laypeople's voices; their narratives of health, ill-health and healing should be taken seriously (Kleinman 1988a, Frank 1995, Williams and Calnan 1996a). Secondly, healers must consider laypeople's knowledge, decision-making and lived experiences which impact upon their capacity to provide lay healing for themselves and their significant others, in the household, social networks and local community. Frequently, lay diagnosis and treatment occurs before, instead of and in addition to choosing another healing option. Therefore, when laypeople present as 'sick' to a healer, their 'expertise' of their 'embodied self', and their prior lay diagnosis and treatment, should not be readily discounted, devalued or regarded as illegitimate (Kleinman 1995b). Thirdly, healers should continue to provide patients (and their significant others) with information on diagnosis, treatment (including medication and procedures), and prognosis, to facilitate lay health decision-making and reach an 'informed decision' (Wood 1996).

The potential, positive outcomes of these approaches are: a closer fit between patient (lay) and healer diagnoses; improved patient compliance with recommended treatment; greater patient satisfaction with the patient-healer relationship; less 'healer-shopping'; and, minimal, negative labelling of patients (and children's parents) as 'neurotic' or 'hysterical'.

**Public Health Research**

Similar to Dean and Hunter (1996), Popay and Williams (1996), Calnan and Williams (1996a), I contend lay knowledge is a topic worthy of rigorous investigation, given its importance for public health. Lay health knowledge, decision-making and healing practices are poorly understood and non-traditional areas of public health research. To redress this hiatus, a public health focus requires creative theoretical and methodological approaches from multi-disciplines, other than epidemiology and biostatistics, and analysis of both quantitative and qualitative data (McKinlay 1993, Baum 1995c, Popay et al 1998). This study contributes to theoretical discourse and empirical research in public health, in terms of medical anthropology, sociology of the body, feminisms and masculinities, and the family.

Future public health research could explore lay health knowledge, decision-making and healing practices by concentrating on gender, age, and social networks and local communities. Firstly, to date there is a gender imbalance in health care research; theoretically and empirically. The dominant official discourse of 'women get sick but
men die sooner' continues, with little examination of the reasons based on gender for these differences (Broom 1998a, 1998b). Researchers continue to perceive women as lay healers, parents and present in the household but do not view men as parents or as lay healers, and consider them 'absent' in the household. To get around this imbalance, more attention needs to be paid to the human qualities women and men share in common. There is a need to include men in projects on lay health knowledge and decision-making - in terms of their social roles as fathers and as lay healers. In addition, given social change in Australia, alterations in gender relations, family structure and the family-work relationship must be addressed. The context of laypeople's everyday lives cannot be divorced from these factors.

Secondly, the lay health knowledge, decision-making and healing practices of other population groups, such as children, adolescents, young adults and older persons, remains to be fully explored. Studies by Williams et al (1989a, 1989b), Mayall (1993b, 1996), Bendelow and Pridmore (1998), Green (1997), are paving the way in developing an understanding of how children conceptualise health and illness, risk and accidents. Further research could address how children look after themselves, what knowledge they draw upon to make decisions about their own health and well-being, and the settings in which they do so: household, school, playground, clubs in terms of their 'work and play' activities. Similar approaches could be applied to other age cohorts. The data on the inter-generational transfer of knowledge could not be fully discussed in this thesis due to word space constraints.

Thirdly, this study concentrates on the household as the principal setting of health and ill-health, and lay healing practices. The household is also the unit of analysis. Public health research (and policy) to date has concentrated on other settings such as cities, islands, workplaces, marketplaces, hospitals, clinics, and more recently, prisons. Social networks and local communities, as Kleinman (1980) makes clear, are also part of the popular sector of the health care system. Previous studies on social networks confirm the importance of social support for laypeople when in 'good health' and also when experiencing 'poor health' or a life crisis (Zola 1972, McKinlay 1973). 'Popular epidemiology' (Brown 1995) is an example of lay knowledge and medical/scientific knowledge being used together to research and act upon a public health issue within a local community.

The potential data from such systematic research on gender, age/generation, social networks and local communities would provide further insights on the complexity and intricacy of the power-knowledge relationship underlying lay healing practices in everyday life.
Health Policies and Programs

My research presents various implications for health policies and programs in general, and those concerning women’s health, men’s health, children’s health, health economics, health promotion and primary health care in particular. Current policies and programs at the macro level have both a downward effect and a 'pond effect' upon laypeople's everyday lives. I agree with McKinlay’s (1979) argument of the necessity to 'refocus upstream', by examining the structural factors (including policies and programs) that affect individual and population health and ill-health. However, it is also important to note the gaps between public health rhetoric and practice, and the relevance of health policies and programs to laypeople in their everyday lives, given changing social and environmental conditions. There continues to be a 'top-down' approach to implementing health policies and programs.

There is also a need for research to inform policy. As Dean and Hunter (1996:748) argue:

The criteria will always remain the utility of the research and the potential for utilisation of the research findings. The critical features of these criteria include: the relevance of the topic, validity of the study, timeliness of the findings, feasibility of the recommendations and targeted dissemination (authors' emphasis).

The inclusion of lay knowledge and discourses on health and ill-health should be evident in health policy documents. Laypeople's 'voices' and experiences must be recognised as being of equal value to and just as legitimate as that of policymakers, health professionals and academics who sit on ethics, research and institutional committees and determine policies and programs which ultimately affect laypeople (McNeill 1996, Jewkes and Murcott 1998, Popay et al 1998).

It is remiss of public health 'experts' to continue implementing health education, health promotion and illness-injury prevention programs without understanding and incorporating laypeople's own views, experiences and practices within the household (or within their social networks and local community). For laypeople, these health professional, policymaker and academically defined categories do not coincide with their own perspectives. Laypeople do not perceive a distinction between health education, health promotion and illness-injury prevention. The types of issues laypeople indicate as pertaining to one or two out of three categories have implications for the emphasis public health experts place when shaping and developing programs. They also will determine their 'success' and their 'failure', as increasing, though fragmented, evidence reveals (Frankel et al 1991, Syme 1997). Furthermore, laypeople are ambivalent about the usefulness of public health messages. Whilst laypeople acknowledge public health messages provide increased knowledge, they are also critical
that what passes for professional knowledge is often professionalisation of commonsense.

Improved collaborative efforts between laypeople, policymakers, academics and health professionals will result in better designed and public acceptance of policies programs.
APPENDIX A
ACRONYMS

ABS  Australian Bureau of Statistics
AIHW  Australian Institute of Health and Welfare
AMA  Australian Medical Association
CHF  Consumers’ Health Forum
COSHG  Council of Self Help Groups
CSIRO  Commonwealth Scientific and Industrial Research Organisation
HBM  Health Belief Model
HHPH  Household Production of Health
IYF  International Year of the Family
MBS  Medicare Benefits Schedule
NCEPH  National Centre for Epidemiology and Population Health
NCHPE  National Centre for Health Program Evaluation
NHE  New Household Economics
NHMRC  National Health and Medical Research Council
NMA  Nursing Mothers’ Association
PBS  Pharmaceutical Benefits Scheme
PHARM  Pharmaceutical Health and Rational Use of Medicines (PHARM) Committee
RACGP  Royal Australian College of General Practitioners
RDNS  Royal District Nursing Service
SNAGs  Sensitive New Age Guys
UNDP  United Nations Development Program
WHOQOL  World Health Organisation Quality of Life (Group)
APPENDIX B

DISCUSSIONS WITH OTHERS (1994-98)

In all cases, the people I talked to or corresponded with were informed of the nature of the research.

The following individuals were consulted but are not cited in the thesis. I thank them for their generosity in providing insights on lay healing practices in the household.


I had correspondence with the following individuals during the project's lifespan. They are not cited in the thesis text.

Peter Berman, Karabi Bhattacharya, Tariq Bhatti, Kathryn Dean, Sandi Gifford, Hilary Graham, Patricia Harris, Carl Kendall, Arthur Kleinman, Margaret Lock, Joel Mokyr, Patrick Mullins, Sarah Nettleton, Don Nutbeam, Anne Oakley, Robert Pearn, Jennie Popay, Dorothy Porter, Roy Porter, Patricia Short, Margaret Stacey, Leonard Syme, Carol Thomas, Gareth Williams, Evan Willis, Irving Kenneth Zola.
## APPENDIX C
### MODELS OF HEALING

<table>
<thead>
<tr>
<th>Model</th>
<th>Practitioners</th>
<th>Aetiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>orthodox allopathic</td>
<td>scientific deductive thinking biomedical</td>
<td>malfunctioning/abnormal structure &amp; function of body organs/systems</td>
</tr>
<tr>
<td></td>
<td>clinicians, nurses, doctors, allied health professionals</td>
<td>single cause &amp; effect, germ theory (micro-organisms), congenital defects (genes) body-mind split</td>
</tr>
<tr>
<td>alternative</td>
<td>holistic</td>
<td>multi-causal</td>
</tr>
<tr>
<td></td>
<td>alternative therapists (complementary healers), Reiki, reflexology, acupuncture, naturopathy, chiropractor, osteopathy, homoeopathy, myotherapy</td>
<td>social, environmental, dietary workplace, body-mind-spirit</td>
</tr>
<tr>
<td>folk healing</td>
<td>spiritual</td>
<td>spirit, soul</td>
</tr>
<tr>
<td></td>
<td>folk healers, bonesetters, herbalists, witch doctors, shamans, spiritualists, faith healers</td>
<td>human beings relationships with each other &amp; the natural world energy</td>
</tr>
<tr>
<td>social</td>
<td>new public health</td>
<td>social &amp; environmental origins of illness culture</td>
</tr>
<tr>
<td></td>
<td>public health professionals (multi-disciplinary), anthropologists, sociologists, psychologists, economists, epidemiologists, biostatisticians</td>
<td>social structure, individual lifestyle, political economy knowledge</td>
</tr>
<tr>
<td>lay</td>
<td>multi-causal inductive thinking holistic preventive</td>
<td>multicausal problems knowledge</td>
</tr>
<tr>
<td></td>
<td>laypeople, diverse socioeconomic &amp; cultural backgrounds, geographical location</td>
<td>multiple sources, specialisation decision making</td>
</tr>
</tbody>
</table>
### MODELS OF HEALING (cont)

<table>
<thead>
<tr>
<th>Education &amp; Training</th>
<th>Subject/Object</th>
<th>Public/Private</th>
<th>Unit of Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>orthodox allopathic</strong></td>
<td>university degrees</td>
<td>objective</td>
<td>public</td>
</tr>
<tr>
<td>. general</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. inservice/on-the-job</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. seminars</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. workshops</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>alternative</strong></td>
<td>university degrees professional colleges</td>
<td>subjective</td>
<td>public</td>
</tr>
<tr>
<td><strong>folk healing</strong></td>
<td>masters as teachers mentor-protege relationship hereditary position specialist</td>
<td>subjective</td>
<td>public &amp; private</td>
</tr>
<tr>
<td><strong>social</strong></td>
<td>university degrees</td>
<td>objective</td>
<td>public</td>
</tr>
<tr>
<td>. generalist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. inservice/on-the-job</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. seminars</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. workshops</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>lay</strong></td>
<td>generational multi-media self-education intuition-instinct commonsense trial &amp; error life experiences</td>
<td>subjective</td>
<td>private</td>
</tr>
<tr>
<td>. general and specific</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## MODELS OF HEALING (cont)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Prevention</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>orthodox</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>allopathic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>case history</em></td>
<td><em>cure disease &amp; save lives</em></td>
<td><em>screening</em></td>
<td><em>randomised clinical trials</em></td>
</tr>
<tr>
<td>. signs &amp; symptoms</td>
<td>. conservative</td>
<td>. monitoring &amp;</td>
<td><em>case histories</em></td>
</tr>
<tr>
<td>. physical examination</td>
<td>. interventional</td>
<td>. surveillance</td>
<td><em>empirical hypotheses</em></td>
</tr>
<tr>
<td>. diagnostic tests</td>
<td>. first aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. pathology</td>
<td>. drugs</td>
<td></td>
<td><em>empirical positivist reductionist</em></td>
</tr>
<tr>
<td>. radiology</td>
<td>. surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. exploratory surgery</td>
<td>. counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>alternative</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>case history</em></td>
<td><em>treat cause</em></td>
<td><em>rest &amp; regular</em></td>
<td></td>
</tr>
<tr>
<td>. signs &amp; symptoms</td>
<td>. diet</td>
<td>. exercise</td>
<td></td>
</tr>
<tr>
<td>. identify cause</td>
<td>. exercises</td>
<td>. good food</td>
<td></td>
</tr>
<tr>
<td>. esoteric healing</td>
<td>. herbal remedies</td>
<td>. limited stress</td>
<td></td>
</tr>
<tr>
<td>. metaphysical</td>
<td>. natural therapies</td>
<td>. emotional stability</td>
<td></td>
</tr>
<tr>
<td>. health care</td>
<td></td>
<td>. everything in</td>
<td></td>
</tr>
<tr>
<td>. magico-religious</td>
<td></td>
<td>. moderation</td>
<td></td>
</tr>
<tr>
<td>. rites</td>
<td></td>
<td>. balance</td>
<td></td>
</tr>
<tr>
<td>. invocation of spirits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>folk healing</strong></td>
<td><em>esoteric healing</em></td>
<td><em>mediation between</em></td>
<td></td>
</tr>
<tr>
<td><em>history</em></td>
<td><em>metaphysical</em></td>
<td>. lay individuals &amp;</td>
<td></td>
</tr>
<tr>
<td>. signs &amp; symptoms</td>
<td><em>health care</em></td>
<td>. communities over disputes</td>
<td></td>
</tr>
<tr>
<td>. infractions of social norms</td>
<td><em>magico-religious rite</em></td>
<td>. Nature &amp;</td>
<td></td>
</tr>
<tr>
<td>. esoteric healing</td>
<td><em>natural therapies</em></td>
<td>. Supernature</td>
<td></td>
</tr>
<tr>
<td><strong>social</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>multi-disciplinary approach</em></td>
<td><em>treat cause</em></td>
<td><em>health education</em></td>
<td><em>survey</em></td>
</tr>
<tr>
<td>. identify risk factors</td>
<td>. change social,</td>
<td><em>health promotion</em></td>
<td><em>ethnography</em></td>
</tr>
<tr>
<td>. economic &amp; political structures</td>
<td>. economic &amp; political</td>
<td><em>illness/injury prevention</em></td>
<td><em>health program evaluation</em></td>
</tr>
<tr>
<td>. population</td>
<td>. substitution</td>
<td>. prevention</td>
<td><em>health policy analysis</em></td>
</tr>
<tr>
<td>. change lifestyle</td>
<td>. change lifestyle</td>
<td>. distinct categories</td>
<td></td>
</tr>
<tr>
<td>. individual</td>
<td>. individual</td>
<td>. professionalisation</td>
<td></td>
</tr>
<tr>
<td>. change physical</td>
<td>. change physical</td>
<td>. defence of</td>
<td></td>
</tr>
<tr>
<td>. environment</td>
<td>. environment</td>
<td>. occupational</td>
<td></td>
</tr>
<tr>
<td>. knowledge</td>
<td>. knowledge</td>
<td>. territory</td>
<td></td>
</tr>
<tr>
<td><strong>lay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>knowing what is normal &amp; abnormal</em></td>
<td><em>diverse healing options</em></td>
<td><em>health education</em></td>
<td><em>trial &amp; error</em></td>
</tr>
<tr>
<td>. signs &amp; symptoms</td>
<td><em>multicausal solutions</em></td>
<td><em>health promotion</em></td>
<td><em>lay experimentation</em></td>
</tr>
<tr>
<td>. embodied</td>
<td>. substitution</td>
<td><em>illness/injury prevention</em></td>
<td><em>self-education</em></td>
</tr>
<tr>
<td>. knowledge</td>
<td>. home remedies &amp;</td>
<td>. prevention</td>
<td><em>lay referrals</em></td>
</tr>
<tr>
<td>. 'knowing your child'</td>
<td>. self-medication</td>
<td>. blurred categories</td>
<td></td>
</tr>
<tr>
<td>. presence-absence at the incident</td>
<td>. lay referrals</td>
<td>. not a social</td>
<td></td>
</tr>
<tr>
<td>. physical examination</td>
<td>. counselling</td>
<td>. movement</td>
<td></td>
</tr>
<tr>
<td>. first aid &amp; self-care</td>
<td></td>
<td>. social support</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D
ETHICAL CONSIDERATIONS

Measures to Preserve the Privacy of Participants

Ethics approval to conduct the study was sought and granted by the University Ethics Committee in July 1994. Ethical issues revolved around the maintenance of confidentiality for participants, where it was desired on part of the participants. They were offered anonymity during and after the study.

The aims of the research were fully explored with participants.¹ They were given a plain language statement which stated the aims and objectives of the project, what type of questions would be asked, and assured of confidentiality and anonymity, during their involvement in the project. A consent form was completed by them prior to involvement. Approval was sought from participants to record interviews and focus group proceedings.

Participants were invited to attend focus group discussions and/or be interviewed on an individual basis, to voice their experiences, views and practices of lay healing in the household. They were given a questionnaire to establish a socio-demographic 'picture' of the sample. The questionnaire included questions concerning the division of household labour for care of the sick, utilisation of health care services and health care financing.

All interviews and focus group discussion undertaken during the project were audio-taped and transcribed. The tape transcribers were not given access to identifying details. All data obtained from questionnaires, interviews and focus group discussions have been coded to preserve participants' confidentiality, and have been analysed in aggregate form. The personal details of each participant have been stored separately from the data. Furthermore, the participants were asked that they maintain confidentiality of discussions held in focus groups. The questionnaire was coded numerically, before the data were entered onto a database and statistically analysed. Any material used as direct quotes in the text of the thesis and other publications have been annotated anonymously.

All participants were sent a summary of the findings of the study.

CONSENT FORM

I, of

Hereby consent to be a subject of a human research study to be undertaken by Anita Peerson

and I understand that the purpose of the research is:

. To explore and understand the everyday life experiences and practices of women and men as lay healers, providing health care for themselves and others, to promote health and prevent illness.

. The findings of the project will inform policymakers, health care providers and community groups of the health promotion and illness prevention practices undertaken by lay women and men, and assist them with developing new policies and implementing programs in public health in Victoria and Australia.

I acknowledge

1. That the aims, methods, and anticipated benefits, and possible hazards of the research study, have been explained to me.

2. That I voluntarily and freely give my consent to my participation in such research study.

3. I understand that aggregated results will be used for research purposes and may be reported in scientific and academic journals.

4. Individual results will not be released to any person except at my request and on my authorisation.

5. That I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease and any information obtained from me will not be used.

6. I understand that discussions of the focus group are to be treated confidentially by myself and by the other participants.

Signature: Date:
Dear Participant

I am a postgraduate student in the Faculty of Arts, Deakin University Geelong, and am doing a project on Women and Men as Lay Healers for my degree: Doctor of Philosophy. I am interested in exploring and understanding your everyday life experiences and practices of providing health care for yourself and for others. Other people may be: your partner, children, relatives, friends, neighbours, and/or local community members. I would like to find out about the things you do to promote health and prevent illness/injury in the household.

I invite you to participate in this project. This means spending some time with me, attending a group discussion (where up to 10 people will be present) which will be audio-taped and be of 1-1.5 hours in length. I will also ask you to fill in a questionnaire, which will take approximately 10 minutes.

I wish to understand your views and attitudes of health and illness; perceptions of the human body; and the things you do to promote health and prevent illness. I will ask you questions about your personal details, for example, education, age, income level, cultural background.

All information will be confidential. Only myself will be able to identify the information given with your name, address and any other personal details. Any direct quotes will be written anonymously in my thesis and other papers resulting from the project. Furthermore, I ask that you maintain confidentiality about what is discussed in the focus groups.

The project will help policymakers in government, health care providers (doctors, nurses, alternative therapists) and community groups making new policies and planning and implementing programs on health promotion and illness/injury prevention in Victoria and Australia.

When the research project has been completed, you will be given a summary of its findings. A copy of the final report will be available on request. Results of the project will be published in journals in Australia and overseas, and presented at conferences.

Deakin University Ethics Committee requirements request that you sign a consent form, which lets me know you are willing to participate in the project. Should you wish to, you will be also able to withdraw at any time during the project.

I am the contact person for the project and am available to answer any queries, at the School of Social Inquiry, Faculty of Arts, Deakin University, Geelong 3217, Victoria. Ph: 271335. Fax: 272018. My supervisors for the project are: Dr. Liz Eckermann (Ph: 271026) and Dr. Jenny Hughes (Ph: 272083). They can be contacted at the School of Social Inquiry, Faculty of Arts, Deakin University, Geelong 3217, Victoria.

Thankyou for your time.

Anita Peerson
APPENDIX E
PILOT STUDY

FOCUS GROUP DISCUSSION AND INTERVIEWS

AIM: To explore and develop an understanding of the everyday life experience and practices of women and men as lay healers.

CHILDHOOD ILLNESSES AND INJURIES

SIGNS AND SYMPTOMS: HYPOTHETICAL SITUATIONS

<table>
<thead>
<tr>
<th>Fever</th>
<th>Cold</th>
<th>Cough</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earache</td>
<td>Headache</td>
<td>Sore eyes</td>
</tr>
<tr>
<td>Warts</td>
<td>Nappy rash</td>
<td>Diarrhoea</td>
</tr>
<tr>
<td>Nausea</td>
<td>Projectile vomiting</td>
<td>Grazed knee</td>
</tr>
<tr>
<td>Sprained ankle</td>
<td>Broken arm</td>
<td>Cut finger</td>
</tr>
<tr>
<td>Bleeding</td>
<td>Loss of consciousness</td>
<td>Convulsions</td>
</tr>
<tr>
<td>Allergies</td>
<td>Burns</td>
<td>Poisoning</td>
</tr>
</tbody>
</table>

HEALTH
- What does it mean to be healthy/in good health?
- What are some things you teach your children (or others) about health? For example - food and nutrition, hygiene, safety, relationships and sexual behaviour

HEALTH PROMOTION AND ILLNESS-INJURY PREVENTION
- What do you do to promote health and prevent illness or an injury in your daily lives?
- Who do you do this for? - yourself and/or others
- What do you do ensure your body and that of your children are maintained? - so that health is actively promoted and illness prevented?
- Where does your knowledge about the body, health and illness come from?
- Where do you go to when you need information to look after someone who has become ill or injured?
- What would you view as being a risk to health?
- What do you do to prevent or reduce risk?

DIAGNOSIS OF ILLNESS-INJURY
- What does it mean to experience ill-health, to feel ill or be sick?
- How do you know when someone has been injured?
- When would you realise there was an illness or injury that needed treatment? - What would be some of the presenting signs and symptoms you might be aware of?
- How would you assess the need for treatment?
- How do you make decisions about what type of health care is needed?
- How would you make a diagnosis?
- Would you investigate the circumstances which led to the condition?
- How would you determine the severity of the illness or injury? - is it life-threatening, require emergency treatment (first aid, surgery), or short to long-term care?
- Do you take into account circumstances surrounding the onset of signs and symptoms? - what context? - time and place.
- Are there additional symptoms from other conditions (co-morbidities)?
- Can the condition be managed at home?
- If someone in your household has a disability or chronic illness, what is the effect (if any) on other relationships eg. with family members, particularly over a long period of time?
TREATMENT OF ILLNESS-INJURY

- How would you determine the need for particular resources?
- What resources do you think might be necessary, in this instance?
- Who would you call on if you felt you couldn't manage the condition by yourself?
- How do you decide lay healing may not be enough and another form of therapy is needed?
- What type of therapy would this be? - What would be your treatment options for this condition?
- Would you consider seeing a health professional, an alternative therapist, or a folk healer?
- Or someone else?
- What would be important to you about this therapy?
- If you were dissatisfied with this form of therapy, how would you choose another?

HOUSEHOLD ECONOMY

- What remedies do you keep at home?
- Do you get things for health from the supermarket, chemist or elsewhere? Examples???
- Who has control over household income and expenditure - the female or male head of the
- How are the household finances generally managed?
- How are payment of health care bills prioritised? - Do you consider when and how will the money
be spent? - to cure disease and save lives or to promote health and prevent illness
- What must be prioritised and for who in the household/which family member? - given their ages and
health needs
- Is the type and extent of private health insurance your household has, a consideration in paying for
health care?
- Given the unpredictability of illness and injury, what aspects of health care are budgeted for on a
regular basis?
- Do you perceive any barriers to health care?
- Have you encountered any financial barriers in accessing health care services? What have these
been?
- Are there any other issues which might facilitate or make difficult financial access to health care?
- What resources (available and potential) does your household have to facilitate health care?
- What are the total resources required in any given instance whereby health care must be provided?
- What are the associated costs (direct and indirect) with these?
QUESTIONNAIRE - PILOT STUDY

YOU DO NOT NEED TO GIVE YOUR NAME OR ADDRESS
Some questions only require a tick. Others may need a word or two.

1. I am  [ ] female  [ ] male  

2. My age is _________ (years).

3. My marital status is:
   Never married  [ ]
   Married  [ ]
   Separated but not divorced  [ ]
   Divorced  [ ]
   Widowed  [ ]

4. I live by myself  [ ]
   I live with my spouse/partner  [ ]
   I live with my spouse/partner and child/children  [ ]
   I live alone with my child/children  [ ]
   Other (please specify)  [ ]

5. I was born in __________________ (country).
   a) IF NOT AUSTRALIA, I have lived in Australia _________ years.
   b) My ancestry is __________________

6. What language(s) do you speak at home? __________________________
   a) I speak English
      Very well  [ ]
      Well  [ ]
      Not well  [ ]
      Not at all  [ ]

7. My highest level of education is
   PLEASE TICK ONE BOX ONLY
   Primary school  [ ]
   Secondary school  [ ]
   TAFE college  [ ]
   University  [ ]
   Other (please specify)  [ ]

8. My qualifications are ______________________

9. My occupation is ______________________

10. How many people in your household earn an income? ________
11. The total household income per fortnight/year (before tax) from all sources is

PLEASE TICK ONE BOX ONLY

Less than $192 ($5,000) [ ]
$192 ($5,000) to $460 ($12,000) [ ]
$460 ($12,000) to $770 ($20,000) [ ]
$770 ($20,000) to $1154 ($30,000) [ ]
$1154 ($30,000) to $1538 ($40,000) [ ]
$1538 ($40,000) to $2308 ($60,000) [ ]
More than $2308 ($60,000) [ ]
Don’t know [ ]

12. What religion are you? (please specify)

a) Do you attend religious services regularly?
   Yes [ ]
   No [ ]

13. In the last 12 months, has any member of your household become

PLEASE TICK THE APPROPRIATE BOXES

Sick [ ]
Injured [ ]
Disabled [ ]

a) Who takes care of someone in the household when they are ill or injured? (please specify)

14. What health care services are used by members of your household in Geelong?

PLEASE TICK THE APPROPRIATE BOXES

How often are these services used? (please specify)

<table>
<thead>
<tr>
<th>Service</th>
<th>How Often Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aids and appliances eg. crutches</td>
<td></td>
</tr>
<tr>
<td>Allied health eg. physiotherapy, social work</td>
<td></td>
</tr>
<tr>
<td>Alternative therapies eg. naturopathy, massage</td>
<td></td>
</tr>
<tr>
<td>Dental care</td>
<td></td>
</tr>
<tr>
<td>Diagnostic services eg. pathology, radiology</td>
<td></td>
</tr>
<tr>
<td>Domiciliary care eg. home help</td>
<td></td>
</tr>
<tr>
<td>Folk healer eg. spiritist, crystals, herbalist</td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>Hospital services eg. emergency department, outpatients</td>
<td></td>
</tr>
<tr>
<td>Pharmacy eg. medication</td>
<td></td>
</tr>
<tr>
<td>Specialist care eg. physician, surgeon, psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>
15. Are health care services in Melbourne used by members of your household?
   Yes [ ]
   No [ ]

a) What health care services are used?

   **PLEASE TICK THE APPROPRIATE BOXES**

<table>
<thead>
<tr>
<th>Service</th>
<th>How often are these services used? (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aids and appliances eg. crutches</td>
<td>[ ]</td>
</tr>
<tr>
<td>Allied health eg. physiotherapy, social work</td>
<td>[ ]</td>
</tr>
<tr>
<td>Alternative therapies eg. naturopathy, massage</td>
<td>[ ]</td>
</tr>
<tr>
<td>Dental care</td>
<td>[ ]</td>
</tr>
<tr>
<td>Diagnostic services eg. pathology, radiology</td>
<td>[ ]</td>
</tr>
<tr>
<td>Domiciliary care eg. home help</td>
<td>[ ]</td>
</tr>
<tr>
<td>Folk healer eg. spiritist, crystals, herbalist</td>
<td>[ ]</td>
</tr>
<tr>
<td>GP</td>
<td>[ ]</td>
</tr>
<tr>
<td>Hospital services eg. emergency department, outpatients</td>
<td>[ ]</td>
</tr>
<tr>
<td>Pharmacy eg. medication</td>
<td>[ ]</td>
</tr>
<tr>
<td>Specialist care eg. physician, surgeon, psychiatrist</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

16. Do you have any of the following?

   **PLEASE TICK THE APPROPRIATE BOXES**

<table>
<thead>
<tr>
<th>Card Type</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance subscription</td>
<td>[   ]</td>
</tr>
<tr>
<td>Health care card</td>
<td>[   ]</td>
</tr>
<tr>
<td>Medicare card</td>
<td>[   ]</td>
</tr>
<tr>
<td>Pharmaceuticals Benefits Card</td>
<td>[   ]</td>
</tr>
<tr>
<td>Private health insurance</td>
<td>[   ]</td>
</tr>
<tr>
<td>Veteran's Affairs Card</td>
<td>[   ]</td>
</tr>
<tr>
<td>Don't know</td>
<td>[   ]</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>[   ]</td>
</tr>
</tbody>
</table>

17. Do you have any comments to make about health, illness and injury?

18. Do you have any comments to make about this questionnaire?
PILOT STUDY
DATA ANALYSIS

Sample Characteristics

The five parents participating in the pilot study were all women, aged 25-37 years. (No fathers attended the focus group discussion). Three women were married, one was divorced (a sole parent) and another was living in a de facto relationship. All had one to three children, aged three to ten years (N=12 children), living at home with them. The women were all born in Australia and of English, Egyptian or German ancestry, speaking English very well. Four women indicated they did not attend religious services regularly and their religion was none or Christian (ie. Uniting Church, Church of England).

Two of the women had completed secondary education, whilst the others had an university degree (Applied Science, Occupational Therapy and Medical Records Administration). One woman had completed a post-graduate diploma in Ergonomics, whilst another was currently undertaking post-graduate study in Community Development. Four women were undertaking paid work: administration, sales/retail, health and community services, and housekeeping. The fifth woman was looking for paid work related to occupational therapy. In all instances, one or two persons (adults) contributed to the household income. The gross household income (before tax) for three women was $460-770 per fortnight ($12,000-20,000 pa), $770-1154 per fortnight ($20,000-$30,000pa) and $1154-1538 per fortnight ($30,000-$40,000pa). Two women stated their gross household income was $1538-2308 per fortnight ($40,000-$60,000pa).

In terms of health status, each woman indicated a member of their household had become sick or injured, but not disabled, during the previous 12 months. It was usually the mother, both parents, grandparents, or additional persons who attended the sick. Health care services in the Geelong Region used by household members were: allied health, alternative therapies, dental care, diagnostic services, general practitioner, hospital services, and pharmacies. See Table 1.

The overall household use of health care services in Geelong seems minimal. The data suggest each woman’s family is generally healthy, only requiring regular checkups and/or much of the treatment of illness and injury occurs at home. The women responded their household members did not use health care services in Melbourne (at least 1 hour drive away). All five women had a Medicare card, whilst two had a subscription for ambulance services, a health care card and private health insurance. One woman had a Pharmaceutical Benefits Card.
Table 1: What health care services are used by members of your household in Geelong?

<table>
<thead>
<tr>
<th>Service</th>
<th>How often are these services used?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allied health</strong></td>
<td>3 visits/year, as required, irregular, yearly</td>
</tr>
<tr>
<td><strong>Alternative therapies</strong></td>
<td>3 visits/year, as required, irregular, yearly</td>
</tr>
<tr>
<td><strong>Dental care</strong></td>
<td>1-2 visits/year, every 18 months</td>
</tr>
<tr>
<td><strong>Diagnostic services</strong></td>
<td>rarely, 1/year, as required with referral from doctor</td>
</tr>
<tr>
<td><strong>GP</strong></td>
<td>2-4 visits/year</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td>1-2 visits/year</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>1/month, 1-2/year, as required for Panadol or referral from doctor</td>
</tr>
</tbody>
</table>

Issues Arising in the Focus Group Discussion

Health for Sandra, Beth, Mary, Joanne and Erika meant being ‘well’, involving notions of ‘wellness’ and ‘well-being’. When teaching their children about health, the women prioritised nutrition and hygiene. They stated their knowledge about the body, health and illness came from family tradition, friends, other people and their own personal formal education. A person’s lifestyle choices, socio economic status and financial situation were viewed as being risks to health.

Mary, Erika, Joanne, Sandra and Beth asserted experiencing illness meant being somewhere on a ‘scale’ or continuum of being superfit and healthy to being unhealthy or dead. An individual’s capacity to maintain their health and their stage of the lifecourse was influenced by incidence and severity of illness. They tended to diagnose illness or injury in the family according to the severity and suddenness of signs and symptoms, whether the condition was familiar to them (for example, tonsillitis had occurred previously), the known cause, their presence or absence, or it was beyond their experience. Each woman endeavoured to treat illness or injury themselves. In situations where the condition appeared severe or they were not present when it occurred, they were more likely to decide lay healing was not enough and seek another form of therapy, usually the family doctor. In other situations, they sought advice from friend or relatives, before consulting a doctor. Erika, Beth, Sandra, Mary and Joanne indicated that they were more likely to consult an alternative therapist for themselves, but were less confident about doing so for their children.

Beth, Sandra, Joanne, Mary and Erika kept various remedies at home. These included: calamine lotion, Savlon (antisepptic solution), Bandaids, Panadol which could be obtained off the shelf at the supermarket. They purchased Gastrolyte (for rehydration when vomiting and diarrhoea occur), antisepptic powders, solutions and ointments (including Betadine) from the chemist. One woman purchased zinc tablets from the
health food shop, whilst another responded her family's 'first aid kit' was stocked regularly.

Mary, Joanne, Sandra, Erika and Beth indicated that either themselves singularly or jointly with their partners, managed the household budget. Their children’s well-being was always prioritised, whilst necessities and luxuries, in addition to each member's likes and dislikes were considered when making decisions about how the fortnightly (or yearly) household budget would be spent. In addition, individual health needs would also be prioritised (sunscreen allergies, special soaps, drinking soy milk instead of cow's milk, and treating thrush with Yakult).²

Paying private health insurance for her family meant reassurance to Beth when her child's tooth fell out due to injury, thus reducing her out-of-pocket expenses. Mary and Joanne had ceased their payments for private health insurance given the rising cost to approximately $1000 per year (in 1995), and perceived minimal benefits.³ They had also decided that in the event any one of their children required emergency care, the local public teaching hospital was well staffed by 'excellent' paediatricians. Payment of dental bills occurred irregularly for checkups, and on a regular basis for their children requiring ongoing orthodontic treatment. Joanne, Sandra, Beth, Erika and Mary perceived cost and information as barriers to accessing health care, whilst at the same time they endeavoured to make informed decisions about formal health care services for their families.

**Issues Arising in the Research Interviews**

During the interview with each participant, I asked Beth, Joanne, Erika, Mary and Sandra about their lay conceptualisations of the body, health and illness, and lay healing practices in the household. The data also reveal their views and experiences of health education, sex-role modelling, parent-child negotiation, risks to health, safety at home and on the road, swimming and the beach, health promotion, sources of lay health knowledge, lay decision-making, lay diagnosis and treatment of illness and injury, and managing the household economy. The final section contains three case studies addressing: responsibility for other people's children; children's perceptions of disability and disabled persons; and, the impact of life transitions upon health and well-being.

---

² *Yakult* is a fluid containing live lactobacillus bacteria, obtainable from the supermarket.

³ Private health insurance premiums in mid 1998 are above $2000/year. The rising cost is frequently cited as the reason for spiralling downward of subscriptions, despite State support for this private enterprise.
Defining Health

I asked Mary, Joanne, Beth, Sandra and Erika: What does it mean to be healthy or in good health? They responded:

Health. Everyone needs it ... I think it is the state of your body and mind which allows you to do the things that you want to do ... To not feel tired ... not feel yuk ... It's the perception of the person to feel happy the way they are ... To me, good health is a peace of mind. So if I feel healthy, I in turn presume I am healthy. And when I feel ill, I aim to be healthy again.

Erika emphasised physical, mental and spiritual health, as well as the importance of 'balance and taking notice of what your body is telling you'. Mary linked health with lifestyle. She perceived her family's health and lifestyle as not perfect, given 'the restraints of living ... of our society in which we live and our backgrounds.' However, 'we try to have a balance between a healthy lifestyle and an unhealthy lifestyle'. She was aware of the multiple public health messages on maintaining a healthy lifestyle in magazines and books. Her children had been exposed to similar messages at their school and the visiting Life Education Van, with a focus on 'healthy' and 'unhealthy' foods.

Joanne admitted taking health and illness for granted, despite the inevitability of death. She related her husband's and children's 'healthiness' were vital to her personal happiness.

... you know that something eventually is going to kill you and make you very ill ... My priorities are that I hope it's me and not my children ... You never wish ill-health on anyone. But you know it's going to strike everyone. Like we [ie. my husband] were talking about testicular cancer and Jim was saying that the numbers were as high as that for women with breast cancer. And I said to him, 'have you ever checked yourself', and he said, 'no, I don't.' And that sort of worried me a bit, because I'm comfortable with my own health, but to know that other people could be unwell. [And people close to you. Is that what you mean?] Yes, I don't sort of worry about the states [ie. illness or disease] that I'm in. But if other people don't know the state they are in, then I tend to worry about it ... At the moment everything is fine. 'Hunky-dory'. I'm a happy person.

Defining Ill-health

To the question: What does it mean to experience ill health or be sick?, Mary responded: 'you can be sick because you're tired or because you've inflicted yourself the wrong way. Or because you've been too busy and need to stop and have a break'. Being sick could include having a hangover from drinking too much alcohol the night before. Mary and Beth viewed personal limitations such as age, agility, health status and pain
impacted upon an individual's 'normal expected level of functioning'. For instance, Mary's 40 year old husband was deciding whether or not he could continue playing football 'this winter season' (mid 1995), as 'his knees swelled up last year.' However, to retain active involvement in a sport he enjoyed, 'He's going to run [around] the boundary and wave the flags ... he's still part of the game'. Beth stated: 'I would feel unhealthy if I had a headache and couldn't play netball. Or I had a stomach ache and couldn't go to work'. Beth indicated some limitations are a 'temporary thing', she tends to 'put up with it and work around it, and keep on doing things.' Beth described her two daughters' different reactions to illness and injury.

Lisa is the type of child that if she had a headache you need to take her off for brain surgery or something ... No, she's not very good with pain. Whereas, Gemma will walk around with a gaping hole in her knee and still do what she wants to do. And she's always been like that. Everybody would hold their breath, but she would get up and run around.

Mary and Beth related their approaches to health and ill-health in everyday life. Mary described the early morning routine of hygiene, school lunches, travel and clothing for herself and her three children.

I don't think I'm any different to anyone else ... I get up like everybody else gets up ... I have a routine where it's same every morning. So they [the children] have breakfast before they get dressed. So that I don't have to yell at them to change their school clothes ... I make sure they all go to the toilet, and they clean their teeth before they go to school. That's part of their routine. So they have whatever I've packed them for their lunch. They like to eat something I've made. They ate all the cake I had made, so I made some biscuits last night ... I respond to their likes and dislikes ... And sometimes I'll ask them what they would like in their sandwiches, but this morning I didn't have much time. But mostly they'll have something I've made for them. And the two [older children] are already in the car, whilst I'm getting the last one ready. We can then get to school on time.

Beth's approach to health and illness is conservative, rather than interventionist. She relied upon her intuition and 'old wives' tales', and also gave 'tender loving care' (TLC) to her daughters when sick. 'So we do things like, instead of giving Panadol, I'll first say, "go lie down on the couch with a pillow and I'll bring you a nice cool drink".' Beth reasoned: 'you know that if it doesn't work then I'll go on to try something a little more aggressive. We might administer some medication, or failing that we might trot off to the doctor. But I certainly don't go off to the doctor very quickly'. Her daughters, now ten and six years old, also extended TLC to each other when feeling unwell.
**Health Education**

Asking Sandra, Erika, Mary, Joanne and Beth the question: What might be some things you teach your children about health? elicited responses on nutrition, hygiene, safety, rest, mental health, the body and role modelling (sex-role behaviour). For example:

> We don't sit around and watch a lot of television ... You don't put too many medications in your body, but should save them for when you really need them ... Social drugs aren't good for you.

Each woman encouraged her children to wash their faces and hands, and brush their teeth on a regular basis to maintain personal cleanliness. Erika recalled teaching her six year old daughter, Raquel, about the human body from a very early age. She has explained about dental plaque, teeth brushing and avoiding unnecessary visits to the dentist. Erika also used the 'bones book' and she believed her own tertiary studies in anatomy and physiology had extended her daughter's knowledge and understanding of the human body.

> She has got a real interest in the body. And ... perhaps because she has had to put up with me doing many hours of study and toddling in at 2 and 3 and 4, and coming into uni[versity] occasionally and sitting through lectures. And taking an interest in what I'm doing ... She could at the time, rattle off how the digestive system worked and how the food is digested and where it goes. And the other day, she came out of the restaurant with my friends and I around her and [said] ... 'Mummy my small intestine is hurting.'

During the interview with Beth, we exchanged our concerns about our 10 year old daughters being very conscious about their bodies, size, height and weight. Our concerns stemmed from potential eating disorders such as bulimia and anorexia widely reported in the mass media to affect young girls. Beth related:

> ... being conscious about not saying to them, that 'if you eat this you'll get fat' ... I'll say to Lisa, 'Oh, just look at your legs. You've got gorgeous legs. They're beautiful' ... I do think she's gorgeous ... And I like her to feel good about her body ... 

Teaching children the importance of nutrition, including eating plenty of vegetables was a priority for each parent. Erika gave the example of her daughter, Raquel, choosing to eat a piece of fruit when hungry, before eating a biscuit. "I won't often let her have something sweet ... she's in that mindset, that if she's really hungry she should eat something healthy and then if she still wishes she can have something else as a treat
... she knows she's got to eat healthy food. She always has. Erika believed that what you feed children in infancy influenced their eating habits in subsequent years.

Beth related conversations with her eldest daughter (10 years old) about their habit of putting butter on their corn at meals, and changing this pattern of behaviour.

I used to put butter on their sweet corn and potato but never did it to my own ... Until I started to think about it. But they just love it. The sweet corn dripping with butter. It couldn't have tasted better. And of course they ate it up. But I put the butter on the corn for them but not for me. And I used to ... But the kids are so lucky, because they have far more knowledge than I did at their age. Because I learnt from my mother. But then I look at these kids and I think 'why am I doing this'? So I stopped doing this ... They went without. [Laughter] ... So then a couple of weeks ago, Lisa said, 'Could I have the butter to put on my corn? And I thought 'what am I going to say'? And she said, 'why haven't you been putting the butter on the corn?' And well I said, 'it was better to just enjoy the vegetables rather than to have everything smothered in butter'. And she said, 'does it make you fat?' [I thought] 'Oh God, what do you say?' It's very hard with a 10 year old girl and neither of them [my daughters] are overweight ... And I said, 'that it's good to set up good eating habits now, so don't do it. But another way of looking at it is if you want butter now on your corn and potatoes, it would be good for you to realise that later on in life when it's not so easy to keep the weight off your bodies, that in fact, that's somewhere you can cut down'. She seemed quite happy with that, and went and got the butter out of the fridge. And put it on the corn. And I thought, 'no, well that's her decision'. So now I put the butter on the table, and I'm not going to put it on their food. But if they want it they can have it.

Beth was reflective upon her own eating habits influencing her daughter. She perceived her own behaviour as not being conducive to good health, and considered what should she do about it, particularly when her daughter also asks, 'well Mum, what's going on here?'. This incidence presented an opportunity for mother and daughter to discuss food and body weight, provide an explanation for the habit, and decide whether they wished to continue the habit of putting butter on the sweet corn.

In terms of mental health, Joanne asserted a 'healthy outlook' on life was an important message to teach her children. 'Obviously if they [my children] are unhappy they might do silly things that would affect their health. But if they are happy, I would hope they would think more in the line of that if I took this substance it would make me unwell'.

**Sex-role Modelling**

Patterns of behaviour and responses to situation learnt within the family through a process of socialisation are gender and age oriented. They also include ideas and
responses about what to do when someone feels unwell. 'If this is what makes me feel good. It is nice for me, I'll do it for them' said Beth.

Mary related her three old son, John, was more curious about his mother's body than that of his father's, due to their different bodily shapes. Her daughters had not taken any particular interest in bodies at a similar age. Mary used the books Where Did I Come From? and What is Happening to Me? as a means of initiating discussions with her daughters about the body and puberty. She observed her children's play at home and sex-role behaviour and attitudes, comparing the two girls and a boy, when playing with a Barbie doll.

He [John] will play with a Barbie doll quite happily, but he hangs the doll down, while Ellen dresses it, while Samantha has ... got a Barbie doll but she hates it. It's packed away, and the only time that she brings it out is to annoy her little sister [i.e. Ellen] who adores Barbie dolls ... therefore she'll bring it out to annoy her and then put it away again ... So they're used differently ... John is rough with anything that he plays. He doesn't have that 'tuck the baby into bed' attitude.

The interview later addressed women changing their surname to that of their husband's upon marriage. Mary admitted that she had, but both her daughters 'have both said that they are never changing their name, they are always going to be a [Wesley'].

Parent-Child Negotiation
Teaching children to get plenty of rest as being important for health, often involves parental-child negotiations about going to bed at night, such as when to put the light out after reading and the importance of sleep. Mary reasoned: 'so that you're not rushing around in the mornings'. She recalled the nightly ritual of her children prolonging the hour of going to bed. Given their various ages, rules had become established as to when each child had to turn the light off to go to sleep.

I find with three kids ... Samantha considers that because she's older she should be allowed to go to bed later, and it's not acceptable that they go to bed at the same time. 'My friends don't go to sleep when I have to go sleep'. So the compensation is, 'well you can read until your light has to go out at 9, regardless of whether you go to bed at 8.30[pm]'. And John [my youngest son] in theory, goes to sleep as soon as his head hits his pillow. [Laughter]. So they all get to bed at 8 o'clock but one gets to read longer than the others. [Are all the children happy with that arrangement?] During school times, yes. When you start going on holidays or on holiday time, they want to be up rather than be in bed. I can't wait till daylight savings finishes. It will turn all their clocks back an hour.
Risks to Health

I was interested in how laypeople identify risks to health in everyday life. During the interviews I asked Beth, Erika, Joanne, Mary and Sandra: What do you view as being a risk to health? What do you do to prevent risk at home?

Sandra considered a person’s daily fat intake a known risk to health. ‘Gone are the days when you’d cook a roast in several centimetres of fat’. Healthy eating was important for her and her children, as a strategy to reduce risks to health such as obesity. The unknown constituted a risk for Joanne. ‘Something you haven’t come across before’, makes it difficult to prevent or reduce the risk. It was only ‘if you know about it, you have got some way of dealing with it’. Joanne recalled her children bathing in a blue-coloured chemical solution (an unknown substance) in an unmarked container they had picked up from the side of the road, put out as rubbish by the local bowling club. Her anxiety extended to not only being unable to identify the substance, but also the potential harm to her children and subsequent affects on their health. She called the Poisons Information Bureau (auspiced by the paediatric hospital in Melbourne) for further information, but the person at the other end of the phone also had difficulty in advising her what to do. Joanne also met with the bowling club staff to ascertain why they had ‘irresponsibly’ put out such a ‘dangerous’ substance, earmarked for waste collection which anyone could have picked up.

Mary gave the example of herbs in her backyard garden as known and unknown risks. Whilst she admitted that her knowledge about the use, storage and preparation of herbs was limited, Mary was aware that the herbs in her garden were all edible. In the event that her three young children eat any of the herbs (marjoram, rosemary, basil, winter savoury, parsley, oregano, chives), they could safely do so without becoming ill. The herb area of the garden served a dual purpose of a safety barrier and natural boundary for a playing area for the children. Mary explained:

We actually live on a hill and so we dug that out so we could put in a third bedroom. So we [my husband and I] flattened out the top to have a grass area. We have hardly any backyard at all. It’s probably about from here to the window [approximately 5 feet wide]. But there’s this drop of about 3 feet. So it’s useful to have something there so that the children don’t jump down. So having the herbs there gives them [my children] a barrier, so they know never to jump down there.

Safety at Home and on the Road

Sandra, a mother of three children, often has other children visiting her home. She and her husband have implemented the following measures to prevent injury and injury at home: having ‘a screen at the back door to stop the flies coming in’, ‘the [buck] doors
are of safety glass', and 'we don't keep rubbish around [the backyard] so that the kids aren't likely to fall on bits of wire'. Safety rules were also important.

You tell them [the children] not to touch things because they're poisonous ... If the dog brings home a dead rat, you tell the kids to 'not to poke it with a stick'. [Laughter]. 'We'll just get the shovel and put it in the bag' ... I told them, 'one on the trampoline at a time'. Otherwise you find you've got two on there, 'you're likely to crash and fall off' ... 'no running in the house.'

Sandra asserted these rules were 'just basic commonsense'. Wrestling, for example, could be dangerous, she said, particularly when 'they knocked one of my stands over in the lounge room and smashed one of my favourite things'. She alluded not only to her wrath that something of sentimental value to her had been broken and could not be repaired, but also her concern that the broken item could cause injury to someone. Another example was: 'I don't let the kids up on the roof. I send my husband up to do those things. Plus, if there is a ball up there, I say, "you can't go up there"', even though it is a very flat roof ... even though I used to do it as a kid'. At the same time Sandra admitted being 'terrified of heights'.

Mary searched for beds in furniture shops in Geelong, until she 'found a bunk that had a low enough rung so that I could reach and cuddle my child'. Her priorities were the bunk was not too high (to reduce the likelihood of her daughter sustaining an injury), and being able to meet her daughter's emotional needs.

Personal safety at home and crossing the road was a major concern for Joanne. 'You try to teach them "the dos and don'ts".' Her two sons (aged 6 and 10 years) were differentially aware of when it was safe to cross the road. 'I think with Michael, it has clicked. But with Paul, no. [He] still darts across on his bike. Always'. And at home, "don't put your fingers in the power points or in anything metal". And then we had the boys cut the cables or do stupid things ... "Don't touch live wires". "ZZZZZ". And they've done it. So it doesn't always sink in'.

Swimming and the Beach

Sandra's children had swimming lessons prior to commencing primary school. She explained:

Because we spend so much time at the beach as a family. Because it is so much uppermost in my mind. And if the worst happens [ie. drowning] ... I couldn't think of anything worse. I did my best for them. Hopefully nothing will happen. They can all float. Panicking might be a different thing [in reference to herself]. I've given them swimming lessons and they can all swim.
Upon their arrival at the beach, the family's strategy was to watch the tides for about five minutes. 'Knowing when they're coming in and going out.' Also, 'I say to the kids, "I don't care if it's surf, up to your waist is deep enough".'

**Health Promotion**

Joanne, Sandra, Beth, Erika and Mary were asked: what do you do to promote health in your daily lives? Erika indicated children received a number of messages about health promotion from their school, for example, putting on sunscreen. Her daughter would remind her that she needed her hat on a sunny day. She commented: 'So as a parent with other commitments, I really appreciate other institutions can have such a big effect on health education as well', about health messages that she agreed with. Angela related her children brought a lot of information home from school about food and drugs, which were subsequently discussed at home.

I asked Joanne: Is everything you do to promote health also taken-for-granted? Or is it something you do without thinking about it? She replied:

> Probably, I'm not aware of anything that I'm conscious of. Maybe it's just the way I've been brought up, that I take it all for granted. I don't say to the children 'pop the vitamin pills in your mouth', like some of their friends do. Like for breakfast some of them take vitamin pills to stop them being ill and getting colds. I don't do that.

Joanne perceived the activities her own health promoting activities within the family as something she was not very conscious about. She explained: 'I had a healthy upbringing, without anything pushed on me, and so I do that with the kids'. Erika believed that 'being aware of anything that helps health, like exercising and water consumption' contributed to health promotion. I asked her to explain further why water consumption was important to her.

> Well your whole body is made up of water, and it's only common sense that you keep replenishing that and I think more research should be done... [on] water and how good it is for you. Just to get all the toxins out of your body and keep replenishing it. It's such a natural and simple thing, that people don't do it.

Joanne observed other people's habits of eating biscuits, drinking coffee and alcohol, for example, are 'very much an accepted part of our everyday lives ... [and because] we like the actual relaxation that it brings.' Erika emphasised the 'first thing I had here to relax, was a cup of tea'. This referred to my undertaking the interview in my home, a place of convenience to us both at the time. The accepted social etiquette of offering her a cup of tea had another purpose: to initiate general conversation and establish
rapport between us, as women, as parents, and as researcher and participant in the pilot study.

Sources of Lay Health Knowledge

I asked Erika, Beth, Sandra, Joanne and Mary: Where does your knowledge about the body, health and illness come from? They responded their sources of knowledge were diverse: books, magazines, parents, grandparents, neighbours, friends, partners, self-knowledge, television, health professionals (doctors, infant welfare sisters), pamphlets on health issues picked up at the hospital or community health centre, commonsense, personal experience, children, professional education, training and practice. These sources of health knowledge also provide an indication of the flows of knowledge between people: parent to child, child to grandparent, parent to health professional, multi-media to individual person, secondary and tertiary education to student (child and adult). This knowledge is not always medically based. Some of it consists of ‘old wives tales’. The following narratives provide examples of health issues where knowledge is passed on and exchanged between individuals.

Erika recounted the influence of her German mother of teaching her the principles of nutrition and how to prepare certain foods for her small daughter.

Well it’s not really German recipes, I guess. I don’t know where she learnt it from. But just cooking up lambs’ brains and how you strain them, and mash them up with pumpkin and potatoes and a bit of butter and a bit of vegemite. Things like that. Things that she fed me. And combine your colour coding of your food [i.e. vegetables]. That is, a bit of white and a bit of yellow and a bit of green. And you know your carrots are yellow. And you kind of go along those lines. I’ve always lived by that, even now. [So she used colour codes for food instead of the five food groups?] Yes, she thinks like that, as well as [with] the fruit. She’d have fruit or icecream.

Further discussion revealed aspects of her mother’s life and efforts in bringing up her children.

My Mum never worked outside of the home. And my father had just a pretty mediocre income, and my Mum took her career as being raising her family as well as she could. Like giving them the education that she never had, and regretted for the rest of her life. Making sure that they knew what healthy food is all about and healthy eating. And making sure that she brought them up to the optimum that she could possibly provide for them, on the resources she had.
Erika's mother and the local infant welfare sister were supportive, when at 18 years of age, she gave birth to her daughter (now six years old). Other important sources of health knowledge were: 'your neighbour over the fence or a friend who might have read something ... or heard something', television, other media, and her formal education in health care. She described self-knowledge as: 'all that you teach yourself. Some of it you take in and some of it "goes over your head". Some of it you don't agree with and some of it you don't take up, and some of it you tend to keep in your mind, and don't do it.' Erika 'sieves' through and sorts out the relevant pieces of information she requires for a situation, from a myriad of knowledge sources. She accepts and uses knowledge that she deems necessary and helpful; the rest is excluded.

Both Beth and Sandra indicated that when they were pregnant with their children, they 'wanted to know everything'. This meant taking an active interest in 'how things work' by asking the doctor, and collecting leaflets on nutrition in pregnancy. Beth stated:

I suppose I didn't take much concern about my health until I was pregnant. Because my body was not just for me then. It was for somebody else as well ... Whereas before I would probably have read quickly a leaflet about the five food groups, and thought, 'oh yea, I'm doing all that'. When you're pregnant, you know, you get these ones [ie. leaflets of information] about eating for two. I suppose I was much more aware ... [about] your eating, whether you're exercising regularly, and having regular health checkups.

Sandra commented that child-rearing, contrary to popular opinion, is not necessarily 'instinctive' knowledge for all people, especially when a first child is born. She relied on her commonsense, in addition to the advice and support from the local infant welfare sister, and her friends with children, to keep her children healthy. Child-rearing 'sort of became instinctive as they got older. Plus you heard different things about what different people did'.

Mary argued knowledge about the body, health and illness comes from life experiences. That comes through by what you've actually done and you've been told by your parents, teachers and friends, and then it's modified because it normally doesn't all add up'. Tertiary education, in her case, was an additional source of knowledge. Her profession as an occupational therapist has included working with people with a disability and/or requiring rehabilitation following a work injury. Her experience had taught her 'the people who cope better are people who accept it and those who keep going with life.' In her endeavours to help others with a disability, she would assess their areas of strength and say, 'fine, and now let's get on and do the things you want to do.'
But maybe there's another way of doing it other than the way you've always done it. If you can't clean the window, maybe there is someone else in the family who can clean the window, and you could do something else that helps them. And that way, you're still an active member of the family, but not doing the things you shouldn't be doing.

Mary indicated her children 'probably teach me as much as I teach them' about food and 'acceptable' behaviour. She gave the example of her husband's tendency to smoke and her children's reaction to his habit. It 'means that they accept that is not good health, but that it is also something that he does. And that's not very good. But growling at him every time is not going to help the issue ... It's acceptable to say you're doing the wrong thing. But it's not acceptable to be constantly saying it to him all the time'. Mary also remarked upon the influence, of reading a recent issue of the Australian Consumers' Association monthly magazine Choice, on her health promotion practices of storing food correctly. She remarked, 'I try to modify some things after I read the article, but that doesn't stop you from getting back to doing things the way your mother did'. She also recalled providing cooking sessions for some elderly people living in a hostel or nursing home.

[II]It's really interesting that a lot of the things what I do has been what those people have shown me. And they always say, 'I suppose I need to now cook differently.' I'm trying to show them that in fact, they've taught me things, that although I'm doing something for them I get a lot of input back. Things like lemon butter ... that are traditional.

Mary frequently made a favourite cake known in the family as 'Edith's Cake' (pseudonym) from a recipe passed on to her by her grandmother's friend. The cake recipe had a 'story' behind it, which became part of the family history. Mary's eldest daughter (10 years old), Samantha, was fond of baking a particular cake called 'Great Grandma's Cake'. 'Which is the recipe that her great grandma, who died at 103 [years of age] gave to her'. This young girl was continuing her great grandmother's tradition of making the cake.

Joanne indicated the 15 years age difference between her mother and herself, enabled her being able to talk with her mother. 'Any single issue I wanted to know about, we would talk about', regardless of whether the issue was sex, nutrition or something else. Her other sources of health knowledge came from reading magazines and books, friends.

Lay Decision-making

I asked Erika, Joanne, Beth, Mary and Sandra: How would you decide that what you were doing was not enough and something else was needed? Where do you go to
when you need information to look after someone who has become ill or injured? The
women discussed their management of illness and injury, and indicated the point at
which they decided to seek further information and support from elsewhere.

Their GP was usually the first port of call for further information: a source of
information they trusted. Sandra remarked of her doctor, 'He hasn't just said "oh well,
you've got tonsillitis and that's that. But he explains what happens ... he explains things
thoroughly'. This was important to her. Her doctor explained bodily alterations and the
recommended treatment, thus facilitating her and her husband to make informed
decisions.

Beth indicating liking her GP for his conservative approach to treatment, and his
provision of information and support when either of her daughters became ill. Her
eldest daughter, Lisa, experienced several bouts of tonsillitis at four years of age. On
each occasion she was vomiting and feverish, pale, with little energy, losing weight and
missing out on kindergarten. Antibiotics were initially prescribed, although prior to
such prescriptions, Beth and her doctor 'discussed the possibility of taking her tonsils
out. But we still let it go another couple of bouts, until I was convinced that yes,
something had to be done. And so he sent me off to the surgeon and I talk to him about
it'.

Beth recalled consulting an alternative therapist was when her eldest daughter
was a small baby suffering colic. She had tried a number of remedies and advice from a
variety of sources, including doctors, but to no avail. The colic 'resolved itself in the
end; 'it was the maturity of her digestive system' In a hypothetical situation of chronic
back pain, Joanne asserted: 'if I hadn't got any results from the doctors, I would
probably try ... massage first, and then acupuncture. I have had good reports from both'.
In another situation she would 'ask as many people as possible whether they knew
someone in a similar situation and whether they knew of any remedies'. She would then
assess the advice she had been given from others (ie. lay referrals) and make a decision
about following through with the advice or not. 'If the advice I got was negative I
would probably leave it. But if you're getting some positive feedback about this
situation, then that's fine. Or if all the feedback is "no, that's as good as it's going to
get", then I probably would settle for that as well.' In contrast, Beth felt she could not
rely on what other (lay) people would suggest to her about health care and life matters.
She relied more on her own knowledge base and that of her doctor, whose judgement
and experience she trusted.

Sandra spoke of her and her husband's experience of being parents for the first
time when their eldest son was born.
It was scary. Not growing up with a lot of babies, I prepared myself. I was so happy being pregnant and everything. I prepared myself so much for the birth, and when they handed me William, I thought, 'now what shall I do with him?' I had not idea what to do. We didn't even know how to fold a nappy. [How did you find out to do that?] We actually waited two days for the infant welfare sister to come around. [Laughter]. And we asked her. Because my mother couldn't remember. And all my friends had different ways ... They'd say, 'there's a special way to fold a nappy, but I can't remember.' So we had him in disposables [nappies] until the health sister came around and she showed us. [Laughter].

Given her view that parenting and child health care was not 'instinctive', the infant welfare sister was very important to Sandra for her information, support and pragmatic approach to caring for a small baby. She could also be relied upon at the regular visits at the local centre, for her infant son's checkups to ensure that he was healthy; weekly for three months, then fortnightly for 6 months and then monthly. In learning how to burp her baby after a feed, Sandra's friends were a major source of information.

Joanne indicated that when her sons had picked up an unknown substance being able to ring the Poisons Information Bureau and obtain information immediately was immensely reassuring for her.

None of this waiting half a hour. You are connected straightaway and talking to someone straightaway. So can ease your conscience and the child will be fine. And look out for this, this and this. Or get them straight to the doctor, that could be dangerous. Or administer a syrup or along those lines.

For Erika having her first aid certificate gave her confidence to respond appropriately to accidents or another situation requiring immediate attention, and then phone for an ambulance if she felt that was also necessary. But she also tended to trust her 'own judgement as far as severity. Speaking with the person, particularly if a child, because I'm not sure about their pain threshold or how sick they are. I tend to rely on my intuition'.

Diagnosis and Treatment of Illness and Injury

To ascertain how confident Erika, Joanne, Mary, Beth and Sandra were at diagnosing an illness or injury, I posed some hypothetical situations such as bleeding and a fractured ankle. How would you know someone was ill or injured? How would you assess the need for treatment? The women narrated actual incidents of illness and injury which they had diagnosed themselves (including a broken arm, a toddler with a gastro-intestinal infection), had assessed the need for treatment and considered the best options for the well-being of their child.
In diagnosing a person's ailment, Joanne would examine them for signs and symptoms of bleeding, 'acting out of the ordinary. Any pain', noting the severity of the condition. She felt confident in handling minor first aid situations alone, such as 'splinters, cuts, short-term fevers, vomiting, diarrhoea. Those sort of things you could treat immediately. If they go on for sometime, or get a bit more out of the ordinary, I would seek someone else's advice'. For example, phoning the fire brigade because 'they get there quicker than the ambulance and they are trained professionals ... and possibly the police' in the event of an accident or a life-threatening situation. Should this type of event occur at home, Joanne admitted that 'I don't think I would cope so well. That's where being part of a marriage is good because you can pass it on to your husband. "Quick, dear, quick. I'll ring the ambulance and you do CPR" [cardio-pulmonary resuscitation].' Joanne considered her marital relationship gave her confidence to manage life-threatening situations. 'We work as a team ... So we bounce things off each other. So if I'm unsure, I'll ask him. And if he's unsure, he'll ask me. But I don't know how either of us would be in an individual situation'.

Given a hypothetical situation of bleeding, Beth indicated she would try to stop the haemorrhage by applying pressure, examine the wound to see how big it was, and determine if it 'was larger than what I would think was Bandaid size, I would probably go straight to casualty [at the local hospital] to try to stop the bleeding ... whether stitches weren't needed.'

Mary's approach was to examine the situation, note the severity of the condition and then make a judgement about treatment. In most cases, she made little fuss of her children's injuries. 'I don't want my children to be "wimps" ... but I don't want them to stop doing things just because they've got a little cut'. She gave the example of her three year old son, John, falling over at school. 'He got "blood" as he calls it. And so we said "yes", and washed it under the tap. And then he went off and continued to play.' Her relaxed attitude to such incidents is: 'I'm quite happy to respond to it, but other than that there's no point in making a big fuss. Life's sort of like that. You've got to cope with small bumps and knocks along the way'. However, she would continue to monitor the presenting condition and her child's response to treatment.

Mary related the incident of her youngest daughter, Sarah, breaking her arm a year ago after falling off the flying fox (playground equipment). When Mary realised what had happened, she took the following actions:

I took her [Sarah] out of the sun and put her in the shade and gave her a cuddle. But she kept on crying. The fact that she persisted made me feel there was something wrong, and then everytime she moved, where her arm moved she said it hurt. So then I felt there was something wrong.
Having two of her own children plus two other children with her at the time, delayed the moment of treatment. Mary took all five children home to her place, rang her husband, Bruce, to 'come home quick' and take home the other children 'who didn't belong to them' and look after the remaining daughter and son. Mary, meanwhile, took Sarah to their local GP for assessment and treatment. In another incident, Mary diagnosed her eldest daughter's ankle as being sprained rather than fractured, based on her assessment of the degree of pain, where it hurt and the extent of movement possible. She bandaged the ankle, applied ice packs and continued her observation until the swelling disappeared.

Joanne recalled her daughter, Elizabeth, having sore eyes from conjunctivitis. Itchiness and discharge from the eyes would occur, and not respond to medically prescribed eye drops. The local pharmacist suggested an eye ointment to treat the inflammation. 'Instead of dropping it into the eye, you get them [ie. the child] to close their eye and rub it from corner to corner. We tried that and within two days it had gone. So now I keep it in the first aid box. Whenever they [my children] get slightest sore eyes from swimming or get an itch or complain of a discharge we [my husband and I] just put it on straight away.'

Joanne reflected upon her youngest son's illness with high fever and vomiting.

The temperature didn't rise until after he finished vomiting, which was unusual. So all these characteristics in the order that they came, was strange. Normally, if you got a temperature and then you're sick, and then after the temperature drops. But this was the other way round. He was vomiting, then the temperature rose afterwards and then he was complaining of abdominal pain, and crying and the rest. But just the temperature itself worried me. Because he had been sick we didn't want to give him Panadol, in case it upset his stomach even more.

Joanne sought medical attention for her son, and was recommended Panadol to reduce the temperature. He didn't vomit again. Joanne questioned: 'Perhaps he may have eaten something he shouldn't have eaten or whether it was due to a virus or a bug or whatever'.

Beth described her difficulties in assessing the symptoms of croup experienced by her youngest daughter, Gemma, when she was 15 months old. Gemma did not have the classic symptoms of croup. 'In that she didn't wake up in the middle of the night with that dreadful cough and laboured breathing. There was none of that. She slept soundly through the night'. However, her sleepiness continued the next day and she was reluctant to breast feed, with laboured breathing developing. Being unsure of the severity of her daughter's condition, and with the encouragement of her husband and a friend, Jennifer took her daughter to the GP. Upon examination, he noted 'rib retraction' and she 'was using her accessory muscles to breathe'. Beth recalled her doctor's haste in
getting her daughter to the hospital for immediate admission to the intensive care unit for intubation. He went in the ambulance with Gemma, worried about the necessity for a possible tracheostomy if her breathing suddenly became obstructed. Beth reflected:

I got into this mad panic, thinking 'Hell, she's quite ill', and I didn't really know how ill she was ... how am I going to react, if they [my two daughters] are seriously ill? if something like that really happens and you don't really know how ill they are' ... I felt a little guilty at the time, not really knowing how ill she was ... But why didn't I know. Why didn't I know that?

Beth asserted that despite her familiarity with the signs and symptoms of croup, she found it difficult to assess her daughter's condition.

*Household Economy*

In providing health care for their children, Beth, Joanne, Sandra, Mary and Erika used financial and material resources as well as their labour. I asked them: What remedies do you keep at home? Where do you usually get these things from? They indicated they kept 'your basic stuff' such as Panadol, Dexsal, bandages and Band-aids, zinc, antiseptic cream, moisturiser, sunscreen. Joanne joked having bandages was very important given the 'high' incidence of accidents in her household.

Well with three males in our house you need something a little more than Band-aids sometimes. You always get sprains. All my children and my husband play sport. There are always injuries. My husband is building an extension [on the house]. Cuts, bruises, bumps, scratches, 'chopped fingers'. You name it.

Sandra used antiseptic cream or powder on her children's small wounds, as they are allergic to Band-aids. 'We found this out recently, when they put a Bandaid on his knee [my son Simon] at school when it [his skin] bubbled up nicely. So we took him to the doctor's and got some cream for it.' Beth kept Dexsal, an antacid, to relieve stomach upsets. 'Very rarely would it be used. I usually throw it out a few months after the use-by-date. And then buy another one.' The majority of these items were purchased from the supermarket, with 'the odd thing' and prescriptions from the pharmacist.

The five women responded they had major responsibility for healing other household members. Sandra, Mary and Joanne consulted their husbands in making a diagnosis and determining the appropriate treatment such as first aid. The men were also involved in caring for other children in the family whilst their wives took the sick or injured child to the doctor or hospital. As sole parents, Beth and Erika replied they largely relied upon themselves when their daughters were sick, but they also requested assistance from grandmothers and friends.
I asked Joanne, Mary, Erika, Sandra and Beth: Who has control over the household income and expenditure? I wanted to explore how families prioritised health care in terms of their budget. Sandra indicated she singularly managed the budget; accounting for the phone, gas, and electricity bills. 'I'm the budgeter'.

I plot all the insurances and the [car] rego [registration] on a yearly basis so that it's done month by month. The benefits [i.e. private health insurance for hospital, dental and ancillary] is in that and whatever is left over is left over. And if the kids need to go to the doctor and they need medicine, the money's usually there.

Any remaining funds were kept in the bank. All grocery shopping was done using EFTPOS (automatic banking). 'And medicines will usually come in with groceries'. Joanne stated that both her husband and herself determined how the total household income (from two salaries) was spent. Money was allocated to pay the premiums for private health insurance (ancillary and dental plus) on a regular basis. As a sole parent, Beth had total responsibility for how the household budget was spent. Her sources of income came from a salaried part-time job and a benefit from the welfare state. Having a health care card and a Medicare card has meant few doctor's bills. She doesn't have private health insurance. However,

when Lisa had her tonsils out, I booked her in as a private patient to see [an ear, nose and throat specialist at the local hospital]. He was the surgeon of my choice ... I had to alter my budget for a time but I thought it was well worth doing that.

Geelong is well serviced by paediatricians. This has been reassuring for Beth; knowing the credentials of these doctors and having trust and faith in their abilities, should the need arise for emergency care of her children. This was affirmed for her when her youngest daughter required intubation during an episode of croup.

Joanne perceived a lack of knowledge as a major barrier to health care. 'A lot of people don't realise that they are paying [for] some things twice or they can get them a little cheaper'. Giving her a hypothetical situation of what she would do if ill and having to go to work on that day, she stated: 'I would not go to work ... I think health is higher than monetary priorities ... to me that wouldn't be a barrier'. She felt comfortable in being able to negotiate some time off with her employer to see a doctor.
Case Studies: Narratives

Three case studies on: 'looking after other people's children', children's perceptions of disability and disabled persons', and 'life transitions', provide interesting insights into the complexity of physical, mental and spiritual health of women, men and children, and parents' endeavours to provide healing for members of their household.

1. Being Responsible for Other People's Children

Sandra often cares for children of other working parents, at her home. Consequently, she and her husband had made adjustments to their physical environment, to ensure the safety and well-being of all children in their care.

You worry about other people's children more than your own. [Why is that?] You're more responsible, I think. I suppose if your own child falls over and breaks their arm, or falls off the trampoline and breaks their arm, that's an accident. But when another child that is in your care falls over, it's like you're not doing your job properly. [Do you worry?] It makes you worry more ... I have regular after school care of children and I take that seriously.

She related an incident of the children playing together. One girl bumped into another and 'cracked her tooth'. Sandra described her emotions and her actions following this 'accident'.

And I felt incredibly guilty over it. Her mother reassured me that it was her own silly fault for calling the dog. But I offered to pay because I felt very responsible. And now I lock the dog up. It was a lesson to me. And although this mother told me that this child is extremely accident prone.

This incident also prompted Sandra and her husband, Neville, to re-assess the safety of their backyard, and rules of behaviour they could set in place, to reduce the likelihood of injuries for all children.

Over a two week period, Sandra and her husband cared for two pre-school children of close friends, aged 15 months and 2.5 years. The parents, from a nearby farming district, had gone away on holidays with the two eldest children. The youngest boy was not yet toilet trained and wore disposable nappies. Sandra noted that on each occasion when she changed him, he had loose bowel motions. 'I thought to myself that every nappy shouldn't be dirty'. Assessing the symptoms, Sandra surmised that he could have 'gastro', ie. a gastro-intestinal infection caused by a micro-organism. Or his digestive upset could be due to the spices in the Chinese food eaten by his family prior to visiting, and which they are not used to, being 'meat and three vegies and potatoes
people'. Sandra evaluated both children's diet and concluded their daily milk intake was higher than recommended for toddlers.

   The little boy was having a cup [of milk] in the morning with his breakfast, a bottle after lunch as well as eating yoghurt and all this other milky stuff, and cheese and stuff. And then he normally has a bottle to sleep at night.

Sandra decided to cut back on his milk intake to just half a bottle at night, and during the day she gave him, and his sister, plenty of water. 'Their reaction to water is quite funny. Because they live on a dairy farm, they drink milk like we drink water. They had a taste of water and they went "yuk!".' Sandra noted the dietary changes led to fewer dirty nappies. She reasoned that if the little boy did have 'gastro' there were two options for treatment.

   You can feed them out of it, or you can starve them out of it. And I don't want to starve him out of it. But it's funny, since I've cut him back on the milk he's eating a lot more. Milk's a food anyway. I'd say that he was [previously] getting a lot of food in the way of milk.

Sandra also sought advice from another mother at the school, a nurse, who 'suggested that his parents need to get him to a doctor. Because it might be his liver, because of a lot of fat.' She resolved to contact his parents that night, to check his symptoms with them, on the basis that 'he not being my child and not being familiar with his nappy habits. It might be normal for him to be like this all the time'. She considered it wise that the child be medically checked.²

2. Children's Perceptions of Disability and Disabled Persons.

Mary is an occupational therapist and has worked for many years in the areas of disability and rehabilitation. Her work involves assessing the individual's presenting condition, expanding their abilities and improving their quality of life. Mary's approach and attitude towards disability and disabled people is reflected in the following narrative.

² I encountered Sandra a couple of weeks after the interview. She remarked the mother had also experienced 'gastro' symptoms, due to a virus. This was the most likely cause of her young son's digestive upset.
In my opinion ... every person has a lot of strengths, and I suppose we consider normal when you see those strengths combine together and you don't see one shine above another. But if you have a disability, everyone looks at your disability, rather than looking at your strengths that are already there. I mean, your strengths might be just normal strengths. It might be that you can make a good noise, or listen to sirens. But they're only limitations ... they are nothing more than that. I mean ... that's hard ... because you get caught up with the disability.

Mary has three children: two girls attending the local primary school and a three year old son. At the time of interview, she was seeking part-time work in occupational therapy. Her children have been exposed to disability issues through her work. Mary spoke at length of her children's perceptions and reactions to someone with a disability.

[One girl had cerebral palsy] She had head control but would never lift her head. And I was constantly working on head control with games, noises and switches and all these other sorts of things. Because if she could lift her head she could then have eye contact, and that was really important for the person working with her and her family, but also for the child. And Samantha [my daughter] ... came in right at her level and she would lift her head for the whole time that Samantha was there. And we [my colleagues and I] used to say, 'I should bring Samantha into work all the time.' Because this child would respond to her.

Mary's daughters' athletic coach, Peter, is disabled following an above knee amputation. On hot days he would wear shorts, and the children would ask her what had happened. She would encourage them to ask him, and he would tell them. But upon the third or fourth request for an explanation, Mary believed that was sufficient and unnecessary. Her children understood this, given that 'Samantha has also birth marks all down her leg.'

Samantha is quite happy to explain what her birthmarks are, but she doesn't need to explain them four times to the same person. And they can respond to that ... because they've heard people ask Samantha and she sort of gets annoyed. Or they ask Ellen, 'why has Samantha got these red marks down her leg?' And she says, 'go ask Samantha'.

In both her parental and professional roles, Mary strove to overcome common societal assumptions about disability and disabled persons. 'You have to be adjusted to your well-being to respond to little children and to everybody asking what it is'. Mary was also teaching her children valuable social skills, in being able to relate to other persons regardless of their backgrounds or conditions, to accept the individual before them as a person, rather than as 'other': an 'object of curiosity'.
It's interesting to listen to Peter to show them how to do high jump. But he can't actually lift his legs off the ground to do a high jump. I mean, he's quite capable of training them. He taught Samantha how to do a back flip or forward ... He's got talents that he's been able to impart, although he physically can't do it ... In fact he's never been able to do it. Because he's in the age bracket that you didn't do it, but he's been trained how to do it. So he's able to impart it.

Mary considered Peter is a good role model for her children: demonstrating his strengths and talents, whilst passing on his knowledge to small children, so that they are able to do athletics with confidence. 'My attitude is, that he's a normal person, but he just happens to have something that's a bit different to what we accept as normal'. Mary is critical of common perception of people with a disability, and the lack of recognition of them as people. Her approach to her work and relationships with other, is an example of the problematic definitions of what is deemed 'normal' and 'abnormal' in our society, and how pervasive these arbitrarily assigned definitions are applied to individuals, to the point of stigma. She said: 'It's like when you read this thing in the [local] Council's News about what they're going to do for the disadvantaged. Well, really, forget about the disadvantaged and take individuals on board and their needs for things'.

3. The Impact of Life Transitions upon Health and Well-being

At 25 years of age, Erika reflected upon her various life transitions, and the effects of these upon her self-identity, health and daughter's well-being during the previous seven years.

Erika married and was pregnant at 18 years of age. She and her husband had a high income and lived in a comfortable home in Melbourne. 'There was never a shortage of housekeeping money or food.' In time she felt 'the environment that I was living in was quite hostile.'

There was a big lack of communication and two people who weren't going along the same lines as far as what they wanted out of life. And I had this 16 month old child [my daughter] ... I felt that might be impacting upon her stability, and big arguments going on in the household, and towards the end, meals weren't being cooked on time. I felt depressed.

It was these factors, in addition to her a husband being 'a twelve-hour-a-day, seven-days-a-week workaholic', and her belief that counselling didn't help, which prompted Erika to make the decision to separate. She explained: 'I had done everything I could then and it was time to get out before it got worse. It was better for everybody'.

Erika moved into a flat behind her parents' home, with her daughter, Raquel, paying a low rent. Her income consisted of a benefit from the welfare state and some child
support paid by her ex-husband. Her low income impacted on her ability to provide a home for a small child. She obtained a small car from the marriage, as a means of transport for herself and her daughter. During this period, Erika was involved in numerous court cases concerning custody, access and child support, which created considerable emotional stress. Any spare income she might have had from the relationship was 'eaten away' by legal fees. She also moved from a middle class suburb to an outer working class suburb in Melbourne.

Erika related her difficulties with societal attitudes towards her for being a sole parent and the various assumptions people made affecting her ability to establish new social relationships.

[What were the things about being a sole parent, looking after your child by yourself, what was it you felt society deemed negative?]

Ah, being a sole parent. 'She can't cope with her relationships.' 'She's irresponsible.' 'She's only young.' 'She couldn't cope with the marriage because she's so young ... there's something wrong with her.' 'She's not normal.' 'She's not married like the rest of us.' Just those sorts of things ... I was very conscious when I was pushing the pram along, that I was not wearing a wedding ring, and being young. Especially with the old community, when you pass them on the street, I really do believe that they do look down at your hand and have a look. And you see the facial expression ... when you going to buy a ticket and you're obviously eligible for a concession and you show your pension card and they tend to look down their nose at you. Like just going to the cinema. As if you're don't have the right like everybody else to have entertainment ... I just find that you feel socially disadvantaged in those ways. [Do you have to justify yourself?] You feel like you do, but you obviously don't have the opportunity to when you're in the public eye. It's not their business. And it's of no interest to them. But you have to just grin and bear it, and just put up with the gestures that people portray. And socially it is difficult too.

The opportunity to study and be with other mature age students helped Erika regain her confidence. She found herself to be more accepted, despite her circumstances. 'A pamphlet came around that the government had decided to put some funding to put women in science ... So I took them up on that and went to uni[versity] two days per week, in learning about chemistry, maths and biology.' The refresher course was at Year 12 level, increased her skills, including computer literacy. She went on to complete full-time undergraduate studies in community development and also did some voluntary work in a nursing home.

Being a university student also enabled her to spend time with her small daughter. Erika investigated joining a playgroup in the local area, as a means for meeting other
mothers, and making new friendships. She had found it a useful setting to meet others, owing to her previous experience in initiating two playgroups, when she was married.

It was quite a shock moving to a new suburb and finding that these married women didn't really want much to do with me because they found out that I was young. I was a single parent ... whether they thought I'd go home and chase their husbands or whether there was something wrong with me.

Erika found these attitudes dispiriting given her efforts to provide for her daughter; making sure they didn't go without food to eat and clothes to wear, despite a low income. The only friend she recalls making at the time was 'a Maltese lady, and she too was socially or culturally disadvantaged because she didn't fit the norm'. She says their friendship 'was a quality one, based on accepting each other, like friendships should be. Not for who or how much money you're earning or where you live or whether you're married or not'. Erika attributed her own attitudes towards people as being grounded in her upbringing and the philosophy of her parents. She said: 'I went to school in a low socio-economic area and I learnt the differences between people, and how to appreciate people for what they have to offer.'

In all these life transitions, Erika found her parents to be morally and emotionally supportive. They also helped her care for their grand-daughter. Her mother encouraged her to go out and socialise with other young people, especially when her daughter visited her father at weekends. Following this access visits, Erika perceived her daughter becoming tired, having to adjust to different rules of behaviour and expectations - of her mother, her father and her grandparents. She also hit her nails for a long time, only stopping recently (early 1995).

Erika coped with the emotional stress of changes in marital status, poverty, study, court proceedings and moving house, by joining a church group and participating in cycling tours.

I'm a Christian now. Fate had it. I met this person who introduced me mysteriously to this church in Melbourne that he went to. I met him on a holiday. He went back to Queensland anyway. I stuck with this church group. They were just a basic Christian outreach group. No particular denomination. Just an open one. I went there every Sunday. And I took my daughter every second Sunday, and she participated in the Sunday School. And the people I met there were the most caring, loving and supportive people I could meet in one group ... And they kept my attitudes where they should be [positive] rather than getting negative.

Erika eventually approached other church groups closer to her home, but felt 'it just wasn't my "cup of tea".' Reflecting upon this, she says:
I don't know why I went. It seemed to make a lot of sense at the time. And I really do believe there is a God. Or there is some power out there. Because too many things happened at a time that I couldn't explain or put an answer forward. It just helped me so much. So yes, it was another way of coping.

Cycling tours around Melbourne provided her with another option for meeting new people, also getting some fresh air and exercise. 'All those endorphins were being released ... You're eating well and your skin's great. You're not overweight'.

In the six months prior to the interview (April 1995), Erika had experienced another set of life transitions. She and her partner decided to live together in a de facto relationship and buy a house, she commenced postgraduate studies, had moved house, had enrolled her (now six year old) daughter at a new school, was travelling to and fro Melbourne for study and recreation, and had begun a full-time job at the local city council. Erika perceived her quality of life and well-being had improved. However, she stated: 'I've come out not having much faith in myself. So I guess I'm putting a lot of energy into my daughter, because she is always my priority with everything'. She was beginning to feel the possibility of some stability occurring in her life and her daughter's, which would relieve some the stress they had both experienced in recent years.
APPENDIX F
LARGER PROJECT
SCHEDULE - INTERVIEW AND FOCUS GROUP DISCUSSIONS

School: [Blank]
Date: [Blank]

ADULT AND CHILD ILLNESSES AND INJURIES
SIGNS AND SYMPTOMS

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Adult</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Cold</td>
<td>Cough</td>
</tr>
<tr>
<td>Earache</td>
<td>Headache</td>
<td>Sore eyes</td>
</tr>
<tr>
<td>Warts</td>
<td>Nappy rash</td>
<td>Diarrhoea</td>
</tr>
<tr>
<td>Nausea</td>
<td>Vomiting</td>
<td>Grazed knee</td>
</tr>
<tr>
<td>Sprained ankle</td>
<td>Broken arm</td>
<td>Cut finger</td>
</tr>
<tr>
<td>Bleeding</td>
<td>Loss of consciousness</td>
<td>Convulsions</td>
</tr>
<tr>
<td>Allergies</td>
<td>Burns</td>
<td>Poisoning</td>
</tr>
<tr>
<td>Hangover</td>
<td>Breathlessness</td>
<td>Pain</td>
</tr>
<tr>
<td>Sweating</td>
<td>Thrush</td>
<td>Itchiness</td>
</tr>
<tr>
<td>Depression</td>
<td>Anxiety</td>
<td></td>
</tr>
</tbody>
</table>

1. HEALTH AND ILLNESS
   - What does it mean to be healthy/in good health? - gender, age
   - What does it mean to experience ill-health, to feel ill or be sick? - gender, age

2. HEALTH EDUCATION
   - What are some things you teach your children (or others) about health? - food and nutrition, hygiene, safety, relationships and sexual behaviour
   - Where does your knowledge about the body, health and illness come from?
   - Where do you go to when you need information to look after someone who has become ill or injured?

3. HEALTH PROMOTION
   - What do you do to promote health in your daily lives?
   - Who do you do this for? - yourself and/or others
   - What do you do to ensure your body and that of your children are maintained? - so that health is actively promoted?

4. ILLNESS - INJURY PREVENTION
   - What would you view as being a risk to health?
   - What do you do to prevent or reduce risk?
   - What do you do to prevent illness or an injury in your daily lives?
   - Who do you do this for? - yourself and/or others

5. DIAGNOSIS OF ILLNESS AND INJURY
   - How do you know when someone has been injured?
   - When would you realise there was an illness or injury that needed treatment? - What would be some of the presenting signs and symptoms you might be aware of?
   - How would you assess the need for treatment?
   - How do you make decisions about what type of health care is needed?
   - How would you make a diagnosis?
   - How would you determine the severity of the illness or injury? - is it life-threatening, require emergency treatment (first aid, surgery), or short to long-term care?
   - Would you investigate the circumstances which led to the condition?
   - Do you take into account circumstances surrounding the onset of signs and symptoms? - what context? - time and place.
   - Are there additional symptoms from other conditions (co-morbidities)?
   - Can the condition be managed at home?
6. TREATMENT OF ILLNESS AND INJURY

- How would you determine the need for particular resources?
- What resources do you think might be necessary, in this instance?
- How would you manage the condition?
- Who would you call on if you felt you couldn't manage the condition by yourself?
- How do you decide lay healing may not be enough and another form of therapy is needed?
- What type of therapy would this be? - What would be your treatment options for this condition?
- Would you consider seeing a health professional, an alternative therapist, or a folk healer?
- Or someone else?
- What would be important to you about this therapy?
- If you were dissatisfied with this form of therapy, how would you choose another?

7. HOUSEHOLD ECONOMY

- Who takes care of someone in the household when they are ill or injured?
- If someone in your household has a disability or chronic illness, what is the effect (if any) on other relationships eg. with family members, particularly over a long period of time?
- What remedies do you keep at home? What are these? - ointments, medication, aids, appliances, herbal
- Do you get things for health from the supermarket, chemist or elsewhere? Examples????
- What resources (available and potential) does your household have to facilitate health care?
- What are the total resources required in any given instance whereby health care must be provided?
- What are the associated costs (direct and indirect) with these?
- Who has control over household income and expenditure - the female or male head of the household?
- How are the household finances generally managed? How are payment of health care bills prioritised?
- Do you consider when and how will the money be spent? - to cure disease and save lives or to promote health and prevent illness. What must be prioritised and for who in the household/which family member? - given their ages and health needs
- Is the type and extent of private health insurance your household has, a consideration in paying for health care?
- Given the unpredictability of illness and injury, what aspects of health care are budgeted for on a regular basis?
- Do you perceive any barriers to health care? Have you encountered any financial barriers in accessing health care services? What have these been?
- Are there any other issues which might facilitate or make difficult financial access to health care?
QUESTIONNAIRE

School: 

YOU DO NOT NEED TO GIVE YOUR NAME OR ADDRESS

Some questions only require a tick. Others may need a word or two.

1. I am female [ ] male [ ]

2. My age is __________ (years).

3. My marital status is:
   Never married [ ]
   Married [ ]
   Separated but not divorced [ ]
   Divorced [ ]
   Defacto [ ]
   Widowed [ ]

4. I live in the suburb ______________________

5. I live by myself [ ]
   I live with my spouse/partner [ ]
   I live with my spouse/partner and child/children [ ]
   I live alone with my child/children [ ]
   Other (please specify) [ ]

   a) I have __________ (number) children living at home.

   b) My children's ages are
      A __________________
      B __________________
      C __________________
      D __________________
      E __________________

6. I was born in ______________________, (country).
   a) IF NOT AUSTRALIA, I have lived in Australia __________ years.

   b) My ancestry is ______________________

7. What language(s) do you speak at home? ______________________
   a) I speak English
      Very well [ ]
      Well [ ]
      Not well [ ]
      Not at all [ ]
8. My highest level of education is

PLEASE TICK ONE BOX ONLY

Primary school [ ]
Secondary school [ ]
TAFE college [ ]
University [ ]
Other (please specify) [ ]

9. My qualifications are

10. My occupation is

11. How many people in your household earn an income? 

12. The total household income per fortnight/year (before tax) from all sources is

PLEASE TICK ONE BOX ONLY

Less than $192 ($5,000) [ ]
$192 ($5,000) to $460 ($12,000) [ ]
$460 ($12,000) to $770 ($20,000) [ ]
$770 ($20,000) to $1154 ($30,000) [ ]
$1154 ($30,000) to $1538 ($40,000) [ ]
$1538 ($40,000) to $2308 ($60,000) [ ]
More than $2308 ($60,000) [ ]
Don't know [ ]

13. What religion are you? (please specify)

a) Do you attend religious services regularly?

Yes [ ]
No [ ]

14. In the last 12 months, has any member of your household become

PLEASE TICK THE APPROPRIATE BOXES

Sick [ ]
Injured [ ]
Disabled [ ]

Which household member?

a) Who takes care of someone in the household when they are ill or injured? (please specify)

15. In the last 12 months, did any member of your household see a GP?

yes [ ]
no [ ]

Who?
How often?
Where?
Why?

16. In the last 12 months, did any member of your household use hospital services (e.g. emergency department, outpatients)?

yes [ ]
no [ ]

Who?
How often?
Where?
Why?
17. In the last 12 months, did any member of your household require dental care?
   yes [ ]
   no [ ]

   Who? ____________________________
   How often? ______________________
   Where? _________________________
   Why? __________________________

18. In the last 12 months, did any member of your household visit a pharmacy (e.g., medication, antiseptic cream)?
   yes [ ]
   no [ ]

   Who? ____________________________
   How often? ______________________
   Where? _________________________
   Why? __________________________

19. In the last 12 months, did any member of your household require diagnostic services (e.g., pathology, radiology)?
   yes [ ]
   no [ ]

   Who? ____________________________
   How often? ______________________
   Where? _________________________
   Why? __________________________

20. In the last 12 months, did any member of your household require specialist care (e.g., physician, surgeon, psychiatrist)?
   yes [ ]
   no [ ]

   Who? ____________________________
   How often? ______________________
   Where? _________________________
   Why? __________________________

21. In the last 12 months, did any member of your household use allied health services (e.g., physiotherapy, social work)?
   yes [ ]
   no [ ]

   Who? ____________________________
   How often? ______________________
   Where? _________________________
   Why? __________________________

22. In the last 12 months, did any member of your household need aids and appliances (e.g., crutches, wheelchair)?
   yes [ ]
   no [ ]

   Who? ____________________________
   How often? ______________________
   Where? _________________________
   Why? __________________________
23. In the last 12 months, did any member of your household use alternative therapies (eg. naturopathy, osteopathy, massage)?
   yes [ ]
   no [ ]

   Who? ________________________________
   How often? __________________________
   Where? ______________________________
   Why? ________________________________

24. In the last 12 months, did any member of your household see a folk healer (eg. spiritist, crystals, herbalist)?
   yes [ ]
   no [ ]

   Who? ________________________________
   How often? __________________________
   Where? ______________________________
   Why? ________________________________

25. In the last 12 months, did any member of your household use any other types of health care services (not mentioned above)?
   yes [ ]
   no [ ]

   Who? ________________________________
   How often? __________________________
   Where? ______________________________
   Why? ________________________________

26. Do you have any of the following?
   PLEASE TICK THE APPROPRIATE BOXES
   Ambulance subscription [ ]
   Health care card [ ]
   Medicare card [ ]
   Pharmaceuticals Benefits Card [ ]
   Private health insurance [ ]
   Veteran's Affairs Card [ ]
   Don't know [ ]
   Other (please specify) [ ]

27. Do you have any comments to make about health, illness and injury?  

28. Do you have any comments to make about this questionnaire?
### APPENDIX G
PROFILE OF PARTICIPANTS: GEOGRAPHICAL LOCATION

<table>
<thead>
<tr>
<th>Geographical Location</th>
<th>Participants (pseudonyms) (N=98)</th>
<th>Interviews (N=24)</th>
<th>Focus Group Discussions (N=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>urban (N=44)</td>
<td>Adrian</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Alice</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Amalia</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Amanda</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Andrea</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Belinda</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Belle</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Beth</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Bianca</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Blair</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Carmel</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Caroline</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Carrie</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Connie</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Dawn</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Dean</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Debbie</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Deidre</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Edith</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Eleanor</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Elsa</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Eric</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Frun</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Francesca</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Francis</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Geoff</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Helen</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Hugo</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Jack</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Kelly</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Kirk</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Lewis</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Louisa</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Michael</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Neil</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Owen</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Rita</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Sandra</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Scott</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Tom</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Tracey</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Valerie</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Wendy</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Yolanda</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Geographical Location</td>
<td>Participants (pseudonyms)</td>
<td>Interviews</td>
<td>Focus Group Discussions</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------</td>
<td>------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>rural (N=31)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christopher</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donna</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elizabeth</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felicity</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fiona</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gail</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gemma</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hannah</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ingrid</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isabel</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jackie</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jennifer</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jo</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kate</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kay</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laura</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Libby</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marcella</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Margot</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nadia</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nancy</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pairotea</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peggy</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renata</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rose</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandra</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarah</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tina</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veronica</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitney</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>coastal (N=23)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blake</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gillian</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hazel</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heather</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irene</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ian</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imogen</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jane</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karen</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leah</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandy</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marciela</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natalie</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicole</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olivia</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pam</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rachel</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Richard</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sian</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simone</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tammy</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teresa</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vicky</td>
<td>*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
BIOGRAPHY

URBAN

Adrian - 36 years old, married with 2 children (aged 11 and 14 years), born in Australia of English ancestry, secondary education, ceramicist, one household income of $5,000-12,000/year, Uniting Church.

Alice - 30 years old, married with 2 children (aged 6 and 7 years), born in Australia of English-Dutch ancestry, Year 11 secondary education, housewife, one household income $40,000-60,000, Church of England/Catholic.

Amalia - 44 years old, never married, living alone with 1 child (aged 9 years) born in Britain of English ancestry, residing in Australia for 35 years, university education, tertiary student, with one household income of $12,000-30,000/year, Church of England.

Amanda - 40 years old, married with 2 children (aged 5 and 7 years), born in the Asia of Filipino ancestry, residing in Australia for 9 years, university education with marketing qualifications, home duties, with one household income of $30,000-40,000/year, Catholic.

Andrea - 39 years old, married with 2 children (aged 8 and 11 years), born in Australia of Australian-English-Irish ancestry, with nursing qualifications, registered nurse, with two household incomes of $30,000-40,000/year, no religion.

Belinda - 36 years old, married with 2 children (aged 4 and 7 years), born in Northern Europe of Hungarian ancestry, residing in Australia for 9 years, TAFE college, qualified as an accountant, home duties, household income of $40,000-60,000/year, Catholic.

Belle - 34 years old, married with 4 children (aged 5 to 10 years), born in Australia of Australian ancestry, hospital training, qualified as a nurse, registered nurse, with two household incomes of $40,000-60,000/year, Catholic.

Beth - 32 years old, married with 5 children (aged 2 to 9 years), born in Australia of Dutch-English ancestry, TAFE college, education, one income of $12,000-20,000/year, Catholic.

Bianca - 33 years old, divorced, living alone with 1 child (aged 6 years), born in Australia of Australian ancestry, secondary education, child care and machinist, with one household income of $5,000-12,000/year, Christian.

Blair - 38 years old, married with 3 children (aged 2 to 7 years), born in Australia of English ancestry, TAFE College with qualifications in plumbing, registered plumber and househusband, one household income of $20,000-30,000/year, Anglican.

Carmel - 32 years old, defaced with 1 child (aged 5 years), born in Australia of Irish ancestry, secondary education with hairdressing qualifications, manageress in hairdressing, with two household incomes of $12,000-20,000/year, Anglican.

Caroline - never married, living with friend and 1 child (aged 9 years), born in Britain of English ancestry, residing in Australia for 8 years, university education, in graphic design, deputy co-ordinator of an aged care hostel, with two household incomes of $30,000-40,000, non-denominational religion.

Carric - 40 years old, married with 2 children (aged 6 and 8 years), born in Australia of German-Irish ancestry, secondary education and secretarial course, interviewer for market research company, income of $12,000-20,000/year, attends regular Uniting Church services.

Connie - 40 years old, married with 2 children (aged 10 and 13 years), born in Australia of English ancestry, secondary education with administration qualifications, housewife and office worker, with one household income of $30,000-40,000/year, Protestant.

Dawn - 39 years old, married with 3 children (aged 1 to 5 years), born in New Zealand of New Zealand ancestry, residing in Australia for 30 years, university education in teaching, home duties, one income, Church of England.
Dean - 40 years old, married with 2 children (aged 2 and 5 years), born in Britain of English ancestry, residing in Australia for 39 years, university education, information systems consultant, two household incomes of more than $60,000/year, Atheist.

Debbie - 40 years old, married with 2 children (aged 5 and 10 years), born in Britain of Scottish ancestry, residing in Australia for 34 years, secondary education, home duties.

Deidre - 32 years old, married with 2 children (aged 3 and 6 years), born in Australia of mixed ancestry, TAFE college with secretarial qualifications, with one income, Church of England.

Edith - 30 years old, married with 1 child (aged 6 years), born in Northern Europe of German ancestry, residing in Australia for 7 years, secondary education, home duties, with one income of $20,000-30,000/year.

Eleanor - 39 years old, married with 2 children (aged 7 and 11 years), born in Australia of German-English ancestry, university education, with food services qualifications, home management and chef, with one household income of more than $60,000, non-denominational religion.

Elsa - 36 years old, married with 2 children (aged 3 and 6 years), born in Australia of English-Irish ancestry, university education in pharmacy, community pharmacist, with two household incomes of $30,000-40,000/year, no religion.

Eric - 39 years old, married with 3 children (aged 7 to 22 years), born in New Zealand of Maori ancestry, residing in Australia for 17 years, secondary education, bus driver, one household income of $30,000-40,000/year, Mormon.

Fran - 38 years old, divorced with 2 children (aged 3 and 6 years), born in Australia of British ancestry, university education, university student, one household income of $5,000-12,000/year.

Francesca - 36 years old, married with 2 children (aged 1 and 5 years), born in Australia of Italian ancestry, university education with commerce qualifications, accountant, with one household income of $40,000-60,000/year, Catholic.

Francis - 43 years old, married with 3 children (aged 8 to 10 years), born in Australia of English ancestry, marketing officer, one income of $40,000-60,000/year, Catholic.

Geoff - 40 years old, married with 1 child (aged 8 years), born in Australia of Australian ancestry, university education, administrator, one household income of $30,000-40,000/year.

Helen - 42 years old, married with 3 children (aged 5 to 17 years), born in Australia of Australian-English ancestry, secondary education, home duties, with one household income of $30,000-40,000/year, Presbyterian.

Hugo - 37 years old, married with 2 children (aged 2 and 5 years), born in Australia of British ancestry, university education, doctor, two household incomes of more than $60,000/year, Agnostic.

Jack - 41 years old, married with 3 children (aged 3 to 12 years), born in Australia of English ancestry, university education, doctor, with two household incomes of more than $60,000/year. Taoism/Christian.

Kelly - 31 years old, married with 3 children (aged 3 to 7 years), born in Australia, of British, German and Welsh ancestry, secondary education, home duties, one income of $40,000-60,000/year, Anglican.

Kirk - 44 years old, married with 3 children (aged 10 to 17 years), born in Greece of Macedonian-Slav ancestry, residing in Australia for 41 years, university education, architect and manager, with two household incomes of more than $60,000/year, Church of England.

Lewis - 35 years old, married with 2 children (aged 1 and 4 years), born in Australia of English ancestry, secondary education, refrigeration mechanic, with two household incomes of $30,000-40,000/year, Agnostic.

Louisa - 47 years old, married with 2 children (aged 7 and 24 years), born in Britain of English ancestry, residing 25 years in Australia, secondary education, housewife, two household incomes of $20,000-30,000/year, Methodist.
Michael - 40 years old, married with 2 children (aged 1 and 3 years), born in Australia of English/Irish ancestry, university education, tutor, with two household incomes of $40,000-60,000/year.

Neil - 45 years old, married with 2 children (aged 5 months and 3 years), born in Australia of Scottish ancestry, secondary education, sales and marketing, presently unemployed, one household income of less than $5,000/year, no religion.

Owen - 42 years old, married with 2 children (aged 6 and 10 years), born in Australia of English ancestry, secondary education, motor mechanic, with one household income of $40,000-60,000/year, Church of England.

Rita - 37 years old, married with 2 children (aged 7 and 9 years), born in Britain of English ancestry, residing in Australia for 25 years, university education with teaching qualifications, home duties and crafts, one household income of $20,000-30,000/year, Uniting Church.

Sandra - 31 years old, married with 3 children (aged 3 to 8 years), born in Australia of German ancestry, secondary education, with one household income of $5,000-12,000/year.

Scott - 40 years old, married with 2 children (aged 4 and 5 years), born in Australia of British ancestry, institute of advanced education, project worker in welfare, with two household incomes of $20,000-30,000/year.

Tom - 45 years old, married with 2 children (aged 4 and 6 years), born in Australia of Celtic ancestry, university education, town planner and policy officer, with two household incomes of $40,000-60,000/year.

Tracey - 36 years old, married with 3 children (aged 7 to 18 years), born in Australia of Scottish-Australian ancestry, TAFE college, clerk, with two household incomes of $30,000-40,000/year, no religion.

Valerie - Female, 42 years old, separated with 2 children (aged 9 and 13 years), born in Australia of Australian ancestry, secondary education, home duties, with household income of $5,000-12,000/year, Anglican.

Wendy - 39 years old, married with 1 child (aged 10 years), born in Australia of English-Scottish-French ancestry, university education, primary teacher and veterinary nurse, with one household income of $30,000-40,000/year, Uniting Church.

Yolanda - 46 years old, married with 2 children (aged 10 and 24 years), born in Australia of Australian ancestry, TAFE college, director of home management, with one household income of $20,000-30,000/year, Anglican.
RURAL

Christopher - 37 years old, married with 4 children (aged 6 months to 6 years), born in Australia of British ancestry, university education, home duties and medical scientist, one household income of more than $60,000/year. Uniting Church.

Donna - 42 years old, married with 5 children (aged 6 to more than 18 years old), born in Britain, has resided in Australia for 36 years, secondary education, home duties/secretary, two household incomes, Church of England.

Elizabeth - 25 years old, married with 2 children (aged 3 and 5 years), born in Australia of Australian ancestry, attended TAFE College with secretarial qualifications, one income.

Felicity - 44 years old, married with 3 children (aged 7 to 16 years), born in Australia, secondary education, home duties, one household income of less than $5,000/year. Baptist.

Fiona - 33 years old, married with 1 child (aged 5 years old), born in Australia of Irish-English ancestry, secondary education with a certificate in catering, home duties, one household income of $40,000-60,000/year.

Gail - 40 years old, married with 3 children (aged 6 to 10 years), born in Australia of English ancestry, secondary education, working as a bank teller, one household income $20,000-30,000/year. Presbyterian, with Health Care, Medicare and Pharmaceutical Benefits cards.

Gemma - 34 years old, married with 2 children (aged 3 and 6 years), born in Northern Europe of Dutch ancestry, residing in Australia for 31 years, university education with teaching qualifications, employment counsellor, with two household incomes of more than $60,000/year, no religion.

Hannah - 39 years old, married with 3 children (aged 6 to 13 years), born in Australia of English ancestry, secondary education, registered qualified as nurse/midwife, two household incomes of more than $60,000/year. Uniting Church.

Ingrid - 32 years old, married with 2 children (aged 6 and 7 years old), born in Australia of English-Irish ancestry, secondary education, home duties, one household income of $40,000-60,000/year. Catholic.

Isabel - 41 years old, married with 3 children (aged 8 to 10 years), born in Northern Europe of German ancestry, has resided in Australia for 31 years, secondary education, home duties, one income, Lutheran.

Jackie - married with 2 children (aged 6 and 7 years), born in Australia of Scottish-Italian ancestry, university education in teaching, child care worker, with two household incomes of $40,000-60,000/year. Church of England.

Jennifer - 31 years old, married with 1 child (aged 6 years), born in Australia of English-Welsh ancestry, secondary education, caregiver, two household incomes of $30,000-40,000/year. Uniting Church.

Jo - 30 years old, married with 2 children (aged 3 and 6 years), born in Australia of Irish-German ancestry, secondary education, home duties and business partner, with two household incomes of $40,000-60,000/year. Catholic.

Kate - 29 years old, married with 2 children (aged 2 and 6 years), born in Australia of Finnish ancestry, secondary education, carer for the intellectually disabled, one household income of $12,000-20,000/year.

Kay - 45 years old, married with 3 children (aged 8 to 16 years), born in Australia of Irish ancestry, hospital training with nursing qualifications, registered nurse and midwife, with two household incomes of $20,000-40,000/year. Uniting Church.

Laura - 40 years old, married with 2 children (aged 5 and 7 years), born in Australia of Australian ancestry, secondary education with clerical qualifications, home duties, one household income of $30,000-40,000/year. Catholic.

Libby - 39 years old, married with 2 children (aged 4 and 7 years), born in Australia of English ancestry, secondary education, home duties and book-keeper, with two household incomes of $20,000-30,000/year. Anglican.
Marcella - 37 years old, married with 2 children (aged 6 and 8 years), born in Australia of Australian ancestry, secondary education with qualifications in business studies, home duties, with one household income of $30,000-40,000/year, Anglican.

Margot - Female, 37 years old, married with 2 children (aged 8 and 11 years), born in Australia of Australian-Irish-English-Welsh ancestry, university education, postal services officer, with two household incomes of more than $60,000/year, Church of England.

Nadia - 34 years old, married with 2 children (aged 4 and 7 years), born in Australia of English ancestry, hospital training as enrolled nurse, with two household incomes of $40,000-60,000/year, no religion.

Nancy - 37 years old, marrier with 3 children (aged 7 to 16 years), born in Australia of Australian ancestry, secondary education with qualifications as nursing aide, personal carer, with two household incomes of $20,000-30,000/year, Church of England.

Patricia - 36 years old, married with 2 children (aged 4 and 6 years), born in Australia of Australian ancestry, secondary education with secretarial qualifications, home duties, with one household income of $40,000-60,000/year, Anglican.

Peggy - 32 years old, married with 2 children (aged 5 and 7 years), born in Australia of Croatian ancestry, secondary education, home duties, one household income of $30,000-40,000/year.

Peter - 41 years old, married with 3 children (aged 5 and 15 years), born in Africa of Ghanaian ancestry, residing in Australia for 12 years, university education, town planner, two household incomes of $30,000-40,000/year, Catholic.

Renata - 38 years old, married with 1 child (aged 7 years), born in Australia of Australian-English ancestry, secondary education, housewife, with two household incomes of less than $5,000/year, Church of England.

Rose - 38 years old, married with 2 children (aged 6 and 9 years), born in Australia of English ancestry, secondary education with secretarial qualifications, with one household income of $20,000-30,000/year, Uniting Church.

Sandra - 34 years, married with 3 children (aged 3 to 7 years), born in Australia of Scottish ancestry, secondary education, machinist and home duties, one household income of $20,000-30,000/year, Uniting Church.

Sarah - 40 years old, married with 2 children (aged 5 and 9 years), born in Australia of English ancestry, hospital training, qualified as nurse, registered nurse and home duties, with one household income of $20,000-30,000/year, Church of England, with ambulance subscription and Medicare card.

Tina - 36 years old, married with 2 children (aged 4 and 6 years), born in Australia of Australian ancestry, secondary education with child care qualifications, family day care, with two incomes of $5,000-12,000/year, Church of England.

Veronica - 36 years old, married with 3 children (aged 11 to 15 years), born in Australia of Australian-English ancestry, secondary education with secretarial qualifications, home duties, with one household income of less than $5,000/year, Church of England.

Whitney - 34 years old, married with 2 children (aged 6 and 8 years), born in Australia of Australian-Scottish ancestry, secondary education with secretarial qualifications, home duties, with one household income of $30,000-40,000/year, Uniting Church.
Blake - 36 years old, married with 3 children (aged 4 to 14 years), born in Australia of Australian ancestry, university education with teaching qualifications, school principal, two household incomes of $40,000-60,000/year, Lutheran.

Gillian - 31 years old, married with 3 children (aged 3 to 8 years), born in Northern Europe of Hungarian ancestry, residing in Australia for 30 years, TAFE college in fashion design, home duties and fashion design, Catholic, with Medicare card.

Hazel - 32 years old, married with 2 children (aged 10 and 14 years), born in Australia, secondary education, home duties and catering, with two household incomes of $30,000-40,000/year.

Heather - 41 years old, married with 3 children (aged 2 to 6 years), born in Australia of Irish-English-Dutch ancestry, secondary education in floristry, home duties, Uniting Church.

Ian - 47 years old, married with 2 children (aged 7 and 10 years), born in Britain of English ancestry, residing in Australia for 46 years, university education, industrial designer, with an household income of more than $60,000/year, no religion.

Imogen - 40 years old, married with 3 children (aged 10 to 15 years), born in Australia of German ancestry, hospital training, qualified as registered nurse, with two household incomes of $30,000-40,000/year, Uniting Church.

Irene - 39 years old, married with 2 children (aged 8 and 10 years), born in Australia of English-Scottish ancestry, secondary education, house-keeper, with one income of $12,000-20,000/year, Christian.

Jane - 31 years old, married with 2 children (aged 4 and 6 years), born in Australia of Australian ancestry, TAFE college with catering qualifications, kitchen hand, with two household incomes of $20,000-30,000/year.

Karen - 41 years old, married with 1 child (aged 7 years), born in Australia of Australian ancestry, secondary education with secretarial qualifications, home duties, with one household income of $30,000-40,000/year.

Leah - 31 years old, married with 4 children (aged 4 to 12 years), born in Australia of English ancestry, secondary education, home duties, with one household income of $30,000-40,000/year, Uniting Church.

Mandy - 43 years old, never married, with 1 child (aged 6 years), born in Australia of Irish ancestry, secondary education, with hairdressing qualifications, hairdresser, one household income of $12,000-20,000/year, Christian.

Marcia - 39 years old, married with 3 children (aged 5 to 14 years), born in Australia of Australian ancestry, secondary education, state enrolled nurse, one household income of $20,000-30,000/year.

Natalie - 40 years old, divorced with 2 children (aged 10 and 13 years), born in New Zealand of Scottish ancestry, residing in Australia for 20 years, secondary education, veterinary nurse, housewife and esoteric healer, with one household income of less than $5,000/year, Buddhist.

Nicole - 35 years old, married with 3 children (aged 1 to 7 years), born in Australia of Irish-English ancestry, secondary education, home duties, with one household income of $40,000-60,000/year, Catholic.

Olivia - married with 2 children (aged 7 and 11 years), born in Australia of Australian ancestry, secondary education, with two household incomes of $30,000-40,000/year, Catholic.

Pam - 43 years old, separated with 3 children (aged 10 to 14 years), born in Australia of Irish-English ancestry, TAFE college, home duties, with household income of $5,000-12,000/year, esoteric religion.

Rachel - 38 years old, married with 1 child (aged 7 years), born in Australia of Scottish-Australian ancestry, secondary education, florist, with household income of $5,00-12,000/year, Church of England.

Richard - 46 years old, married with 2 children (aged 1 and 3 years), born in Australia of Welsh-English ancestry, university tutor, with two household incomes of $40,000-60,000/year, Taoism.
Sian - 37 years old, married with 2 children (aged 2 and 6 years), born in Australia, secondary education, with secretarial qualifications, home duties, with one household income of $20,000-30,000/year, Uniting Church.

Simone- 37 years old, married with 4 children (aged 4 to 13 years), born in Australia, secondary education, housewife, with one household income of $12,000-20,000/year, Church of England.

Tammy - 40 years old, de facto with 2 children (aged 5 and 8 years), born in Australia of English ancestry, university education, qualified in social work and teaching, social worker and TAFE teacher, with two household incomes of $30,000-40,000/year, no religion.

Teresa - 31 years old, separated with 1 child (aged 10 years), born in Australia of English ancestry, secondary education, housewife, Church of England.

Vicky - 9 years old, married with 2 children (aged 2 and 5 years), born in Australia of Australian ancestry, secondary education, with household income of $5,000-12,000/year, Catholic.
Introducing the Participants: a socio-demographic 'picture'

The questionnaire was administered to each participant and provided details on the socio-demographic characteristics of the sample. Details of the Geelong Region socio-demographic characteristics from the ABS 1991 and 1996 census data are provided where possible (City of Greater Geelong 1994, 1998). The 98 participants (78 women and 20 men) in the study were aged 25-47 years (median: 38 years) (Table 1), and were parents of at least one child under the age of 12 years. They were residing in urban (44), rural (32) and coastal areas (22) of the Geelong Region.

<table>
<thead>
<tr>
<th>Table 1: Age by Gender</th>
<th>Participants 1995</th>
<th>Geelong Region 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=98 participants</td>
<td>N=208,474 persons</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>25-29 years</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>30-34 years</td>
<td>24</td>
<td>-</td>
</tr>
<tr>
<td>35-39 years</td>
<td>28</td>
<td>7</td>
</tr>
<tr>
<td>40-44 years</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>45-49 years</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Family Structure

The majority of participants were married (86), whilst three had never married, were separated (3), divorced (3) or living in a de facto relationship (3) (Table 2). There were 89 couples and nine sole parents with dependent children, aged one year to more than 18 years (Table 3). The majority of participants had two children (N=52) of preschool age (1-5 years) and primary school age (6-12 years). Fifty-two participants had two children, 26 had 3 children, whilst 14 participants had one child, five had four children and one participant had five children. There was a total of 232 children in the entire sample, of which eight children were not living in the same household as their parent(s) due to their age (i.e., more than 18 years old) or lived elsewhere with the other parent (Table 4). Participants' children were aged 1-5 years (71), 6-12 years (122), 13-18 years (31), and 18+ years (5) (Table 5).⁵

---

⁵ Children's gender was not asked in the questionnaire, although participants referred to their daughters and sons by name during interviews and focus group discussions. The demarcation between children's age groups represents pre-school, attendance at primary and secondary schools, tertiary education and/or paid employment. This delineation differs from ABS statistics which tends to use 15 years as the age cut-off point. It is argued that 15 year old women and men are eligible to participate in the paid labour force and live away from home. Theoretically, they are able to financially support themselves, independently of their parents. However, they are not accorded citizenship, are ineligible to vote until they are 18 years old, nor buy alcohol.
Table 2: Marital Status

<table>
<thead>
<tr>
<th></th>
<th>Participants 1995</th>
<th>Geelong Region 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=98</td>
<td>N=147703</td>
</tr>
<tr>
<td>Never married</td>
<td>3</td>
<td>40626</td>
</tr>
<tr>
<td>Married</td>
<td>86</td>
<td>86233</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
<td>3776</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>7025</td>
</tr>
<tr>
<td>Defacto</td>
<td>3</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Table 3: Family Structure

<table>
<thead>
<tr>
<th></th>
<th>Participants 1995</th>
<th>Geelong Region 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=98</td>
<td>N=208472</td>
</tr>
<tr>
<td>Couple with children</td>
<td>89</td>
<td>54610</td>
</tr>
<tr>
<td>Sole parent with children</td>
<td>9</td>
<td>123369</td>
</tr>
</tbody>
</table>

Table 4: Participants 1995 - Family by Number of Children

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple with children</td>
<td>9</td>
<td>49</td>
<td>25</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Sole parent with children</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Participants 1995 - Number of Children in Household by Children’s Ages

<table>
<thead>
<tr>
<th></th>
<th>1-5 years</th>
<th>6-12 years</th>
<th>13-18 years</th>
<th>18+ years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 child</td>
<td>2</td>
<td>12</td>
<td>-</td>
<td>-</td>
<td>14</td>
</tr>
<tr>
<td>2 children</td>
<td>38</td>
<td>60</td>
<td>9</td>
<td>4</td>
<td>111</td>
</tr>
<tr>
<td>3 children</td>
<td>21</td>
<td>38</td>
<td>19</td>
<td>4</td>
<td>82</td>
</tr>
<tr>
<td>4 children</td>
<td>8</td>
<td>9</td>
<td>3</td>
<td>-</td>
<td>20</td>
</tr>
<tr>
<td>5 children</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
<td><strong>122</strong></td>
<td><strong>31</strong></td>
<td><strong>3</strong></td>
<td><strong>232</strong></td>
</tr>
</tbody>
</table>

Education, Qualifications and Occupation

Participants in the study had attended secondary school (51), TAFE College (10), university (26) or a professional training institution (8). Only 12 participants had less than Year 11 education. The remainder had completed secondary education (3), tertiary non-award studies (9), a bachelor degree (29) or a higher degree (8); having undertaken courses in, for example, secretarial work, plumbing, mechanical engineering, medicine, town planning, industrial design, medicine, commerce, catering, nursing, architecture and social work (Table 6). Fifty-two of the participants stated their current occupations as home duties and caregivers (52), whilst others were professionals (20), plant and machine operators (1), clerks (1), trades persons (4), para professionals (4), managers and administrators (4) (Table 7).
Table 6: Participants 1995 - Education and Qualifications

<table>
<thead>
<tr>
<th>Education</th>
<th>N=98</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary School</td>
<td>51</td>
</tr>
<tr>
<td>TAFE College</td>
<td>10</td>
</tr>
<tr>
<td>University</td>
<td>26</td>
</tr>
<tr>
<td>Professional Training</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

Qualifications*  
- Less than Year 11 | 12   |
- Complete Year 11   | 5    |
- Complete Year 12   | 3    |
- Tertiary Non-award | 9    |
- Graduate Degree    | 29   |
- Higher Degree      | 8    |
- Other              | 7    |

* Missing cases (25)

Table 7: Occupation

<table>
<thead>
<tr>
<th></th>
<th>Participants 1995*</th>
<th>Geelong Region 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=98</td>
<td>N=74830</td>
</tr>
<tr>
<td></td>
<td>persons</td>
<td>%</td>
</tr>
<tr>
<td>Home duties and Caregivers</td>
<td>52</td>
<td>n/a</td>
</tr>
<tr>
<td>Plant and Machine Operators</td>
<td>1</td>
<td>7051</td>
</tr>
<tr>
<td>Salespersons and Personal Services</td>
<td>7</td>
<td>10634</td>
</tr>
<tr>
<td>Clerks</td>
<td>1</td>
<td>9486</td>
</tr>
<tr>
<td>Tradespersons</td>
<td>4</td>
<td>12071</td>
</tr>
<tr>
<td>Paraprofessionals</td>
<td>4</td>
<td>5422</td>
</tr>
<tr>
<td>Professionals</td>
<td>20</td>
<td>9057</td>
</tr>
<tr>
<td>Managers and Administrators</td>
<td>4</td>
<td>7142</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* Missing cases (3)

Household Income

Five participants had an yearly household income of less than $5,000 ($192/fortnight). Whilst others had annual household incomes of $5,000-12,000 ($192-460/fortnight) (10), $12,000-20,000 ($460-770/fortnight) (10), and $20,000-30,000 ($770-1154/fortnight) (15). The majority of participants had a yearly household income of $30,000-40,000 ($1154-1538/fortnight) (24) and $40,000-60,000 ($1538-2308/fortnight) (21). Eight participants had a household income of more than $60,000 per year ($2308/fortnight). Only one participant stated that they didn’t know their annual or fortnightly household income (Table 8). The number of persons earning an income in the household were: one person (51), two persons (37), nil (6) (Table 9).* In terms of their health care financing, the majority of participants in 1995 stated they had

* There were four missing cases, and participants were not asked the sources of household income, their employment status (full-time, part-time, casual, student, retired, pensioner), nor the gender of the person working in paid employment.
ambulance subscription (63), a Medicare card (87) and private health insurance (52) (of which four indicated they had ancillary insurance cover). Thirty participants responded they had a health care card and nine had a pharmaceutical benefits card, indicative of Commonwealth government concessions for medical, public hospital and pharmaceutical services. Only one participant indicated her household had 'a passbook [bank] account for health emergencies' (Table 10).

<table>
<thead>
<tr>
<th>Table 8: Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ per fortnight</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Nil</td>
</tr>
<tr>
<td>1-192</td>
</tr>
<tr>
<td>193-460</td>
</tr>
<tr>
<td>461-770</td>
</tr>
<tr>
<td>771-1,154</td>
</tr>
<tr>
<td>1,155-1,538</td>
</tr>
<tr>
<td>1,539-2,308</td>
</tr>
<tr>
<td>2,309+</td>
</tr>
<tr>
<td>Not stated</td>
</tr>
<tr>
<td>Don't know</td>
</tr>
</tbody>
</table>

* Missing cases (3)

<table>
<thead>
<tr>
<th>Table 9: Participants 1995 - Number of People Earning an Income in the Household*</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=98</td>
</tr>
<tr>
<td>1 person</td>
</tr>
<tr>
<td>2 persons</td>
</tr>
<tr>
<td>Nil</td>
</tr>
</tbody>
</table>

* Missing cases (4)

<table>
<thead>
<tr>
<th>Table 10: Participants 1995 - Health Care Financing*</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=98</td>
</tr>
<tr>
<td>Ambulance Subscription</td>
</tr>
<tr>
<td>Health Care Card</td>
</tr>
<tr>
<td>Medicare Card</td>
</tr>
<tr>
<td>Pharmaceuticals Benefits Card</td>
</tr>
<tr>
<td>Private Health Insurance</td>
</tr>
<tr>
<td>Veterans' Affairs Card</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

* Missing cases (1)

Ethnicity

Most participants were born in Australia (78), whilst others' birthplace was Britain (9), Asia (1), Northern Europe (5), Southern Europe (1), Africa (1), New Zealand and Oceania (3) (Table 11). First and second ancestry was mainly Australian (27), British (66), and Northern European (18) (Table 12). Of the 20 migrants, four
participants were recent arrivals (7-10 years) and 16 were long-term residents (10+ years) (median: 25-31 years) (Table 13). English was spoken at home by 88 participants, which they spoke very well (89) or well (7) (Tables 14 and 15).

<table>
<thead>
<tr>
<th>Table 11: Birthplace</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants 1995</strong></td>
</tr>
<tr>
<td><strong>N=98</strong></td>
</tr>
<tr>
<td>Australia</td>
</tr>
<tr>
<td>Britain</td>
</tr>
<tr>
<td>Asia</td>
</tr>
<tr>
<td>Northern Europe</td>
</tr>
<tr>
<td>Southern Europe</td>
</tr>
<tr>
<td>Africa</td>
</tr>
<tr>
<td>NZ and Oceania</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 12: Participants 1995 - Ancestry*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Ancestry</strong></td>
</tr>
<tr>
<td>Australian</td>
</tr>
<tr>
<td>British</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Northern European</td>
</tr>
<tr>
<td>Southern European</td>
</tr>
<tr>
<td>African</td>
</tr>
<tr>
<td>NZ and Oceania</td>
</tr>
</tbody>
</table>

*Missing cases (9)*

<table>
<thead>
<tr>
<th>Table 13: Participants 1995 - Migrants: Years of Residency in Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N=98</strong></td>
</tr>
<tr>
<td>7-10 years (recent arrivals)</td>
</tr>
<tr>
<td>10 years + (long-term residents)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 14: Languages Spoken at Home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants 1995</strong>*</td>
</tr>
<tr>
<td><strong>N=98</strong></td>
</tr>
<tr>
<td>English</td>
</tr>
<tr>
<td>German</td>
</tr>
<tr>
<td>Other European</td>
</tr>
</tbody>
</table>

*Missing cases (8)*

<table>
<thead>
<tr>
<th>Table 15: Participants 1995 - Proficiency in English*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N=98</strong></td>
</tr>
<tr>
<td>Very Well</td>
</tr>
<tr>
<td>Well</td>
</tr>
</tbody>
</table>

*Missing cases (2)*
Religion and Religiosity

Participants indicated their religion as: Protestant (50), Catholic (15), other Christian (2), Buddhism (1), Agnostic (2), Atheist (2), No religion (13), and other (3). Participants' responses to religious denomination was recoded to Christian (68), non-Christian (7) and no religion (12) (Table 16). In this survey participants were asked whether they attended religious services regularly or not, as a measure of their religiosity. Twenty participants responded they attended religious services, whilst 78 indicated that they did not. Eighteen Christian participants described themselves as religious, whilst 50 stated they were not religious. Five Christians and 12 participants of no religion indicated they were not religious, but two non-Christians were religious (Table 17).

<table>
<thead>
<tr>
<th>Table 16: Religion</th>
<th>Participants 1995*</th>
<th>Geelong Region 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=98</td>
<td>N=208468</td>
</tr>
<tr>
<td>Christian</td>
<td>68</td>
<td>147397</td>
</tr>
<tr>
<td>Protestant</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Other Christian</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Non-Christian</td>
<td>7</td>
<td>2149</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Agnostic</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Atheist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>No Religion</td>
<td>13</td>
<td>37874</td>
</tr>
</tbody>
</table>

* Missing cases (10)

<table>
<thead>
<tr>
<th>Table 17: Participants 1995 - Religion by Religiosity</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=98</td>
</tr>
<tr>
<td>Religious</td>
</tr>
<tr>
<td>Christian</td>
</tr>
<tr>
<td>Non-Christian</td>
</tr>
<tr>
<td>No Religion</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Not Religious</td>
</tr>
<tr>
<td>50</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

7 Protestant was coded for: Uniting Church, Anglican, Church of England, Methodist, Presbyterian, Baptist, Lutheran. Other Christian was coded for Mormon (Church of Jesus Christ of Latter Day Saints), and Other (religion) was: Taoism and Esoteric. Note there were 10 missing cases for this question: no response was given.

8 Indicators of religiosity have been defined by Bouma (1992) and Fukuyama (1995) as membership, practice, experience, belief, consequences, church attendance and donations to religious organisations. See also Mullen (1990, 1992), Black (1991).
BIBLIOGRAPHY


Commonwealth Department of Community Services and Health (1989) *National Women's Health Policy: Where is it Now?* Canberra: AGPS.


Commonwealth Department of Health, Housing and Community Services (1993b) *Towards Health for All and Health Promotion: Evaluation of the National Better Health Program*. Canberra: AGPS.


Commonwealth Department of Human Services and Health (1994b) *The Heart of the Matter: Families at the Centre of Policy*. Discussion paper prepared by the National Council for the IYF. Canberra: AGPS.

Commonwealth Department of Human Services and Health (1994c) *Our Children, Our Future*. Canberra: AGPS.

Commonwealth Department of Human Services and Health (1994d) *An Optimistic Future: Attitudes to Ageing and Well-being into the Next Century*. Office for the Aged, Aged and Community Care Division. Canberra: AGPS.


Commonwealth Department of Human Services and Health (1996b) *Draft National Men's Health Policy*. Canberra: AGPS.


Kleinman, A. (1998a) *Clinical or Critical: Is There a Place for Medical Anthropology in Public Health?* Interactive seminar, School of Nutrition and Public Health, Faculty of Health and Behavioural Sciences, Deakin University, Burwood, 25th March.


National Health and Medical Research Council (NHMRC) (1991) *Women and Mental Health.* Canberra: AGPS.

National Health and Medical Research Council (NHMRC) (1992) *NHMRC Statement on Human Experimentation and Supplementary Notes.* Canberra: AGPS.

National Health and Medical Research Council (NHMRC) (1993a) *Review of Child Health Surveillance and Screening.* Canberra: AGPS.

National Health and Medical Research Council (NHMRC) (1993b) *General Guidelines for Medical Practitioners on Providing Information to Patients.* Canberra: AGPS.


National Health and Medical Research Council (NHMRC) (1995b) *Men and Mental Health.* Canberra: AGPS.

National Health and Medical Research Council (NHMRC) (1995c) *Ethical Aspects of Qualitative Methods in Health Research: An Information paper for Institutional Ethics Committees.* Canberra: AGPS.


National Health and Medical Research Council (NHMRC) (1996b) *Promoting the Health of Australians: A Review of Infrastructure Support for National Health Advancement.* Summary Report and Recommendations. Canberra: AGPS.


Numbers, R.L. (1997) *Making of a Medical Monopoly: Myth or Reality*. Seminar paper presented at Centre for Health and Society, Faculty of Arts, University of Melbourne, Melbourne, 10th June.


Peerson, A. (1996a) Submission to the NHMRC Standing Committee: Health Australia. Faculty of Arts, Deakin University, Geelong. March.


National Centre for Epidemiology and Public Health, Australian National University, Canberra. 16-17th February.


Turner, B.S. (1993) *Rights of Bodies, Bodies of Rights.* Inaugural Address at Faculty of Arts, Deakin University, Toorak.


