Negotiating With Helping Systems: An Example of Grounded Theory Evolving Through Emergent Fit

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A strength of substantive grounded theories is that they are modifiable. Yet, little attention is given in the research literature to the evolution of grounded theories through the process of emergent fit. In this article, emergent fit is discussed, and the evolution of the theoretical understanding of relationships with helping systems is provided as an example. In a feminist grounded-theory study of women's caring, emergent fit with existing inductive research on health care relationships resulted in a framework of negotiating, which includes four strategies: reframing responsibility, becoming an expert, harnessing resources, and taking on more. This explanatory model demonstrates how the use of emergent fit can avoid the generation of isolated theories and contribute to knowledge accumulation by producing a substantive theory with wider applicability.

In the scholarly discussion of grounded method, little attention has been given to the process of emergent fit in the creation and extension of grounded theories. Despite the fact that theory generation in grounded theory is an "ever modifying process" (Glaser, 1978, p. 5), rarely are examples of evolving theories present in the research literature (Baker, Norton, Young, & Ward, 1998). Rather, there are many overlapping custom-tailored grounded theories that are rarely consolidated (Kearney, 1998). Knowledge accumulation from completed qualitative research has been addressed primarily from the perspective of meta-analysis or metasynthesis (Estabrooks, Field, & Morse, 1994; Jensen & Allen, 1996; Kearney, 1998; Noblit & Hare, 1988; Sandelowski, 1997; Schreiber, Crooks, & Stern, 1997). Although meta-analysis is essential work, the systematic use of emergent fit in the grounded-theory research process might extend existing grounded theories and limit the production of substantive theories as "respected little islands of knowledge" (Glaser, 1978, p. 148):

> We do not have to discover all new categories nor ignore all categories in the literature that might apply in order to generate a grounded theory. The task is, rather, to develop an emergent fit between the data and a pre-existent category that might work. Therefore as in the refitting of a generated category as data emerges, so must an extant category be carefully fitted as data emerges to be sure it works. In the

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> bargain, like the generated category, it may be modified to fit and work. In this sense the extant category was not merely borrowed but earned its way into the emerging theory. (p. 4)

The importance of emergent fit has surfaced in my research program, particularly in the ways that relationships with helping systems affect caring and caregiving. In this article, I discuss emergent fit in the development of a theory of women's caring, with particular regard to relationships with helping systems. Recent inductive research has revealed that relationships between those caring for themselves or others and the health care system are frequently problematic and has resulted in substantive theory that explains such relationships in specific contexts (Anderson & Elfert, 1989; Burke, Kauffman, Costello, & Dillon, 1991; Thorne, 1990; Thorne & Robinson, 1988, 1989; Wuest, 1991; Wuest, Ericson, & Stern, 1994, 1998; Wuest & Stern, 1990a, 1990b).

In a feminist grounded-theory study of women's caring, I named negotiating as a central strategy used by women to address adversity and disillusionment in relationships with helping systems, including health care, social systems, education, religion, and justice. The theoretical sampling of data from earlier grounded-theory studies (Merritt-Gray & Wuest, 1995; Wuest, 1991; Wuest et al., 1994; Wuest & Stern, 1990a, 1990b) and from the literature produced an emergent fit of processes during the development of the present theory. Negotiating involves four processes: reframing responsibility, becoming an expert, harnessing resources, and taking on more. The negotiating process described here represents a small step toward cumulative knowledge development because it offers an explanatory model with a broader application than the previous substantive theories.

PREVIOUS RESEARCH

Thorne and Robinson (1988, 1989) describe relationships between the chronically ill and the health care system as moving through stages of naive trusting, disenchantment, and guarded alliance. Thorne (1990) extends this theory of guarded alliance by using the metaphor of navigating troubled waters to capture the process of health care relationships. Burke et al. (1991) explored the experience of families of children with repeated hospitalizations for chronic illness and found that parents began to mistrust health care professionals when they withheld information or behaved incompetently. Parents became more vigilant, and they reluctantly took charge of the situation. Grounded-theory studies of Caucasian (Wuest & Stern, 1990a, 1990b) and Aboriginal (Wuest, 1991) families' experiences dealing with children with persistent middle-ear disease identified similar patterns in the effect of health care relationships on families' ability to manage. Although the family initially entrusted the child to the health care system, they quickly became disillusioned by paternalism, having their knowledge of the child ignored, iatrogenic effects of treatment, incongruence between their perceptions and those of the health professionals, and the continuation of the illness. Women, as the major caregivers, were most likely to be engaged in adversarial relationships with the system. Families had to alter their expectations of the health care relationship and acquire knowl-

edge and skills that would allow them to protect the child and manage the problem. The potential for relationships with health and social systems to negatively influence family caregiving was also evident in a study of elders with Alzheimer's disease (Wuest et al., 1994, 1998). These grounded-theory studies each used induction to produce a substantive theory that explained the problematic nature of health care relationships within the context studied. Each middle-range theory developed was context specific and open to modification in response to new information (Glaser, 1978).

THE STUDY OF WOMEN'S CARING

Changes in the Canadian health care system have resulted in women being increasingly called on to assume additional responsibility for caring for family members. The research on which health policy is based has failed to consider the contextual realities of women. Therefore, the purpose of the study discussed in this article was to expand the nursing knowledge of women's caring as a base for policy development. The feminist grounded-theory method (Wuest, 1995) was used to develop an explanatory substantive theory of the process of women's caring within the existing social structure.

Data collection began with interviews of those who are likely to have knowledge of caring, that is, mothers with young children, and continued with theoretical sampling. Individual or group interviews were held with 21 women across the life span who were caring for well, disabled, developmentally delayed, and chronically or acutely ill selves and others. Data were also gathered through participant observation at self-help groups and information sessions directed toward women. Thus, the women in the study had diverse characteristics in terms of age, socioeconomic status, culture, education, abilities, and sexual orientation.

Concurrent with data collection, data were analyzed using the constant comparison methods of grounded theory. The central concepts related to helping systems that emerged were very similar to the concepts identified in previous studies of family caregiving of Caucasian (Wuest & Stern, 1990a, 1990b) and Aboriginal (Wuest, 1991) children with otitis media, and elders with Alzheimer's disease (Wuest et al., 1994, 1998), as well as a study of women leaving abusive relationships (Merritt-Gray & Wuest, 1995). Thus, the theoretical development undertaken in this study was further refined through the theoretical sampling of conceptual indicators previously identified, and it remained consistent with the analysis of the original studies. The inclusion of a sentence in the consent form of any grounded-theory study that gives permission for the data to be used for additional analysis in studies that build on the central processes discovered in the initial study is one way of providing explicit protection for participants. In addition, literature was sampled for comparison and emergent fit with the emerging theory when it was relevant (Glaser, 1992). Three recent overviews, a metastudy of chronic illness (Thorne & Paterson, 1998), a meta-analysis of diabetes management (Paterson, Thorne, & Dewis, 1998), and an integrative literature review of parent's experiences with health care providers (Dixon, 1996) provided data for constant comparison in the continuing development of the theoretical process of negotiating.

Emergent Fit

Emergent fit is a complex iterative process that has preoccupied me since my first grounded-theory study of family management of otitis media with effusion, supervised by Phyllis Noerager Stern. In my first study, I paid close attentions to Glaser's (1978) advice to avoid reading the literature until the framework was stabilized. I discovered that relationships with the health care system were a central issue for families who learned to manage in stages of acquiescing, helpless floundering, becoming an expert, and managing effectively (Wuest & Stern, 1990a, 1990b, 1991). Families moved from being reactive to proactive in their health care relationships through the above-mentioned stages, respectively entrusting, becoming disillusioned, learning the rules, and negotiating. Next, I turned to the literature on health care relationships and found Thorne and Robinson's (1988) similar theory of guarded alliance in chronic illness, which included the stages of naive trusting, disenchantment, and guarded alliance. To my novice eyes, my discovered theory became meaningless, and only through dialogue with Phyllis Stern did I begin to understand how to use this literature as data to support my emerging theory. However, had I known about this research earlier and understood the grounded-theory process better, emergent fit, particularly with Thorne and Robinson's processes of naive trusting and disenchantment, might have resulted in my using their language rather than my own. The benefit of such a decision would have been the recognition that these processes are applicable to a wider population.

Emergent fit became a more critical issue as I began a second study of family response to otitis media with effusion, specifically among Aboriginal families. My dilemma was whether to simply begin theoretically sampling from the theory that I had already developed or to start as if beginning a new study. I feared that the latter approach would result in a forcing of the data. I recall reading and rereading *Theoretical Sensitivity* (Glaser, 1978) looking for guidance and yet again telephoning Phyllis Stern for further dialogue. I ultimately embarked on this study by having the families speak about their experiences, just as I had done in the original study. I cautiously began coding the data, trying to keep the previously developed theory bracketed. I soon learned that this was a hopeless venture. My own theoretical sensitivity was informed by the previous theory. The constant comparative process led me from the data to the previously constructed categories, but new variations became evident. I returned to Glaser's (1978) discussion of conceptual versus logical elaboration and began to understand more clearly that what I was actually engaged in was the iterative process of theoretical sampling: "Conceptual elaboration during theoretical sampling is the systematic deduction from the emerging theory of the theoretical possibilities and probabilities for elaborating the theory as to explanations and interpretations" (p. 40). I had hypothesized that Aboriginal culture would influence the relationships with the health care system and hence had begun to study Aboriginal families. Glaser (1978) notes,

> these deducted hypotheses are not forced on the data when they fit poorly, they are discarded and others emerge in their place by constant comparative analysis. This method underlines and assumes the fact that the interpretation of patterns must be researched and grounded just as much as the patterns themselves. (p. 40)

Thus, I learned to trust the constant comparative process, recognizing that my hunches would only be confirmed if the data supported them through constant comparison. However, what about deriving hunches from extant theory or, as in this case, the substantive theory that I had already developed? Glaser (1978) continues to give direction:

> Logical deductions are a re-entry of the primarily deductive approach after a bit of grounded theory making. The subtle switch back to the deductive approach occurs because the analyst flashes on an extant theory that seems to explain or interpret what is going on. (p. 40)

This suggested that comparing the codes and categories in the new data with those developed in the previous study would be a logical next step. Stern and Pyles (1986) state,

> if concepts in the literature fit the emerging theory, use them to tell your story; if they are not relevant and do not really fit or work, leave them out. Otherwise the data can be forced in the wrong direction. (p. 13)

Glaser cautions, however, that investigators can become so engaged in logically developing explanatory schemes that the scheme becomes irrelevant to the data. This does not mean that logical deduction from extant theory should be discarded, only that the investigator must attend to the emergent fit:

> To summarily discard deductive elaborating as a tool for discovery is clearly unwise. It is vital in the constant comparative analysis of data for generating theory. To write about the subtle interplay of deductive and inductive generating is not easy. The analyst need only remember that the deductive is in the service of an inductive method; it is subservient to it, and ideas arrived at deductively must be discarded unless grounded. (Glaser, 1978, p. 41)

Gradually, I began to understand that the investigator's knowledge of relevant literature and theoretical schemes comes into play during constant comparative analysis and as long as primacy is given to what can be inductively derived from the data,only the components of preexisting theory that fit the data will survive. One does not then code the new data according to the concepts and interrelationships of an existing theory; rather, one compares the conceptual indicators in the new data with similar concepts in the existing theory for fit. The result can include actual named concepts from the existing theory in the emerging theory. However, the constant comparative process more often results in modifying and building the emerging theory such that it fits both the new data and the relevant concepts from the existing theory.

The final issue for me in my struggle with emergent fit is the issue of theoretical sensitivity and knowledge of the literature. Theoretical sensitivity refers to an individual's ability to "render theoretically their discovered substantive, grounded categories" (Glaser, 1978, p. 1). Thus, theoretical sensitivity is what allows the investigator to move beyond pure description to see theoretical possibilities in the data. Although Glaser cautions the investigator to gain such sensitivity by entering "the research setting with as few predetermined ideas as possible" so that the data is not

"filtered through and squared with pre-existing hypotheses and biases" (p. 3), he also acknowledges that "sensitivity is necessarily increased by being steeped in the literature" (p. 3) and understanding how variables are constructed in diverse fields. "Disciplinary or professional knowledge as well as both research and professional experiences, that the author brings to his or her inquiry" enhances theoretical sensitivity (Strauss & Corbin, 1994, p. 280). I found it difficult to reconcile these apparently contradictory positions. As I continued to conduct grounded-theory studies related to caregiving and caring, my knowledge of the related literature within various disciplines expanded. Relationships with health care and other related helping systems consistently emerged, and I found myself, in turn, exploring concepts such as medical dominance, patriarchy, negotiation, and expertise. As my knowledge expanded, so did my theoretical sensitivity to related conceptual indicators in the data. However, at the same time, I was entering the research setting with more and more knowledge of related literature and diverse theoretical frames, and this seems to be in direct violation of Glaser's dictum to enter the field with as few preconceived ideas as possible. The solution to this apparent paradox, I think, lies in the notion of constant comparison:

> Grounded theory does not confront other theories with being wrong or off, nor does it synthesize with other theories that seem right on. It does not, because these other works simply become part of the data and memos to be further compared to the emerging theory to generate an even more dense, integrated theory of greater scope. Thus their variables of relevance become included and integrated into the grounded theory. (Glaser, 1978, p. 7)

Phyllis Stern sums it up best: "It's all data!" (personal communication, January 23, 1999). The constant comparative process then continually checks for fit and produces modification. Once I realized that the constant comparative process provided this ongoing check and balance, I ceased to worry that extensive knowledge of the field of study would drive the analysis. Although one does not conduct an extensive literature review before entering the field of study, the investigator also does not attempt to clear one's mind as in the phenomenological strategy of bracketing:

> The analyst's assumptions, experiences, and knowledge are not necessarily bad in and of themselves. They are helpful in developing alertness and sensitivity to what is going on in the observational-interview data, but they are not the subject's perspective . . . forcing is routinely corrected by constantly comparing to discover underlying patterns. A preconceived meaning by the analyst will not pattern out. (Glaser, 1992, p. 49)

I have learned to remain close to the data in my initial open coding, to avoid language that is theory laden, and to keep asking, "What category does this incident indicate?" and, "What is actually happening in the data?" (Glaser, 1978, p. 57). These strategies ensure that the initial coding and category development is grounded in the data. It is from this base that the constant comparative process is used to check for emergent fit with existing knowledge.

These reflections on emergent fit informed the research process during my study of women's caring. Emergent fit played a role in that I began the study conscious of the findings of my previous studies and with a knowledge of much of the

related literature and thus able to integrate this knowledge as data for the constant comparative process.

THE FINDINGS

The analysis revealed that the competing and changing nature of caring demands are most problematic for women. Intervening environmental conditions, that is, caring ideals (beliefs about how caring should be), caring options (availability and suitability of resources and services), caring proximity (relational, geographical, and cultural distance or closeness), and caring rewards influence the ways in which women respond (Wuest, 1997b). A two-stage process of precarious ordering was discovered. In stage one, the process of responding reactively to caring demands produces fraying connections in the form of struggles with caring work, relationships, and helping systems; altered prospects for the future; and ambivalent feelings (Wuest, 1997a). In stage two, women become proactive, using the interdependent processes of setting boundaries (Wuest, 1998), negotiating, and repatterning care (Wuest, 1999) to limit demands, change intervening conditions, and improve management.

These processes are both intuitively and consciously learned and refined in response to new competing or changing demands. In this article, the process of negotiating will be discussed with particular reference to the ways in which emergent fit influenced the development and refinement of the process. Although it is only one process in the theory of precarious ordering, its explanatory power regarding relationships with helping systems is significant because it builds on earlier substantive theories.

Negotiating

Negotiating is the process of interacting with professional and lay helpers, and helping systems to limit fraying connections and to facilitate caring in a manner acceptable to the woman. Strauss (1978) defines negotiation as a way of getting things accomplished. Adversity with helping systems and the concomitant disillusionment (Wuest, 1997a) are the central antecedents to negotiating. The degree of adversity with systems varied according to the availability and suitability of resources and services from families and communities as well as from health, education, justice, religious, and social systems, and according to women's caring beliefs (Wuest, 1997b). Adversity stemmed largely from the demeaning process of seeking help from systems that failed to help, provided inadequate help, or made things worse. The conceptual indicators for adversity and disillusionment were compared with theoretically sampled data from previous studies, particularly the middle-ear study, and the process of disillusionment previously identified as an outcome of adversity. Moreover, findings in the literature offered further support for disillusionment with helpers in chronic illness (Thorne, 1990). Dixon (1996), in an integrative review of parent's experiences with health care providers, notes that, in 12 reviewed studies, investigators identified a period when parents were dissatisfied, angry, or in conflict with health care professionals and began to redefine their relationship from one of trust to one of caution.

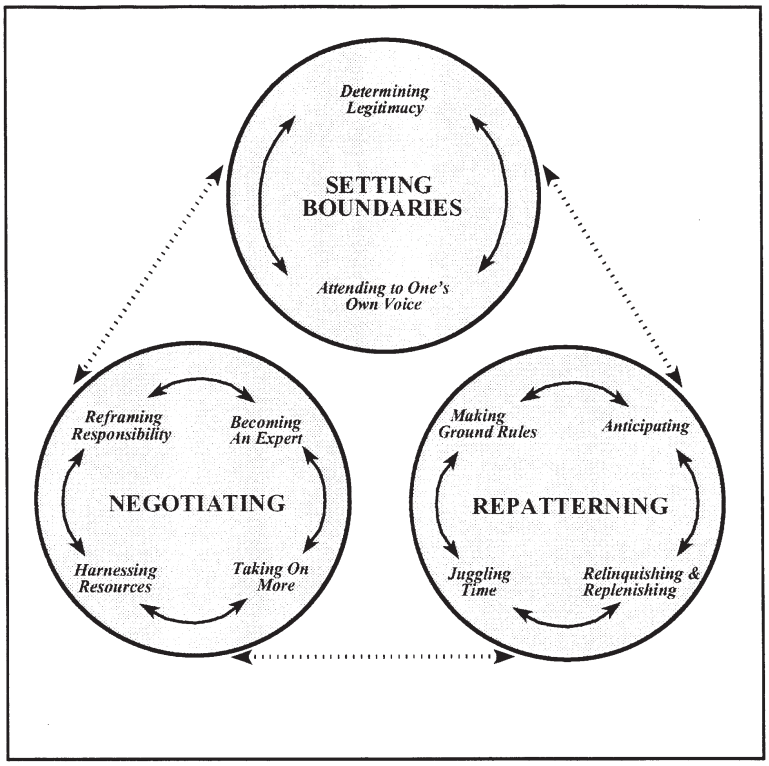

FIGURE 1: A Depiction of the Interrelationship of the Process of Negotiating With the Processes of Setting Boundaries and Repatterning.

Negotiation is carried out by women, both for women themselves and for others. It involves four strategies: reframing responsibility, becoming an expert, harnessing resources, and taking on more, all of which may be employed individually or sequentially in response to changing demands and environmental conditions. Women's relationships with helpers and helping systems are not static; this conceptualization captures both the volatility of individual relationships and the variable patterns among relationships.

Reframing Responsibility

Reframing responsibility is the process of reconsidering who is responsible for which aspects of caring, and it stems directly from disillusionment. The greater the disillusionment, the more likely women will begin to question what they can reasonably expect of themselves and of the system. Women's ideals about their own responsibility for caring have a major influence on this exploration. This process is interrelated with the process of setting boundaries (Wuest, 1998) in that women's knowledge of their own strengths and limitations and trust in their own judgments influence the reframing process.

The process of reframing responsibility, then, entails weighing personal expectations of self and expectations of helping systems. When women were first

confronted with new or changing caring situations, such as pregnancy, birth, illness, or disability or developmental delay, they asked for and expected assistance from helping experts. Cumulative disappointments led to the realization that professional help is frequently not appropriate and that the helping process requires participation. Glaser (1972) states that, although one may be willing to give an expert carte blanche in emergencies, "One cannot assume that an expert deserves a complete edge just because of his position" (p. 163).

The satisfaction or disillusionment with helping systems was further associated with the availability and suitability of resources. Women's expectations for helping services depended on the system's ideals, that is, what service providers led them to believe could be provided. Ultimately, it is service providers who control the definition and interpretation of need and the allocation of service in a particular situation (Twigg & Atkin, 1995).

Reframing responsibility is associated with women's perceptions that they have a role to play in making resources work. Women said that they did not want handouts or free rides, and they spoke of doing their part. Women's ambivalent feelings about caring further contributed to this process. Guilt associated with the extent or manner of their caring affected how women weighed their contribution. Expectations of support from helping systems varied inversely to women's beliefs about their responsibilities for caring.

Because women face multiple competing and changing demands, they may be simultaneously in positions of satisfaction, frustration, and complete disillusionment associated with specific demands. Myra, a parent of a developmentally disabled child, was extremely satisfied with her partnership with the education system, disillusioned by the way she was repeatedly devalued by health care professionals, and frustrated by her partner's failure to be available for much of her daughter's care.

Paterson et al. (1998), in their meta-ethnography of adapting to diabetes, found that the decision to take control was critical to learning to balance diabetes and was often taken in response to recognizing that prescribed regimens were ineffective or to feeling betrayed by health professionals. Reframing responsibility is not a process of deciding to directly take control so much as it is a commitment to become an active player rather than a passive recipient. The extent of disillusionment and ideals about responsibility influenced the reframing of responsibility as women reexamined notions of their own and other's obligations, moving toward becoming more informed participants in the process of becoming an expert. The degree of disillusionment influences the effort expended and the urgency in the process of becoming an expert.

Becoming an Expert

Becoming an expert is a process of learning more about a particular phenomena (breast-feeding, birth, wife abuse, dementia), finding out about existing and potential resources and services, and finally, acquiring a practical understanding of how a phenomenon manifests in one's own caring situation under one's own unique conditions. Becoming an expert was first named in a study of family management of middle-ear disease (Wuest & Stern, 1990a, 1990b) and is similar to Thorne's (1990) strategy of developing self-reliance in chronic illness. Emergent fit through the con-

stant comparative process resulted in the label, becoming an expert, being retained, although the properties were expanded from its initial usage.

Strauss (1978) notes that power stems from both knowledge and experience. The expertise that women develop is similar to that of expert nurses (Benner, 1984), but it is more focused on particular individuals under particular circumstances: "A layman need not be an expert in general but only in his specific case" (Glaser, 1972, p. 163). Daisy said, "We know quite a bit about her condition. Because, every child, even though they might have similar problems, is still different, and they all react differently. But as for Jamie [their daughter], we're Jamie's experts."[1] "Experts can also recognize when a pattern or rule does not fit the situation and when the knowledge they have is inadequate" (Hampton, 1995, p. 16), an observation evident in the behavior of women in this study, who quickly turned to professional experts when they needed help. Becoming an expert is achieved through three interactive processes: learning the rules, experimenting, and networking. Depending on particular demands, caring ideals, resource options, and the extent of disillusionment, both the work of acquiring expertise and the degree of expertise acquired are highly variable.

Learning the Rules

Learning the rules is the process of purposefully and serendipitously acquiring knowledge about systems, specific issues, or concerns, and about how the care recipient acts under particular conditions. Learning the rules was first used in the middle-ear study (Wuest & Stern, 1990a, 1990b), and through the process of emergent fit, modified for this study to include knowledge of the care recipient's responses and system knowledge. Knowledge was accumulated about the availability of resources and the ways to access them just by using them. This knowledge included not only the formal rules of referral, availability, and eligibility, but also the informal rules. The latter may be unwritten but just as rigidly enforced. Hilary wanted to have her son present at her baby's birth. Although there were no formal rules to prohibit this, she gradually learned that there were many informal rules that had to be addressed:

> Well, I talked to the Senior Clinical and the first thing she said was, "Well, will there be someone to look after him?" and I said, "Yes." But I feel it's been like a full-time job, getting the library books, borrowing the videos, calling the hospital to set up a hospital tour for my son.

During appointments with such professionals as physicians, social assistance counselors, health nurses, speech pathologists, and teachers, women had opportunities to observe and ask questions. A major problem for women dealing with new caring situations was that they did not know which questions to ask or which information was going to be important to them later on in their caring. This was a common concern among the study participants when they encountered changing demands. However, each contact with a professional provided an opportunity to ask more questions and to make more sense out of their particular situation.

Attitudes of professionals are very influential. When professionals treated women as partners by respecting and seeking their input, providing extensive information about possible courses of action and their implications, and ensuring

that women were a significant part of the decision-making process, women's development of expertise was facilitated:

> The doctors that we've encountered are quite respectful, and they realize that sometimes parents do know more than they do. We're around her more every day so that they rely on our observations. The doctors sort of treat you as an equal . . . listen to what I have to say. And the same with nurses, too.

This reinforcement of developing expertise encouraged Daisy to value her knowledge and skills. On the other hand, Alice was continually deflected from her efforts to be an active participant in her developmentally delayed child's education:

> It was a constant struggle. They didn't want my input. They had their own ideas of what was right. Well, they [the high school staff] made up their minds in half an hour what all her problems were. They didn't even know her and they didn't know me. This was the way they were going to deal with it and that upset me because I felt that I should . . . I was the one that would work with Wanda [the daughter], and I knew her. Why, I should be consulted!

This patriarchal approach devalued Alice's expertise about her daughter's learning needs.

Formal courses such as prenatal, parenting, diabetic care, assertiveness training, self-defense, and dealing with aging parents were purposeful routes to expanded knowledge and skills that are used to varying degrees by women. Libraries, special interest groups, media, and lay and peer helpers were all resources that women consulted in the process of learning the rules. Dixon (1996) found that information gathering was similarly used by parents of chronically ill children to gain control. When women in this study were able to access services in which there was continuity of provider, services were age appropriate, appointments were a suitable length of time, and there was some community follow-up, the development of expertise was most enhanced. Women spoke positively about nurses at well-baby clinics, pharmacists, community mental health workers, and rehabilitation services that met these criteria.

Women also learned the rules by observing themselves, or the persons for whom they cared, very closely to understand patterns of response under particular conditions. This process is similar to diabetics understanding the basics of their disease in a way that is personally meaningful (Paterson et al., 1998). Astrid learned to avoid being hit by leaving the house as soon as her abusive husband began drinking. Pam detected by observation that her adult epileptic son only had seizures at a certain time of day or when he had a fever. Alice determined that regular routines helped her developmentally delayed daughter to be more independent.

Networking

Networking is a strategy of tapping into sources of information, assistance, and support. Networking occurs at an individual and group level with professional and lay helpers, family, and friends, and it can take place casually or purposefully. Thorne (1990) uses the term *making connections* to refer to similar alliances formed between people living with chronic illnesses. Personal relationships with secretaries, clerks, and professionals, developed by cultivating these relationships at rou-

tine appointments, resulted in trust that could be drawn on later. Ivy had a long-standing relationship with her dentist, who filled her child's teeth and trusted her to pay a little bit each month. Sarah said that networking allowed her to know "who is best to look after me" when her postpolio syndrome needed attention.

More active networking occurred when women purposefully sought out involvement with individuals or organizations with similar interests. Women frequently networked purposefully by helping out at school, volunteering for special interest group boards, or running for elected positions. The outcome of such involvement was the expansion of knowledge and connections with system structures that potentially influenced caring. Alice said that the links that were created through serving on such boards gave her access to people with power to make decisions that affected her mentally handicapped child. Another outcome is the development of new skills and talents from taking active roles in advocacy and self-help groups. Such extended caring work often provides a woman with opportunities not available in traditional mothering roles (Traustadottir, 1991).

Networking provides women with support in the process of developing expertise. Such support can be found by networking with friends and neighbors or by finding formal self-help groups. Carly said no one in her neighborhood breast-fed, so when she talked about infant feeding, she always "threw out a line" to test whether her perspective was shared. These personal attachments gave women someone with whom it was safe to test ideas, pool information, and plan strategies. The telephone was a vital networking link for most women. Friends were seen as significant resources for developing expertise; they supported expanding knowledge and offered insights and direction for action. Nora lent the books she had obtained at a parenting course to her friend, and soon, several women were sharing them.

Personal networks were expanded by forming or joining self-help groups such as play groups, breast-feeding groups, or groups of parents with older, developmentally delayed children. These groups reduced individual isolation, increased collective knowledge, and provided a base for cooperative action. Participation in such groups is contingent on having substitute care for children or dependent adults, time, and transportation, conditions that may not be available, especially to rural or working women.

Schools were important vehicles for networking and acquiring useful information. One elementary school had a noon-hour networking program in which parents could learn such skills as cardiopulmonary resuscitation and first aid. Olive spoke about parent programs on drug and alcohol use in teens. Myra met parents and children who were comfortable with her disabled child, and this opened up avenues of support for caring.

Experimenting

Experimenting was first identified in the middle-ear study, and it reflects the family's efforts to use their acquired knowledge of the rules to influence the illness trajectory and the ultimate effects on the child and the family. There was emergent fit in this study, with the label *experimenting* being maintained to reflect the application of knowledge acquired by learning the rules and networking in individual situations. Dimensions of experimenting were modified through a constant comparison,

which includes monitoring the situation, interpreting observations in light of new knowledge, taking actions based on observations and knowledge, and evaluating the outcomes. Monitoring focused on diverse indicators such as eating patterns, fatigue, behavior, medications, mobility, mood, and progress in response to interventions. Behavior during developmental transitions such as toilet training in toddlers or self-esteem in adolescence was carefully watched to provide a base for action. Women who were dealing with common health problems such as otitis media, asthma, diabetes, or hypertension became skilled at understanding the meaning of their observations and, through experimenting, knowledgeable about which course of action was best, a finding supported by Paterson and Thorne (1997) in their documentation of the ways in which diabetics use trial-and-error experimentation to gain control. In this study, Ann read that people with Alzheimer's disease have difficulty with verbal directions. She stopped telling her partner what to do and showed him instead, discovering that he would mimic her behavior. This knowledge allowed her to facilitate his continuing independence in daily hygiene by establishing a routine in which they showered, brushed their teeth, and dressed together each day. Thus, experimenting has implications for establishing order by repatterning care (Wuest, 1999).

Increased knowledge helps women to experiment in their interaction with the system. Pam knew how to access emergency treatment for her granddaughter who developed a fever and pneumonia while she was caring for her:

> They gave her a strong antibiotic because they said, you know, that she needed it. I couldn't tell them if she was allergic to anything when they asked and I said, "Well just ring the drugstore and ask them." They have computers, you know. . . . So I mean, the doctor was just a young one.

The success of her application of her knowledge to this situation enhanced Pam's sense of her own capability and gave her confidence in actively participating in her granddaughter's care. In this way, there is interplay between the process of experimenting and the process of trusting judgment.

Knowledge acquired from informal sources such as friends and family was also put to the test. Home remedies such as rest, fluids, and vitamin C for colds were tried and evaluated. Nora turned to an old book of family remedies for a cough syrup based on onions and honey when she could not afford commercial medicine, and she found it to be effective. Each family culture is a source of traditional approaches to dealing with health, illness, and developmental transitions. Women from specific cultural backgrounds, such as Native Canadian or Vietnamese, tested out these culturally specific approaches to determine their effectiveness: "I tried that yellow root for colds, but it didn't seem to do much." Ellen found her parenting more effective when she adopted the native custom of letting children set their own pattern of sleeping and eating.

Based on expanding knowledge, hypotheses were developed and purposefully tested. Were there fewer ear infections when no one smoked at home? Did curtailing coffee consumption reduce agitation in elders with Alzheimer's disease? Did specific foods, such as chocolate, trigger severe headaches? Such experimentation led to greater expertise. Women were very cognizant that such expertise was acquired: "I think it's not there in the beginning, but you learn that you are the

expert when it comes to your child." Experimenting reveals the limits of women's expertise and helps them to make further decisions about responsibility.

Outcomes

Becoming an expert gives women more confidence in their dealings with resource people and systems because, to some extent, it balances the power. "To have power really means to have entry to a network of relationships in which one can influence, persuade, threaten, or cajole others to do what one wants or needs them to do" (French, 1985, p. 509). Knowledge, experience, and networks acquired in the process of becoming an expert help to balance power in helping relationships.

Harnessing Resources

Harnessing resources involves drawing on acquired expertise to interact effectively with helping systems so that caring is enhanced. The goal in lay-professional interaction "is not to dominate but to achieve a goal with some control in the layman's favor to secure what he wants" (Glaser, 1972, p. 160). Harnessing resources often takes place when the woman is already somewhat disillusioned with the system. A particular problem that women face as they attempt to harness resources is whether professional helpers consider issues to be legitimately negotiable. When one party perceives that the other has no grounds for negotiation, negotiation is precarious (Strauss, 1978). Hence, the process of harnessing resources may take place under circumstances in which women are humiliated, stonewalled, or devalued, as well as under conditions of partnership. Although one alternative for some women was to abandon an unsuitable service, many women had no options, especially when they were dealing with unique issues or were geographically distant from other services. Women, in one community, found that they were locked into their particular family physicians because no other physicians were taking new clients. Small communities may have only one specialist, such as a speech therapist, mental health counselor, or special needs teacher. When relationships are strained or there is dissatisfaction with the care, developing expertise and connections provide a base for women's continuing efforts to improve the usefulness of available resources in helping them to respond to caring demands.

The specific strategy used by particular women depended on the particular situation and the woman's personal style, age, social status, and previous interactions with the system. Strategies of assertion, confrontation, manipulation, and bargaining were employed to varying degrees. Some of these strategies were identified originally in a study of family interaction with health professionals when a child had persistent otitis media with effusion (Wuest & Stern, 1990a, 1990b). This study reveals that these same approaches are used in negotiating with a wide range of lay and professional helpers.

Assertion was most consistently useful in acquiring suitable services. Assertion involves persistence, a clear statement of needs and expectations, and determination. Alice said, "You go back and you keep going back." Persistent assertion was employed by Daisy in her attempt to get her daughter some physiotherapy. When she met the physiotherapist, she joked, "If I don't hear from you by Friday, I'm calling you." Humor, tact, and meeting people halfway facilitate the effectiveness of

assertion. Assertion related to a particular issue is facilitated when women trust their own judgment. Kate was assertive when she refused to let the hospital staff disrupt her breast-feeding with supplements or soothers:

> I knew what I wanted. I felt comfortable with my decisions, and if somebody wanted to do something that I didn't agree with I would say no. But I was 30 when I had my first child and older and more mature for my other ones.

Assertion was used to propose alternate approaches for management, to organize more appropriate service periods and times, and to establish more equal partnerships in helping relationships. Even women who considered themselves to be normally unassertive felt able to take assertive action when the needs of others were chronically unmet. Vera noted how searching for help for her handicapped daughter helped her learn assertion: "I don't think I was a real assertive person when I was younger. But with my daughter I think I became . . . I think she taught me that. I learned it, you know, from daily practice."

Confrontation is a strategy that requires a direct encounter and often includes some element of conflict. Sometimes the element of conflict stems from previous disillusioning experiences. Beth's first birth experience, despite her wishes to the contrary, had included episiotomy, monitoring and medication, and her subsequent attempts at breast-feeding had been a disaster. Describing her second pregnancy, Beth said,

> It was, "This is what I'm going to do," and you know, "Well we don't do that." It's, you know, fine. "I'll find somebody who will or I'll just stay home. I'm not asking permission, and I'm not giving you any alternatives. I'm just telling you what I'm going to be doing." And that was out of anger.

Conflict can also originate in the cultural difference between the caregiver and the professional. For example, professionals can hold stereotypical views of cultural groups that intensify conflict. One Aboriginal woman learned to be very assertive with a school staff who, rather than recognizing her child's health problems, attributed the time missed from school to a belief that First Nations families did not value education.

Confrontation can be an immediate response or an organized campaign. When a physician complained to one mother about bringing her child to the emergency room for an ear infection, she responded, "You're getting paid, aren't you." In contrast, Olive launched a campaign against the Department of Defense when they ruled that she was not entitled to a full pension when her husband, a sailor, died. She struggled for 3 years to create an effective argument to successfully reverse the decision. The money was essential for raising her six young children. Other confrontational campaigns were the outcome of combined efforts, such as women joining together to write letters confronting the system about the inadequacy of the respite services.

Bargaining strategies involved a mutual exchange that benefited both parties and could only be employed by women who had a skill to trade or the potential to create an embarrassing situation. Alice traded child care for physiotherapy. When the doctor decided to send her father, who had sexually abused her, home under her

care, Queen said she would lay charges against him for sexual abuse. The physician quickly decided that there were other options.

Manipulation involves exploiting the system to one's benefit, and it is frequently used as a last resort when women feel that they have few alternatives left. Jo drew on her acquired knowledge of the system and called Social Services anonymously to report child abuse in her home because she needed professional help to extricate herself from her abusive partner. When social workers talked to the children about what they had witnessed, they told Jo that, unless she left, they would take the children. This gave Jo the incentive and support that she needed to leave.

Taking on More

Taking on more is a process of taking more control by taking risks, working outside the system, or working within the system to modify existing structures. Both dissatisfaction with system resources and a desire to improve resources lead women to taking on more. Limited success at harnessing resources can be a catalyst. When resources available to women are unsuitable and their attempts to discuss, question, and assert fail to change the situation, women may choose to go outside the system by ignoring directions and living with the consequences. Queen stopped taking hormone replacement therapy because she disliked the resumption of monthly bleeding and was offered no alternatives or dialogue from her physician. Myra ignored her physician's advice to institutionalize her daughter.

The strategy of taking risks occurs more commonly when existing resources are unsuitable. Some risks seem unavoidable. Hours of service were problematic for many women who needed substitute care. Violet felt that she had no choice but to leave her demented sister alone for 15 minutes until the homemaker arrived at 8 in the morning, the same time when Violet had to be at work. Other risks are associated with personal caring ideals. When Fran met resistance from her obstetrician in planning a vaginal birth for her twins, she finally determined to stay home until she judged herself to be fully dilated as a means of avoiding a C-section.

Risks are potentially intensified when women choose to work outside the system. Carly chose to have what physicians would call an unattended home birth. This was motivated by the lack of concern for her wishes at her previous birth:

> "Episiotomy? Everybody gets one." That's a quote. I was really worried. That was the one thing I worried about most. I was terrified of someone cutting my vagina with scissors. It was bad enough thinking about an 8-pound baby coming through. That was something we had discussed with the doctor, that I wanted to try, and I'd sooner rip than have an episiotomy. And I ended up getting one done. They never even said they were going to do an episiotomy. It was so fast. I didn't see the scissors coming. I couldn't believe it. I was so angry. It was a year before I could really enjoy intercourse with my husband and not feel that scar.

Anger and disempowerment led Carly to take the risk of a home birth. Because midwifery was illegal in her location, she had no safe options to hospital birth. Decisions to take such risks outside the system were not made rashly. As other options were explored with unsatisfactory outcomes, women began to weigh which risks were reasonable to achieve their desired outcomes. Each decision involved some possibility of misjudgment.

Many women chose to take on more by using their expertise to work within the system to create new resources or to modify old ones, either because they personally needed the service or because they hoped to prevent others from experiencing similar difficulties to theirs. Sara identified scooter safety as an issue for many physically handicapped adults like herself and was working on a driver safety program. Carly and Beth were offering birth support for women to enhance their hospital experience.

Involvement in the work of creating and modifying resources results in women developing new skills and potentials and may also increase demands. Vera described her involvement in an action group for the mentally handicapped:

> It's made me a different person, I think. It certainly opened doors that I never dreamt I would be involved in, and I just sort of decided and it just mushroomed. So I had a lot of good opportunities . . . had a lot of good discussions and brainstorming sessions with people across Canada. But a lot of stress, too. Because you had two kids at home you had to organize and a husband and, you know, all that sort of stuff.

IMPLICATIONS

The process of negotiation offers a framework for interpreting women's relationships with helping systems and provides guidance for health policy development. Negotiation is an outcome of conflict and disillusionment with unsuitable or unavailable resources within helping systems. The strategies of redefining responsibility, becoming an expert, harnessing resources, and taking on more employed by women demonstrate their willingness to take responsibility. Women want to be active participants in finding solutions to problems created by diverse caring demands. There are two major implications from the substantive theory. First, women have the strengths and skills for redesigning and developing services to support caring. Second, failure to provide an environment that supports women in their caring makes women vulnerable. In their search for suitable resources, they may take on more responsibility outside the existing system structure and put themselves at risk, such as in the case of home birth. The lack of suitable and available resources may limit their caring so severely that those for whom they care are at risk.

CONCLUSION

Inductive approaches to theory development include knowledge synthesis (Walker & Avant, 1988) or grounded theory (Glaser & Strauss, 1967), and they have been called initial steps in theory development based on the assumption that the resulting theories would then be tested using traditional scientific methods. Silva and Sorrell (1992) recognize the limitations of confining theory testing to such approaches, noting the need to go beyond positivist dogma, and offering three alternative approaches, one of which is grounded theory. Grounded theory is a means of theory development that is consistent with the constructivist worldview.

Thus, the middle-range theory developed is context specific and open to modification. Within Dickoff and James's (1968) theory typology, theory developed through grounded theory is factor relating or explanatory; it does not purport to produce a predictive theory from which hypotheses can be derived to test causal relationships in an objective and static reality. Thus, theory testing within the traditional scientific method is inconsistent with the ontological and epistemological roots of grounded theory. Morse (1997) argues that, because qualitative theory is confirmed in the process of development by its nature, it fits the empirical world and testing would be redundant. Instead, substantive theories evolve and are modified in response to new information. Yet, as Baker et al. (1998) note, rarely do we track this evolution in the research literature.

Negotiating arose in a grounded-theory study of women's caring in which the emerging concepts were similar to those previously identified in studies of caregiving for children, the elderly, and those in the literature. Constant comparison between current data, conceptual indicators in data previously collected, and the literature allowed for emergent fit and the development of an integrated theory that applies to relationships with helping systems under diverse circumstances. This framework of negotiating has broader application than previous theories in that it applies to relationships with a broad range of helping systems and not just the health care system. This conceptualization is consistent with the current recognition that all public policy, rather than only health policy, determines the health status of populations. The framework of negotiating is pertinent for women across the life span whose caring is directed at promoting, maintaining, or restoring their own and others' health during developmental or situational transitions, disability, and acute or chronic illness. Although this process focuses on women, it does expand the scope beyond the chronic illness focus of much of the previous work on health care relationships. The theory is limited in that it was developed with Canadian women and, like all grounded theories, may or may not be transferable. Nevertheless, the strength of grounded theory as a method of theory development is that it is modifiable with new data. This means that, through the continued use of emergent fit, the theory can be expanded, revised, and adjusted to maintain its usefulness in explaining relationships with helping systems.

NOTE

1. The names of the participants have been changed to ensure confidentiality.

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