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The role of felt or enacted criticism in understanding parent's help seeking in acute childhood illness at home: A grounded theory study

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ABSTRACT

Background: Parents with young children often worry about whether or not to seek medical help for a sick child. Previous research identified parents' anxieties surrounding help seeking from health services but did not explore or explain the underlying psychosocial processes taking place in families at these times.
Objectives: This paper presents findings from a British grounded theory study on family management of acute childhood illness at home, which provide an explanation for parent's helping seeking behaviours.
Design: Glaserian grounded theory methodology was used for the study.
Setting: The sampling sites for the study were in two towns in the East Midlands with population profiles close to the national average for the UK.
Participants: Initial purposeful and later theoretical sampling resulted in a sample of fifteen families with children aged between 1 month and 8 years of age.
Methods: Four sets of data collection took place between 2001 and 2007. Unstructured family interviews were conducted with adult family members and a draw, write or tell technique was used to interview any children over 4 years of age. Theoretical sensitivity and constant comparative analysis were employed to achieve theoretical saturation around a core category.
Findings: Felt or enacted criticism teaches parents informal social rules which direct how they are expected to behave. Their desire to avoid such criticism of their moral status as 'good' parents creates significant hidden anxiety about when to seek medical help. This anxiety sometimes leads to late consultation with potentially serious consequences for their child's health.
Conclusion: The grounded theory indicates the need for significant investment in the training of nurses and other health professionals to reduce parents' (and other patients') experiences of felt or enacted criticism and the consequent hidden anxiety. When parents are worried about their child's health, they need to be able to seek help from health professionals without fear of criticism. These conclusions are primarily limited to universal health care environments.

What is already known about the topic

- Parents worry about bothering the doctor when their children are acutely ill at home unless they are sure the illness is serious.

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- Past experience of serious illness, sometimes referred to as past frights, acts as a sensitising factor, increasing parents anxiety about illness in their children.
- Parents will try to contain childhood illnesses within the immediate family unit wherever possible.

What this paper adds

- Parents' decision making in acute childhood illness is driven by their understanding of informal social rules.
- Parents learn that breaching informal rules puts them at risk of experiencing felt or enacted criticism.
- Experiences of felt or enacted criticism create hidden anxiety around any decisions to ask others, particularly those in positions of authority such as nurses and doctors, for advice. Such anxiety can lead to delayed consultation and increased morbidity for the child.

1. Introduction

Acute childhood illness is an inevitable part of family life with young children. These are the common childhood illnesses such as coughs, colds, ear infections, viral rashes, chickenpox, vomiting and diarrhoea. The majority of these are managed at home without seeking help from health services (Bruijnzeels et al., 1998; Holme, 1995; Mayall, 1986). Parents are concerned not to bother the doctor unnecessarily (Ehrich, 2000; Houston and Pickering, 2000; Neill, 2000). Yet in the UK those that do decide to seek help constitute a significant proportion of the workload in primary care (Royal College of General Practice, 2007). A different picture might emerge in countries which do not have a universal health care system. Despite the commonality of such illness there is a paucity of research which investigates family processes at these times. The research from which findings are presented here set out to '*discover the psychosocial processes which take place in families when a child is acutely ill at home, and the influence of these processes on families' response to such episodes of illness.*' This paper presents findings drawn from this British grounded theory study which provide an explanation for parents' decisions concerning whether or not to seek help from health services for an acutely sick child at home. Readers are referred to Neill (2000, 2008) for more detailed critical review of the limited literature in the substantive area of the research.

In grounded theory it is usual to avoid immersion in the literature at the beginning of a study as there is a risk that preconceived ideas from prior research will result in foreclosure of the analysis (Heath, 2006; McGhee et al., 2007). Relevant literature is only identified and explore for its 'fit', in Glaser's (1967, 1978) terms, with the emergent theory once the core category has been identified. In this project the core category directed a review of sociological theory concerned with social rules of behaviour, an overview of which is presented below. This literature is then referred to within the findings section to show how this research contributes to pre-existing theory.

1.1. Social rules of behaviour

Classic sociological theory purports to inform the behaviour of everyone in social life. It presents the back drop to all social encounters and it is therefore important to consider in the interpretation of behaviour in social life. Society is viewed by symbolic interactionists as created through social interactions (Blumer, 1969/1986; Mead, 1934; Sandstrom et al., 2001). It is these interactions which lead to shared meanings from which people coordinate social action and create social order. Denzin (1970) conceptualised these meanings as rules of conduct for society. These social rules are, Denzin (1970) suggests, reaffirmed every day through the rituals of interactions and individual's reflections on those interactions. Here these rules are seen in the context of managing acute childhood illness within the family.

1.2. Social rules

Social rules can be categorised as formal or informal rules. Formal rules are those official rules enshrined in law, codes of ethics and official morality (Stokes et al., 2006), such as legal and ethical frameworks for the wellbeing and safeguarding of children (Children Act, 2004; Department for Children Schools and Families, 2010; Department for Education and Skills, 2003). Informal rules, with which this paper is concerned, include ceremonial rules, which function to maintain social and moral order (Denzin, 1970; Goffman, 1972), and rules of relationships (Denzin, 1970). Rules of relationships are, of course, relevant to relationships within family groups, whilst ceremonial rules apply to interactions between families and health services (Strong, 1979). These rules may be symmetrical or asymmetrical, reciprocal or non-reciprocal. Where asymmetry exists, these (Goffman, 1972) – part of the 'micro-politics' of everyday life (Williams, 1993). An individual may not be aware of these social rules, becoming aware only when transgressed and s/he fails to perform as expected and feels shame or guilt (Goffman, 1972).

Talk of rules suggests clear definitions of what is acceptable or 'normal' in social life. However, the nature of these social rules, particularly informal rules, may be less clear than at the time of Denzin's (1970) and Goffman's (1972) writings. Patterns of social change in contemporary Western society, such as more flexible working patterns, increasing emphasis on engaging mothers in the workforce and fathers in parenting, has created a world of '*less determinative social structures*' (p. 56) with recognition of a wide range of appearances and lifestyles, although these are not always accepted (Williams, 2000). This ambiguity, about social expectations of families, may have created a situation in which parents are increasingly sensitive to the impression they create in interactions with others, particularly where they feel they may be subject to scrutiny.

Families with young children are regularly exposed to public scrutiny (Voysey, 1972), in, for example, child health surveillance programmes (Bloor and McIntosh, 1990; Department of Health, 2009), in schools and other child care settings (Department for Children Schools and Families, 2010). It should not be surprising, therefore, that parents engage in managing the impressions they make on those who scrutinise them.

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1.3. Impression management

Parents are concerned with the impressions they create, either directly in their capacity as parents or through their children's behaviour or appearance (Collett, 2005; Smart and Cottrell, 2005; Voysey, 1972). It is concerned with others perception of one's moral worth or moral character – the desire to develop positive identities – which appears to be one of the key motivators for impression management (Goffman, 1959; Leary and Kowalski, 1990). Parents want to be seen as moral or 'good' parents. Presentation behaviours which obtain the desired reward or positive regard from others raise self-esteem (Collett, 2005; Leary and Kowalski, 1990; Myers, 2008). Therefore, when parents' self-presentation elicits positive regard for their parenting ability, their self-esteem in their parenting role is likely to increase. The converse also appears to be true. Parents' knowledge that they are being scrutinised, in a situation of ambiguous expectations, may act as an alert or sensitisation to signs that they have conformed or transgressed the informal social rules of the encounter.

How people present themselves is affected by how individuals think they are regarded by others now, and how they think they may perceive them in future (Leary and Kowalski, 1990). Goffman (1959) has suggested that people will be less guarded in their self-presentation in longer term, more intimate relationships, suggesting that within families interactions are likely to be more relaxed. However he has also written that one-off encounters leave the individual free to create either a positive or negative image of themselves (Goffman, 1972) as there are no or few consequences of such encounters in the future. This may have a bearing on where parents choose to seek help for their children. Goffman (1959) suggests that individuals will take actions to minimise any threat through managing the impression they make and selecting an audience which presents the least risk.

> 'It is apparent that care will be great in situations where important consequences for the performer will occur as a result of his conduct' (Goffman, 1959, p. 219)

Such situations may include families' interactions with health care professionals, as these professionals have power to affect access to treatment, expert advice and other services. The findings presented below illustrate how these social rules shape how parents behave in response to acute childhood illnesses in the home.

2. Methodology

Glaserian grounded theory methodology was chosen as it ensures that the analysis stays close to the data, facilitating the inductive emergence of an explanatory grounded theory (Glaser, 1992, 2001). The project followed the tenets of Glaserian grounded theory, evolving from initial purposeful to later theoretical sampling, using theoretical sensitivity and constant comparative analysis to achieve theoretical saturation around a core category (Glaser, 1978, 1998, 1992). The methodology has been described previously in Neill (2010). A core category is central to the data as it accounts for a large proportion of variation in behaviour and, therefore, most of the other categories are related to it (Glaser, 1992, 1998). Variables which do not fit are not included in the theory (Glaser, 1978). Once the core category had been identified areas of the literature relevant to the emerging theory were reviewed (see preceding section for a synopsis of this literature) and subjected to the constant comparative process to establish their fit with the emergent theory. It was then possible to identify new contributions to prior theory. Data analysis was assisted by QRS NVivo v2.0 (Richards, 2002), a computer software package for qualitative data analysis. Throughout the process supervision provided checks on the rigor of the grounded theory process. On completion the grounded theory was assessed against Glaser's (1998) evaluation criteria of fit, work, relevance and modifiability.

Four sets of data collection generated 29 interviews with 15 families with children aged from 0 to 9 yrs in the home. See Table 1 for characteristics of participants and number of interviews per family. Sampling sites were identified in two towns in the East Midlands with socioeconomic profiles close to the national average. Purposeful sampling initially directed sampling through primary health care. The direct connection to health care appeared to hinder recruitment. This is not, now, surprising, given the findings reported herein that parents are particularly sensitive to criticism from health care professionals (HCPs). Consequently this approach was followed by theoretical sampling through sites not directly connected to health care, in a SureStart Programme, a Junior School, a private nursery and an Infants school (see Neill (2007) for further detail). The final data set used selective sampling from within the families already in the study.

Ethical approval was received from the local research ethics committee prior to each of the 4 sets of data collection. Adults were provided with written and verbal explanations about the project and an opportunity to ask questions prior to completing consent forms. Where families were involved in additional interviews consent was reviewed. Consent for children's participation was initially sought from parents, following which the researcher met with the children in each family to develop trust and rapport, prior to seeking consent verbally and in writing, in an age appropriate manner, at the beginning of the interview.

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

Family interviews, using an unstructured in depth interviewing technique were conducted with adults as these interviews enable the exploration of family beliefs and experiences (Astedt-Kurki and Hopia, 1996). Adult family members were asked the starter question: '*What*

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Table 1
Characteristics of the sample interviewed.

Data set	Family code	Family composition within household	Parent's occupation	Family members interviewed Family x Interview x = FxIx Bold shows Set 4 int.s	Presenting acute illness
1	1	Mother 37 Father 31 Son 2 years Daughter 12/12	Mother: nurse Father: drayman	F1I1: mother and father	Conjunctivitis Ear infection
	2	Mother 33 Daughter 12 years Son 7 years	Mother: occupational therapy assistant	F2I1: mother F2I2: daughter F2I3: son (drawing only)	Heat rash
	3	Mother 34 Son 8/12	Mother: teacher (6th form)	F3I1: mother	Vomiting, chesty cough
2	4	Mother 40+ Father 40+ Son 13 years Daughter 8 years	Mother: classroom assistant (PT) Father: HGV vehicle fitter	F4I1: mother and father F4I2: daughter	Croup
	5	Mother 43 Father 43 Son 8 years Daughter 7 years	Mother: health care assistant Father: building site manager	F5I1: mother, father and paternal grandmother F5I2: daughter (son present)	Vomiting
	6	Mother 22 Father 23 Son 2 years Daughter 2/12	Mother: housewife Father: unemployed	F6I1: mother	Rash
	7	Mother 30+ Father 30+ Son 2 years Son 13/12	Mother: accountant (PT) Father: carpenter	F7I1: mother	Gastroenteritis
	8	Mother 21 Father 24 Son 13/12 New baby girl at time of F8I2	Mother: SHOP assistant (PT) Father: factory shift worker	F8I1: mother and father F8I2: mother and father	Chicken pox
	9	Mother 32 Step-father 30 Son 8 years Daughter 7 years New baby girl 2/12 at time of F9I3	Mother: school assistant (PT) Father: motorbike journalist	F9I1: mother and step-father F9I2: daughter and son F9I3: mother and step-father	Ear infection Sore throat
	10	Mother 27 Father 45 Son 2 years New baby girl at time of F10I3	Mother: secretary (PT) Father: unemployed driving instructor	F10I1: mother and father F10I2: maternal grandmother (regular carer for grandson) F10I3: mother and father	Croup Chicken pox Chest infections
3	11	Mother 34 Father 39 Son 3 years Twin girls 2 months	Mother: medical secretary (PT – on maternity leave for Interview 1) Father: boat builder	F11I1: mother and father F11I2: mother and father	Gastroenteritis
	12	Mother 30+ Father 30+ Daughter 4 years Son 2 years	Mother: childminder Father: telecommunications engineer	F12I1: mother and father CM1I1: mother in her childminder capacity F12I2: mother and father	Conjunctivitis Cold Sore throat
	13	Mother 31 Father 33 Son 5 years Son 2 years	Mother: business assistant (PT from home) Father: teacher (11–16 science)	F13I1: son 5 years F13I2: mother and father	Chicken pox
	14	Mother 31 Father 37 Daughter 6 years Daughter 4 years Daughter 3 years	Mother: own business (PT from home) Father: parts manager for car sales	F14I1: daughter 6 years F14I2: mother and father	Head cold Croup Diarrhoea
	15	Mother 30 Father 35 Son 4 years Daughter 2 years	Mother: student nurse Father: surgical implants sales officer	F15I1: mother and father	Chicken pox

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was it like when... was ill the other day/last week?' Neutral prompts and probes were then used to help research participants to tell more about their experiences, giving the necessary depth to the data (Chenitz and Swanson, 1986; Rubin and Rubin, 1995). A draw, write and/or tell technique (Pridmore and Bendelow, 1995; Williams et al., 1989) was used with children over 5 years of age. Each child was able to choose how they would like to tell the story of their illness. All interviews were tape-recorded, transcribed verbatim and returned to participants to check for accuracy. Interviews later in the process of theoretical sampling, all with parents, continued to use the same open starter question and conversational style with added questions about emerging categories, if these areas had not been mentioned spontaneously. The final set of interviews was devoted to discussion of the emerging theory to confirm category saturation. Inherent within this process is the assessment by participants of the credibility or 'fit' (in Glaser's (1998) terms) of the emerging theory.

2.1. Findings

A brief synopsis of the core category of the grounded theory which emerged from the research is given here to set the discussion in context. Further detail is available in Neill (2010). This is followed by the main focus of this paper – findings which explore how parents learn the informal social rules to which they are expected to conform. The data extracts identify families by F and a number, e.g. F1 and the specific interview with that family is also numbered in the same way, e.g. I1. F1I1 is the first interview with Family 1. M is used to indicate a mother speaking, D for a father and Int for the interviewer.

2.2. Containing acute childhood illness within family life: core category

Repeatedly parents were found to strive '*to do the right thing*' for their child and in the eyes of others by attempting to conform to informal social rules (ISRs) for the management of common acute childhood illness. Key amongst these ISRs is the expectation that families will contain the illness within family life unless the illness is serious when they are expected to seek help.

F9 I1 M: *I never once thought oh we need to ring the doctor. I quite like to manage it myself. . .. I'm reluctant to go to the doctor's because I can manage it myself, it's not life threatening and I know that in a day or two it'll pass. . .*

F12 I2 M: *Managing yourself, I think that's something again that's put on to you by society and even people like GPs, health visitors.*

Earlier research in the 1980s and 90s exploring the sociology of child rearing (Backett, 1982; Ribbens, 1994) also identified families desire to manage independently within their nuclear group – to seek outside advice was viewed as an admission of failure. Containing the illness represents a modification for theory in this field. It is an ISR for the care of sick children but parents often have to balance this against other expectations. Broader research concerned with mother's roles (Cunningham-Burley et al., 2006; Elvin-Nowak, 1999; Hochschild and Machung, 2003) has also identified such conflicting expectations. The quote below shows a mother's multiple concerns to do the right thing – for her child, in the eyes of the teachers and her employers.

F5 I1 M: *"Sometimes I feel sorry for them because they say 'oh I've got a cold and so and so stays off school for a cold' and I said 'Yes but we've got to go to work, if it's that serious the teachers will send you home'. Sometimes I feel as if, am I doing the right thing there?"*

2.3. Informal social rules

Informal social rules were found to include the following expectations:

- the family unit will be defined as parents and dependent children, rarely including a grandparent in families with younger parents;
- parents will assume traditional gendered roles for illness management purposes – even when mothers were working and fathers not;
- normal or minor illness will be contained within the family whilst medical attention will be sought for 'real' illness. Therefore, all but 'real' illness should be contained within the family.

Cornwell (1984) also identified normal and real illness categories in her ethnographic study exploring accounts of health and illness in East London in the 1970s. In her work real illness was defined as more severe, even to the extent that it presented a challenge to medicine. This may reflect changing perceptions of illness over time or simply the different focus of her work on adult, rather than, child health.

These informal social rules create a pressure on parents to define the illness so that they can determine whether or not it is a serious 'real' illness for which they should seek help or whether it is a minor illness which they should manage independently. Their definition of illness becomes their rule frame for seeking help. Illnesses which are unfamiliar are seen as 'real' illnesses by the parents concerned. This finding explains why new parents or parents with young children, experiencing an illness for the first time, may consult more frequently. But how do parents learn these informal social rules?

2.4. Learning informal social rules – do I, don't I ask for help?

Parents learn informal social rules from interactions with family, friends, the wider community and health care professionals. Table 2 lists the categories and coding nodes pertinent to the process of family learning. Parents learn from their own childhood experiences, in early pre-parenthood adulthood and vicariously as new parents. Yet advice is not sought, although it is sometimes offered unsolicited, unless from a source unlikely to criticise.

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Table 2
Learning social rules: categories and coding nodes.

Category	Pre-parenting learning	Parenthood learning				
Substantive categories	Learning about childhood illness	Learning about childhood illness	Social expectations Family responses to illness:		Child care, education and illness	Health professional contact
Coding nodes	Learning from own childhood Prior experience with children Learning from family Generational expectations Information source: media	Prior experience with children Family HCPs Social network Lay experts Health care professional source Learning from experience Information source: media	Gendered expectations Mother's worry Mother's instinct Mother's guilt Father's guilt Leaving it to Mum Generational expectations Responsibility	Social circumstances Employment: • mothers • fathers Social attitudes Social support Sharing care	Nursery illnesses School illnesses	Professionals' attitude / manner • positive attitudes • negative attitudes • gendered response Social attitudes Service users thoughts and feelings
Theoretical categories	Felt and enacted criticism Hidden anxiety					
Core category	Containing family life					

Source: From Neill (2008).
Coding is presented under each substantive category as, within NVivo, coding 'trees' (or emerging substantive and theoretical categories) were developed as the analysis progressed. It is not possible to show a linear process from coding to substantive categories to theoretical categories as the researcher moves backwards and forwards between data collection and analysis, constantly comparing emerging coding with those that already exist for 'fit' or new concepts.

Parents learn most from their encounters with professionals, in child care and education and, most powerfully, from their interactions with health care professionals. The rest of this paper will now focus on findings which explain how parents learn these ISRs from each of these sources. Learning from the lay community is presented first followed by learning from non-health care professionals. Then majority of the discussion, which then follows, is focussed on learning from health care professionals.

2.5. Learning from the lay community

Sources of learning from the lay community include learning in childhood, learning from family, from friends and the wider community and from those regarded as lay experts by the parents.

Parents in the study reported that memories of being cared for by their parents in childhood influenced how they cared for their own children.

F3 I1 Mum: *And Mum with us, ...she never was like oow, like you know. although she was a nurse she never. . .. was like overly concerned. . . ..You just took it in your stride and I think it's from that that I'm pretty laid back with R really and truly, that unless he's really, really. . ..*

These memories influenced parents' general approaches to illness (as in the quote above), sometimes directed their use of medication, and, for some, provided a form of pictorial memory of symptoms on which they could draw when their own children were ill. They also learnt social roles for the management of childhood illness as it was uniformly their mothers who had cared for them when they were ill.

Family members outside the immediate family group were not asked for advice. Most grandparents were considered to be outside this small family group, and were, therefore, not asked for advice as they were reported to be critical or imply criticism. Those grandparents defined as part of the immediate family, for the purposes of managing a child's illness, were part of the family process of managing the illness so were asked for advice second only to one parent asking the other. Siblings were not referred to as a source of advice or support, although caring for their sibling's children, prior to having their own, was a source of vicarious learning. However family members who were also health care professionals were perceived to be a relatively non-critical source of advice. Therefore parents did ask them for advice, often seeking legitimation for decisions to contact their local health services.

Parents also learnt ISRs vicariously from friends and their wider community. Parents did not usually ask for advice about illness management, rather they listened to, and told stories about, childhood illness experiences, usually after their child had recovered. This might take the form of stories told at the dinner table or the school gate. Learning in this way did not expose parents to scrutiny at the time of the illness, and stories could later be told in the safe knowledge that their child had recovered. These stories appear to be a form of moral tale, like those reported in a range of prior research (Baruch, 1981; Ehrich, 2000; Smart and Cottrell, 2005). They were used to enable parents to present themselves as morally competent parents, who have taken the appropriate steps to cope with their child's illness, or have learnt about what to do in the future through their experiences. This appears to be a form of impression management.

The exception, to the rule that advice is not sought from non-health care professionals in their community net-

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work, concerned people considered to be lay experts. The lay experts referred to by parents were either parents who had more than two children or a childminder and were therefore viewed as having expertise in managing common childhood illnesses. These lay experts were perceived to be less likely to criticise and were therefore easier to ask for advice. It seems the reciprocity within the relationship – exchange of information for respect in the community – meant that these parents were perceived to be unlikely to criticise.

2.6. Learning from non-health care professionals

Professionals in nurseries and schools reinforced the ISR that it is parent's responsibility to care for children with minor illness through enforced exclusion of the child. This was even reinforced in school by teachers directly to the children concerned, as can be seen here in this interview with a 7 year old girl (F5I2) whose parents sent her to school with a cold.

Interviewer:	*So what did the teacher say?*
Child:	*You should be at home.*
Interviewer:	*Did you want to be at home?*
Child:	*No. Because I think school's fun.*

Parents reported that nurseries and schools send children home with very low levels of illness for which they felt uncomfortable asking employers for time off work. Working parents are in a double bind here between their responsibility for their child and responsibilities at work.

2.7. Learning from health care professionals

The majority of data on learning informal social rules came from encounters with health care professionals. In the UK interactions with health services are unavoidable in early childhood, from midwifery care in pregnancy, through delivery either at home or in hospital, to the visits of health visitors from 14 days of age through child health clinics and child health surveillance. Encounters are particularly frequent in the early years as most child health surveillance happens at this time, children are most often ill under the age of 5 years and parents meet illnesses new to them for which they then seek help. Families are therefore exposed repeatedly to the scrutiny of health care professionals from conception onwards, particularly in pre-school years.

F11I2 D: *It's not just illness, is it?.. it's everything the child does and all their development. It's, if the child is not developing properly, it's why are they not, then you want to know what you're not doing. . . ..*

M: *. . .. . .you feel that you have to prove yourself, don't you, in every field, you know. It's so competitive nowadays, isn't it, really.*

Parents learn about social rules from experiences they considered either positive or negative, although the latter most powerfully.

Positive encounters provided information about the nature of the child's illness and how to deal with it, and reassurance that the illness is not serious which may confirm that they are doing the right things. These findings replicate parents' desires identified in earlier research (Ehrich, 2000; Kallestrup and Bro, 2003; Neill, 2000). These encounters validate their decision to seek help and can empower parents to care for their children independently in the future. These findings concur with impression management theory's suggestion that self-presentations which elicit positive regard will increase self-esteem (Collett, 2005; Leary and Kowalski, 1990; Myers, 2008).

Negative encounters were the most frequent. Given the natural tendency of people to tell atrocity stories this should not be a surprise. However analysis of these reports does contribute to an understanding of how parents learn informal social rules. Negative encounters usually involved doctors and were seen as negative because they generated negative emotions. All such experiences were related to the perception of criticism, sometimes direct and verbal 'enacted criticism' but, more often, 'felt criticism' communicated through the attitude of the professional consulted.

2.8. Felt criticism: 'Being made to feel stupid'

Parents reported being made to feel stupid or silly in these negative encounters with HCPs, usually doctors. They felt that they had been criticised, even when no directly critical comments were made the criticism was communicated through the attitude or manner of the doctor concerned.

F12I2 M: *We've all taken a sick child to the doctor only to be pooh-poohed away, you know, Calpol for the next 2 days and the child will be fine and then you feel silly. . .. So I think you get a reluctance that builds up.*

Felt criticism (or the impression of having been criticised) acts as a motivator to avoid further such encounters. Individuals become aware of informal social rules when they have transgressed (Goffman, 1972; Leary and Kowalski, 1990), here resulting in 'feeling silly' or 'stupid', close relatives of shame and guilt. Parents are already sensitised by their awareness of the extensive scrutiny to which they are subjected. Such negative experiences act as an additional sensitising factor for future encounters – they have learnt the rules from these negative encounters. This sensitisation is also reported in the chronic illness literature (Bury, 1982, 1991). Here it appears also to occur in the context of acute childhood illness.

2.9. Consequences of felt or enacted criticism

Felt or enacted criticism in such encounters leads to parents avoiding encounters likely to involve criticism. The unequal distribution of power evident in these interactions makes it difficult for parents to ask questions as the implied message is that they should know how to manage

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the illness. Consequently parents leave such encounters without the capacity to manage the situation, still anxious about their child's illness and therefore may need to seek advice again. They have been told the illness is not a 'real' illness requiring medical attention but to them it may continue to be seen as 'real' as they do not know how to manage it. This may offer some explanation for parents' frequent use of NHS Direct (UK health service telephone helpline) and some parents' preference for using A & E services where they are less likely to see the same professional twice. The impression they feel they have made in any previous encounter will not carry through to new interactions with the service. One-off encounters leave the individual free to create either a positive or negative image of themselves as there are no, or few, consequences of such encounters in the future (Goffman, 1972). However where contact with these services also elicited criticism, parents perceived these avenues of support to be closed to them, unless their perception of the threat to their child's health outweighed the risk of criticism.

Whenever parents decide to seek help they will choose the route with the least risk of criticism. Where and/or who that is, is determined by parents perception of the seriousness (or 'realness') of the child's illness. Parents try to balance their desire to conform to ISRs against their perception of the seriousness of the illness.

F12I2 M:... *and then he was the one that ended up in hospital as I'd left it too late and then I was made to feel amazingly silly for having not done anything. But if, you know, a day earlier... I wouldn't have even got an appointment because they would have just said, you know, oh... it's just, you know, this time of year... in his case he reacted really badly, didn't he, and ...luckily for me his final like (gasps) of breath was whilst he was sat on the GP's knee who had already called an ambulance because he recognised things had gone on a level ... and then I felt terrible because I hadn't taken him to the doctor's until he'd got, you know, quite serious so – you can't win.*

This mother had learnt the informal social rule (to contain the illness) and tried to conform, only to end up breaching another social rule – the expectation that parents will consult when the child's illness is more serious. This type of double bind creates additional '*hidden anxiety*' for parents as they try to judge what is, and what is not, an 'appropriate' or 'real' illness for which they should seek professional help. Parents find that they need to balance the risk of criticism against the perceived threat to their child's health.

F10 I1 Int: *...you said something quite important there which is about you never know at what point to take him.*

M: *You don't. Because you don't want to umm,*

D: **You don't want to waste their time and you don't want to harm him...It's a fine line.**

Whether or not they decide to seek help parents are at risk of felt or enacted criticism.

2.10. The social order: antecedent to felt or enacted criticism

The social order, or social hierarchy, emerged as an antecedent of 'felt criticism', which explains some of the variation in parents' experiences. The extent to which parents experience, and then fear, criticism, appears to be related to the social status of the individuals with whom they interact. A power imbalance is characteristic of encounters between doctors and parents (Ehrich, 2000; Strong, 1979). Interactions between parents and nurses, where this power imbalance is less marked, are reported to be more relaxed or informal in nature. Power has been identified as necessary for stigma to occur, illustrating the way in which social structures, social order and stigma interact (Link and Phelan, 2001; Scambler, 2006). Here power appears to play a similar role in the occurrence of felt or enacted criticism.

Encounters with health care professionals were identified in Strong's (1979) seminal work as being shaped by the ceremonial rules which govern interactions within social hierarchies, such as those between parents and health care professionals. Therefore it is not surprising that parents usually demonstrate deference towards health care professionals. This leads to parents experiencing another double bind illustrated by the father in the following extract from the data:

F12 I2 Int: *What do you think parents are expected to know?*

D: *Spot the symptoms of every disease on the planet and know what it is before you take them to the doctor..... All the common things, you have to spot everything from chickenpox to a common cold to... we're supposed to know the symptoms now for meningitis. You're not told about this as a parent, I mean, but ...*

And later in the same interview:

M: *You've still got to know your place. That's the difference, you've got to have the knowledge but you have to know when to use it, yes, that's... You know, there is still, there is, in society there's still this acceptance that a GP has a much better social standing than a shop worker.*

Parents feel they are expected to know what to do, yet act as if they know nothing in encounters with doctors.

2.11. Variables influencing felt or enacted criticism: gender and relationship length

Two variables were identified which were perceived by parents to influence felt or enacted criticism experiences. These were gender and relationship length.

Mothers perceive a greater social divide between themselves and the, usually male, doctor. Mothers also report felt criticism more often than fathers. This is

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unsurprising, as it is mothers who continue to be responsible for childcare in families. However parents do feel mothers are treated differently to fathers and are more likely to feel labelled as fussing or overanxious. Gender, therefore, seems to affect the likelihood of criticism and fear of such criticism. Fathers reported that they were more likely to be taken seriously if they took their child to see the doctor and therefore would experience less criticism. Perhaps they were seen as not expected to cope with childhood illness? Or perhaps the illness was viewed as more serious if father had had to take time off work to seek help.

This communicates to parents that informal social rules differ for mothers and fathers, reinforcing traditional gendered parenting roles – mothers being responsible for children's health, whilst father's responsibility is to provide financially. Parents' reports suggest that others' responses, in encounters such as consultation with a doctor, are also shaped by these shared social rules.

The second variable is the duration of the relationship with the person from whom parents seek help. Parents often reported electing to seek help from services where they were likely to speak to a different professional on each encounter. Their moral character was unlikely to have been damaged by such one off encounters, reflecting Goffman's (1972) view that single encounters leave people free to create either positive or negative images of themselves.

In longer term relationships such as with a GP, when parents know a professional well, they are likely to know that professional's informal social rules, to act accordingly and avoid criticism. The likelihood of criticism is reduced if parents conform but this is not through the development of a more relaxed relationship but through learning to conform to ISRs. Goffman's (1959) suggestion that people will be less guarded in their self-presentation in the longer term does not seem to apply here as the social order prevents any familiarity from reducing the likelihood of criticism. Consequently, if one of the known ISRs is not to seek help for minor illness, parents need to find other sources of help when they feel their resources to manage the illness have been exhausted, in order to conform to the rule. Seeking help from sources which do not appear to have links with one's local services (such as a family HCP or lay expert) prevents their need to ask from appearing on the medical record held for their child by the GP. In this way parents retain their moral character as 'good parents' in the eyes of the GP as parents who manage such illness at home without asking for professional help.

2.12. Felt or enacted criticism – the key mechanism in learning informal social rules

The desire to avoid felt or enacted criticism is the primary motivator for parents' decision making in response to a child's acute illness, apart from the obvious concern for the child's health. This fear of criticism appears to be experienced as a hidden anxiety.

F11 I 2 M: *And maybe when you go down to say, to see the GP, ...you should be able to walk in with anything and just say but maybe part of you feels that you shouldn't be, you shouldn't be there, you should be. . .*

F10 I1 M: *. . ..you don't know at what point to take them in because you don't want to waste their time so. . .*

This anxiety to avoid criticism leads parents to check whether or not it is legitimate to consult a doctor for their child's illness. This might be through phoning NHS Direct, as in the quote below, or a family HCP.

F10 I3 M: *I think we use NHS Direct before taking them to the doctor just so that we don't waste the doctor's time and just to see if there is anything to be worried about but. . ..*

D: *Well, there's nothing worse than going into a doctor's surgery and then just getting told, you know, nothing wrong, don't worry about it, take 2 aspirin and away you go.*

M: *But you just want a bit of reassurance sometimes I think . . . so if they say, yes, it's OK* (to see a doctor), *then it's OK.*

Felt or enacted criticism emerged repeatedly throughout the findings as the key component in parents' learning of informal social rules. Such criticism leaves parents feeling that their moral character, as parents, has been judged and found wanting. Repeated experiences may reduce parents' self-esteem and self-efficacy, reflecting impression management theory (Leary and Kowalski, 1990). Damage to parents' self-esteem and self-efficacy results in lowered perception of their ability to manage acute childhood illness. This in turn leaves parents needing further help and advice whilst also increasing their anxiety about seeking help.

2.13. Felt or enacted criticism – a modification of stigma theory?

The notion of felt or enacted criticism and hidden anxiety has similarities to Scambler's theory of felt and enacted stigma and hidden distress (Scambler, 2004; Scambler and Hopkins, 1986), albeit at a lower level of intensity. Felt or enacted criticism shares some of the characteristics of stigma identified in Link and Phelan (2001) review. It is experienced when parents perceive they have been discredited, breached an informal social rule (of which they may only then become aware) and may be associated with the perception of being labelled as, for example, 'a neurotic mother'. However, the magnitude of the social rejection experienced is less than that reported for stigma (Charmaz, 2000; Gray, 2002), for example, parents do not report acts of discrimination considered part of the experience of enacted stigma.

Felt criticism differs from felt stigma as it concerns parents feeling of having been criticised without any overt

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verbal criticism, whilst felt stigma is concerned with the fear of enacted stigma. In the theory offered here this fear of criticism applies to both felt and enacted criticism and is experienced as a hidden anxiety whenever they are considering seeking help for a sick child.

The concept of 'felt or enacted criticism' is proposed as a minor form of stigma. Parents fear, and will actively avoid, being negatively labelled as 'bad' or 'incompetent' parents. It may be a precursor to stigma, opening up an avenue for future research. A review of the literature failed to identify any attempts to define 'felt or enacted criticism' as a concept. Dixon-Woods et al. (2005) used the term without definition, clarification or elaboration within their interpretive literature review. It appears that the felt or enacted criticism theory provides a contribution to knowledge concerning the nature and consequences of parents' experiences of criticism, albeit limited to interactions concerned with the management of acute childhood illness at home in the UK. Felt or enacted criticism and its corollary, 'hidden anxiety', appear to be minor forms of felt and enacted stigma and hidden distress.

3. Conclusions

3.1. Implications for health professionals

Parents' decision making in acute childhood illness is driven by their understanding of informal social rules. They learn that breaching these informal rules puts them at risk of experiencing *felt or enacted criticism*. This creates *hidden anxiety* around any decisions to ask others, particularly those in positions of authority such as nurses and doctors, for advice. Doctors, in particular, appear to be acting as moral agents creating an official morality for parents caring for acutely sick children at home. When parents transgress, their moral character is damaged. The ambiguity of ISRs in modern life contributes to hidden anxiety as parents can never be sure ISRs will be the same in any given encounter.

These findings indicate a need to develop professionals' skills, particularly doctors', in facilitating family care through positive learning encounters rather than felt or enacted criticism. Focussing on professional development works with the dominant social structure and, as Scambler (2006) suggests for stigma, may therefore be a more successful strategy to reduce parents experiences of criticism. Work is needed to raise GP's awareness of parent's sensitivity to criticism and, when criticism is perceived, its possible consequences, including delayed consultation. Demand management in primary care in the UK has, to date, focussed on attempts to teach patients how to use services 'appropriately'. These findings suggest that the emphasis might more profitably be placed on developing professional's consultation skills to remove implied or direct criticism.

Families need to feel their help seeking will not be judged as moral inadequacy if they are to make decisions about seeking help based on the child's illness rather than 'hidden anxiety'. Experiencing positive regard increases self esteem and is likely subsequently to increase self efficacy resulting in an increase in parents' ability to manage minor childhood illnesses independently when provided with the information to do so.

There are important messages here for nurses who are increasingly being employed in ambulatory care centres, minor illness and injury services and GP out of hours services. As this nursing role expands nurses have an opportunity to act as moral agents and adjust the official morality to one which enables parents to seek help without fear of criticism whenever they are worried about a sick child at home. When such encounters are viewed positively by parents, they provide opportunities to enhance parents self esteem and self efficacy and for health education about the management of minor illnesses at home. Improving parent's confidence in home management of minor illnesses has the potential to reduce consultations in primary care and emergency departments.

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