

CHAPTER 1

INTRODUCING CULTURE, COMMUNICATION AND CHILD HEALTH

Introduction

Cultural beliefs and values implicitly shape every aspect of the way we parent our children and how we communicate about parenting. For parents who are migrants or new arrivals to Australia, experiencing parenting in a new country, how child health professionals communicate their understandings of culture is essential. In the current climate of mainstreaming and population-based approaches to health care, all child and family health professionals regularly find themselves working with people who come from cultural backgrounds that are different to their own. How we deal with these encounters is the focus of this research into communication, culture and child health.

Working with difference is often difficult. Human nature does at times bind us. Human beings across the globe have many aspects of their humanness that can be essentialised. We all have eyes, ears, and thoughts, and feelings, and mostly we love our children. It is how we express that love and care that differs. The most difficult aspect of working with difference is determining which aspects of human nature we can comfortably essentialise and which bits must be privileged as different. There is no single theory or practice that helps us to know the answers to this question.

In health care, we have often managed difference through borders and binaries. In hospitals, people with medical conditions are separated from people with surgical conditions, while old people or 'geriatrics' are separated from children or 'paediatrics'. People generally enter hospital ill and leave 'well' or at least further along the continuum to wellness. For reasons of specialty knowledge and maintaining specialty care, these borders and binaries have mostly served professionals and consumers well. However, when health care moves into the community, where the focus changes from treating illness to promoting health and wellbeing, the legitimacy of these borders, based on anatomy and physiology and the principles of scientific reason, become less clear. When these borders are transposed across Australia's diverse cultural makeup, the basis for their sustained

use wavers. This bordering results in health inequalities for parents, primarily mothers, babies and children who are migrants or refugees in South Australia.

In this first chapter I introduce the reader to concepts of cultural care as they are represented in Australian policy and South Australian health care policy. Through an examination of literature and policy I identify women and children who are migrants or refugees to South Australia as vulnerable to health care inequalities. I introduce myself as a child health nurse, parent and researcher, and describe how these multiple and competing positions intersect with this study into culture, communication and child health. Using the literature, arguments are then made to sustain an investigation into intercultural communication practices between child health professionals and parents who are migrants or new arrivals to South Australia. Finally, I outline how the thesis is presented.

Cultural care in multicultural Australia

Multiculturalism has influenced the formulation of Australian Government policies and programs for migrants since 1978 (Department of Immigration and Multicultural and Indigenous Affairs 2004). The introduction of policy on multiculturalism was a progressive step towards valuing and including difference in Australian society. In a move away from the white Australian policies of the 1940s to early 1970s, multiculturalism in South Australia refers to 'policies and practices that recognise and respond to the ethnic diversity of the South Australian community' (Multicultural SA 2001).

While it was necessary to move away from policies of assimilation and integration, 'multiculturalism' as a term, has been critiqued for reducing the value of plurality. Hodge and O'Carroll (2006) present an argument that multiculturalism as policy has rarefied minority ethnic groups as different and marginal to the mainstream Anglo-Australian population. As the white majority of Australians perceive themselves without 'ethnicity', they do not consider policies of multiculturalism as relevant or of interest to them. Hodge and O'Carroll (2006) further suggest that *multiculturalism* as a noun has taken over the adjective. In this way we focus on policy and problems without attention to the complexities of what happens in a multicultural society. In this thesis I use the term *multiculture* instead of multiculturalism, as it places culture at its centre and accounts for the 'shifting, dynamic interweaving of cultures and diversities' that exist in Australia today 'as well as do political policies and aspirations' (ibid, pp. 3-4).

Australia continues to develop its multiculturalism through migration and humanitarian programs (Department of Immigration and Citizenship 2006). A migration program provides for skilled migration based on a migrant occupation demand list (MODL), as well as family migration, whereby citizens or permanent residents of Australia can sponsor family members living overseas to join them to live in Australia. Through the refugee and humanitarian program, people in humanitarian need overseas can apply for offshore resettlement, and those arriving in Australia unlawfully or with temporary visas can apply for onshore protection.

Australia experienced an increase of ten percent in net overseas migration (NOM) between 2004 and 2005 (Australian Bureau of Statistics 2006). 70 percent of these permanent arrivals were from the migration program, 11 percent from the refugee and humanitarian program and 19 percent from the non-migration program, which consists mostly of citizens of New Zealand (ibid). In the same period, South Australia experienced a NOM of 6.7 percent, making it less than the national average (ibid). These statistics do not account for those who are living in Australia unlawfully or on temporary protection visas (TPVs).

The arrival and residency status of those seeking to live in Australia deeply affects their settlement experiences and outcomes (Holmes, Hughes & Julian 2003; Rees 2004). New arrivals under refugee status experience higher levels of welfare dependency, housing problems and challenges to entering the workforce than people entering under the migration program (Holmes, Hughes & Julian 2003). These challenges affect refugee arrivals who are on temporary protection visas more deeply, particularly women and children. For example, a study of East Timorese women on TPVs indicated psychological problems of fear, anxiety and depression, social exclusion and inaccessibility of services (Rees 2004).

The current policy *Multicultural Australia: United in Diversity* incorporates a strategic direction for access and equity, ensuring that 'government services are attuned to the realities of diversity in Australian society' (Department of Immigration and Multicultural and Indigenous Affairs 2003, p. 8). This policy highlights the need for greater investment for vulnerable individuals and groups, including migrants and refugees living as permanent or temporary residents in Australia.

Relating this to health care policy, the *South Australian Generational Health Review* (Department of Human Services & Menadue 2003) identified both new arrivals and those in early childhood as at-risk populations requiring specific effort for equity

strategies within health. The interface between these two policy recommendations is the provision of culturally appropriate and safe parenting and child health services to families who are refugees or migrants² to South Australia.

Research shows that culturally appropriate services are an important part of the effort to address the specific needs of these vulnerable groups (see for example Long et al. 1999; Small et al. 2002). However, while new policies in Australian health care shift the focus for service delivery for migrants from specialist providers to generic health care providers, there is little research in the area of practice development and cultural safety in mainstream child health organisations. This thesis builds on an emerging assertion that practice development in the area of culturally appropriate child health services requires different strategies to analyse and enhance current practice.

The South Australian *Early Childhood Services Framework* (ECSF) cites women and children as particularly susceptible to inequalities in health and welfare, mainly during the antenatal period and throughout the early childhood years (Department of Human Services 2003a). Evidence presented by the Department of Human Services (DHS) contends that women and children from migrant families face even greater challenges in having their health care needs met, primarily due to problems relating to communication and culture. Providers of child health services to migrant families need to address issues of culturally appropriate communication to meet the goals of the ECSF, particularly to 'enhance the quality of early childhood for children who are disadvantaged as a result of their early childhood experiences, and to increase the equality of outcomes between groups of South Australian children' (ibid, p. 4).

Parenting and child health services provide a unique window of opportunity to explore how health professionals provide services in the key areas of child and migrant health. In South Australia these services are community-based and are provided by a multidisciplinary primary health care workforce that includes predominantly nurses, but also social workers, psychologists, physiotherapists and medical practitioners.

Cultural beliefs and values implicitly and explicitly shape the way we parent our children. Service provision to parents in Australia needs to reflect a range of cultural practices that support parents as they establish themselves in this new and

² These terms are at times used interchangeably in this thesis. Most often the term 'migrant' is used to represent people settling through both migrant and refugee programs.

challenging role. Becoming a parent brings with it profound changes to a person's identity and social status. For immigrant parents, the birth of their first child in a new country is laden with additional meanings. It often joyfully symbolises the parents' first real claim to citizenship in their new country. These parents often have to resolve the cultural, practical and ideological conflicts of childbearing, parenting and employment alone soon after their arrival in Australia. It is usually a time when their English is poor and their familiarity with the Australian health care system is minimal (Rice 1999).

Culture is equally critical and complex in the context of service provision (Long et al. 1999). Most of us working in health care think of ourselves as culturally sensitive. We may hold this belief without understanding how we know this about our practice. Most child health professionals do not question the cultural assumptions implicit in the information they give, nor do they ask how culturally appropriate are particular interactions they have with consumers of their services. Long et al. (1999) argue that we often work in environments where assumptions about the cultural appropriateness of interventions are rarely questioned from within, or 'where the preparedness to accommodate alternative cultural paradigms is by no means assured or even seen as necessary' (ibid, p. 22).

Parents constantly make implicit and explicit choices about the way they parent their children. In this way they become active participants in the construction and translation of culture. Small (1998, p. 52) suggests that 'parents today, in the more modern anthropological view, are seen not as passive translators of culture but as active participants, making choices about this or that pattern in bringing up a particular kind of adult citizen'. People who migrate to Australia and become parents negotiate their cultural knowledge and experiences of parenting with the expectations of parenting in their new culture as they seek to belong. Child health professionals, including child health nurses, social workers, psychologists and doctors, have the potential to be key moderators in affecting the experience of first-time parenting for this group. It is essential that we examine how this health interaction is played out. To explore how child health professionals understand both themselves and their practice and the role they play in supporting parents who are 'others', is essential for the future of Australia.

Introducing myself

As a critical inquiry into how child health professionals understand their constructions of culture, multicultural and intercultural communication, I use the following section to introduce my situated understandings of the assumptions and agendas that shape this research. In this way I 'place myself on the same critical plane as the overt subject matter' (Harding 1987, p. 9). I wish to be explicit about my understandings and how they present me as visible, real and historically situated, with consequential beliefs and values. Further, I would like to relate political and theoretical considerations to the experiential base from which my thesis emerges.

In the role of child health nurse since 1990, I have often felt that rather than enhancing the parenting practice of clients, I have at times compromised and constrained their confidence in their parenting ability. I have tried to address this concern within the practice arena for many years. At first aiming to empower parents with information I 'knew' to be best even if it didn't always suit the parent, I believed that once they trusted me and did as I advised, their problems would work out due to a relationship based on trust and 'good' information. What is more, I really believed that power was something I could give to a mother through giving the right information at the right time.

Over time and with the experience of parents who refused to share my beliefs but allowed me to follow them in their approaches, I learned to listen and work within parents' frameworks rather than my own. Eventually, I determined that while only certain approaches to parenting were sanctioned by the organisation for which I worked, I would 'work around them', as they were not always what I thought a parent wanted or needed to hear. It seemed most helpful to listen and work with parents to enhance their self-understanding and come to a place where they trusted and valued themselves as parents to their children. My professional confidence in this approach grew as I travelled to live and work in varied metropolitan, rural and remote locations within South Australia (SA) and New South Wales (NSW).

As a mother, I was astounded at how differently people parented their children. For example, family friends in a mid-west farming community in New South Wales who worked the land from 4 am, confidently left their five- and three-year-old children to get themselves up and dressed, prepare breakfast, tidy up and make their way, two kilometres down the road to the care of ageing grandparents. Meanwhile, city friends spoke of the need to plan their babies' every moment so that they could

maintain the 'right' routine and ensure enough age-appropriate stimulation. Some friends held their babies so close that in continuing to breastfeed when the babe was three years old, they became a topic of intrigue and sometimes consternation from others.

How all of these differences came about troubled me. I was struck by how alike we all seemed, yet how different the value systems that informed our approaches were. A further trouble from my position as child health nurse was that while I was charged to 'empower' parents, the information I was instructed to use was surprising in its singularity of instruction. Confusingly, these concerns didn't seem visible: parents came and went to child health services; there was never a problem of not having enough parents to work with. It was recognised that some parents 'didn't like' the way we did things or 'didn't want' our services, or that with some parents we had to work 'harder' to get through to them, but this was accepted as a part of child health practice.

Returning to work for a state-wide child health organisation in 2003, I noticed that many child health professionals continued to employ the 'party line' with no apparent conflict with alternate parenting ideas. Those who were working around the edges, however, were increasingly disgruntled and dissatisfied. Within the organisation there was a growing movement towards working more collaboratively with parents using the Parent Advisor Model (PAM) (Davis, Day & Bidmead 2002), alongside a shift in the philosophy around managing challenges to infant sleep from a behaviourist approach to one that considered more of the infants' emotional and mental health development. While I was excited by learning a 'new' collaborative approach to working with parents, I was concerned that the changes in recommendations for sleep management might be replacing one suite of recommendations with another, rather than working towards a pluralist approach that acknowledged the diversity of parenting styles.

Interestingly, clinicians who were most confronted with challenges to their professional approach and the content of recommended information were those working the edges. In a service anecdotally understood as being run by middle-class white women for middle-class white women, families at the edges include those working with parents with multiple challenges or who came from cultures other than middle-class and white. It seemed as though parents from the edges continued to have a more difficult time accessing and engaging with services. Child health professionals continued to be challenged by working with families who differed from

their own construct of 'normal'. Families who were 'othered' in this way appeared to receive services that were in some way less equitable than those within the dominant white mainstream. I had no words or framework with which to name these observations of care, let alone strategies that might help to mediate practice.

My own cultural awareness and education has developed throughout my personal and professional life. As the youngest of six in a working class Irish Catholic family, I remember vividly my mother's confusion and discomfort when a neighbour at the front door asked her to sign a petition to 'keep the Aboriginals from moving in up the back'. My mother seemed unable to explain her uncertainty but refused to sign the petition. She tried to explain to me the neighbour's concerns and her concerns about the neighbour's approach but they didn't make sense. We lived in our belief, inculcated by the nuns, that we would all live together, people of different colours, and end up a big beige melting pot. While that didn't make sense either, it sat more comfortably with our belief in treating everyone the same and with the same level of respect.

I embraced learning about the PAM amidst a flurry of impassioned discussions. These ranged from outpourings of great accolades in support of the model by those who felt it would 'revolutionise' child health practice to those who saw the mandated engagement in learning the model as a personal affront. They saw no problem with their current practice and they vehemently resented the PAM. Many argued that the model focussed on a rehashing of existing communication strategies that were already widely used, such as the well-known work of Egan (1990) and Rogers (1959).

Throughout exploration of this discomfort with practice, I began to link together the strands that informed the questions of this thesis. These strands were about child and family health practice, culture, and communication. Culture seemed to envelop child health practice, yet was given little consideration other than how it was used as a marker of difference.

In the following section I use existent literature to discuss the central place of culture within parenting practices. In Australia, support to parents in the early childhood years is primarily offered through the health system. I therefore follow with a brief review of literature about migrant experiences of health care services in Australia. In the absence of literature on intercultural communication in parenting and child

health, this discussion relates particularly to the time around of the birth of a baby and the proceeding postnatal period.

Parenting and culture

While navigating the choices of first time parenting, new arrivals to Australia are also dealing with the chaos of moving from all things familiar, and often from an environment of violence and political unrest. They are redefining their identity and that of their family. Foss (1996), a North American researcher, explored the dual transition into parenting for first-time migrant parents. She proposed a conceptual model of determinants of healthy parenting in immigrant populations which builds on original work by Belsky (1984). This model comprises three determinants, personal or parental, infant, and contextual. The social and economic environment is described as part of the contextual determinants to parenting. Access to health care services is a key part of the social and economic environment and health care providers often do not understand how migrants express health related problems, nor what various migrant groups expect from a health care provider. Similarly, migrants do not understand the health care system or know how to communicate with health care providers (Foss 1996).

Ling Liem (1999), an Australian researcher of the challenges of migrant motherhood, also describes a dual transition of simultaneously becoming a first-time mother and migrant. The unique biological and social changes attached to the transition into motherhood are exacerbated by a cultural change where they face a 'value system and a physical, social and political structure which is foreign to them' (ibid, pp. 136-137).

While these researchers identify the challenges of parenting while simultaneously experiencing cultural change, the majority of research to date has focused on birth and the early postnatal period. There is an absence of exploration into care in the ensuing area of child health and parenting. There is also a lack of research that investigates how health professionals, including child health professionals, practice in a culturally safe way. In the following section, I briefly summarise current research of women's experiences of birth in a new country.

Current research

The Victorian *Mothers in a New Country* (MINC) study investigated views and experiences of maternity care among Vietnamese, Turkish and Filipino women

giving birth in three major teaching hospitals in Melbourne, Australia. A total of 318 women participated in interviews between six and nine months after the birth of their babies (Small et al. 1999). This study resulted in a number of publications addressing issues such as immigrant women's experiences of postnatal hospital stay (Yelland et al. 1998), cultural and language issues in immigrant women's experiences of maternity care (Small et al. 1999) and immigrant women's views about care during labour and birth (Small et al. 2002).

Unhelpful attitudes and behaviours of staff were a key issue for health practitioners identified by migrant women in this study. Yelland et al. (1998) describe a lack of assistance, even unfriendliness and rudeness. Small et al. (1999, p. 66) cite examples of women being "scolded", ignored or shouted at'. Both studies found that women were intimidated and coerced into practices that contradicted cultural practices they wished to observe.

In a phenomenological study of Muslim women in Queensland, Vose and Thurecht (1999) illuminate the women's experiences during perinatal care. They describe how the women felt disliked, had problems with communication, felt that nurses were suspicious and distrusting of them due to attitudes and insensitive care, and were reluctant to complain due to a need to fit in. Bayly (2000) researched medical staff experiences of working with women from different cultural backgrounds at the Royal Women's Hospital, Melbourne. She concluded that communication is more difficult across cultural boundaries and that 'these difficulties may contribute to a less favourable experience of care by women from different cultural backgrounds' (ibid, p. 106). She suggested that both communication difficulties and negotiating conflicting values cause distress for doctors as they continually strive to overcome them.

Similarly, (Long et al. 1999), in a study of Australian mental health services, found that the major barriers to accessing timely and appropriate services for non-English speaking consumers included poor communication, stigma and cultural differences between client and clinician. This national study involved data collection from all states in Australia and three community mental health service case studies, one each in Victoria, Western Australia and Queensland.

Blackford and Street (2002) conducted research with nurses working with migrant families in a paediatric setting in Melbourne. In their review of Australian research on women's health, they noted findings of 'discriminatory practices amongst health

professionals towards women who were not Anglo-Australian' (ibid, p. 666). Their study found that discourses of equity rather than equality fuelled discriminatory practices, rendering them invisible to nurses who privileged issues of gender over issues of race, ethnicity and class.

Markovic (2001), in *Responding to Cultural Diversity in Women's Health: A Resource for Health Professionals*, concludes that health professionals often have difficulties communicating appropriately with migrants who do not have English fluency. She suggests that they may not understand the terms women use, that they may worry about giving culturally inappropriate or unacceptable advice, and that they may feel they do not know enough about particular cultural groups and their beliefs and practices.

In Britain, Schott and Henley (2004), writing from a social justice in health care perspective, cite poor communication as the most common cause of dissatisfaction migrants have with health services. They suggest this can lead to inappropriate treatment, to clients rejecting beneficial advice, or to migrants not accessing services.

Two elements are repeatedly identified throughout these studies: problems of communication, and problems with the way care is provided. Small et al. (1999) suggest time on cultural awareness programs may be better spent addressing quality of care issues and barriers to communication. Expanding on this issue, Small et al. (2002) argued that the current accepted strategy of focusing on awareness of cultural difference through cultural awareness programs is inappropriate. They suggest moving staff training away from the study of women and cultural diversity towards caregivers and, more specifically, to addressing staff attitudes and the culture of care.

Spence (2004), a New Zealand nurse and researcher, used a framework of cultural safety to undertake a hermeneutic study of nurse experiences of caring for people from cultures other than one's own. She suggested that assumptions and values are intrinsic to practice, and that nurses be challenged to unblock prejudices that prevent the exploration of new possibilities. While prejudices can be helpful in enabling us to make sense of situations, they can also 'constrain understandings and limit the capacity to come to new or different ways of understanding' (ibid, p. 163).

In recommending communication strategies for working with people from cultures other than one's own, Schott and Henley (2004) describe a double barrier of culture. They say the first barrier is our own culture. A picture of one's own culture includes prejudices coexisting with a range of assumptions, values and beliefs. In accord with the tenets of cultural safety, Schott and Henley state that 'only when we become aware of what in ourselves is cultural can we step outside our cultural constraints and care for other people in terms of their own needs' (2004, p. 13).

Cultural self examination

A primary role of Australian child health professionals is to support parents, particularly those experiencing parenting for the first time. Parenting for the first time is a major life event, accompanied by heightened sensitivity and vulnerability. In order to provide specific and appropriate care, cultural frameworks that inform the selection and delivery of information to migrants need to be questioned.

Foss (1996) described nursing standards of parenting behaviour based on her 1995 research into North American public health nursing practice. She suggested that these standards came from the nurses' 'personal values, interpretations of how the dominant culture defines "good parenting," and professional experiences with other frequently encountered cultural groups in their caseloads' (ibid 1996, p. 86). Similarly, in explaining the actions of nurses in New Zealand, Polaschek (1998, p. 453) suggested that a nurse always operates 'from her/his own cultural mindset which influences how she/he relates to those she/he cares for'. While this makes sense, the challenge for health care professionals is to develop reflexive strategies for examining how our own culture and our own cultural self inform our professional practices so that we grow our cultural competence and capacity to advocate for all our clients (Ramsden 1995). A cultural mindset comprises values and beliefs relating to race, gender and class, all developed through the intersection of personality traits, family socialisation and broader socio-cultural conditioning. Research to explore how cultural shaping influences practice has not been done in an Australian context.

Gender, for example, is an inherent and pervasive variable when questioning communication practices. Feminist theory has shown unequivocally that gender is a form of communication, that people go through life not merely as individuals but as men and women, and that the experiences available to them and how they talk about these are closely related to gender. Since the early 1990s, critical and

postmodern feminist theory has increasingly examined the complex interrelationships gender has with other markers of subjectivity. However, Blackford and Street (2002, p. 670) found that the 'liberal feminist ideal that privileges gender over issues of race, ethnicity and class created a distorted image of the lives of migrant women'. They also saw the nurses' practices and beliefs as shaped by the beliefs of the organisation for which they worked. Organisational practices did not consider gender within the context of the women's culture, instead using their own cultural frameworks of gender as the normative reference point. These findings led to changed practice for the nurses involved in the study and an ongoing commitment to working with other nurses in their health service.

Another variable not found in the literature is the intersection of class with child and family health communication. While child and family health services in South Australia have historically been underpinned by principles of equity and access, in many areas the service was anecdotally described as predominantly serving middle class needs. Prior to the implementation of the universal contact visiting and family home visiting programs, it seemed that appointment times and bookings into parenting groups were overloaded in middle-class areas. Staff in lower socioeconomic areas appeared to work harder to engage parents to attend recommended health checks and group parenting education sessions.

Blackford (2003) reviewed the data from the study of working with women from non-English speaking backgrounds to explore the health care culture that informed the frameworks of clinical practice. She suggests that nurses' practice is informed by a health care culture that intersects with 'the broader socio-political structures of Australian life' (ibid, p. 242). She states that 'cultural differences have the potential to be marginalized or rendered invisible', particularly in light of the Australian health care policy focus on 'mainstreaming' (ibid, p. 242).

In the area of child and family health, Vimpani, Patten and Hayes (2002) offer a summary of the debate between universal and targeted health care provision in early childhood. They suggest that services in Australia tend to offer a compromise between the universal and targeted services. However, advocates of targeting suggest that the most disadvantaged often miss out on universal interventions. Vimpani, Patten and Hayes (2002) also reflect that the provision of additional services to families with high needs may have a stigmatising effect.

Most child health professionals are well-intentioned in their provision of care to immigrant parents and their children and attempt to integrate cultural knowledge into their practice. However, if child health workers view themselves and are in turn viewed by first time parents who are migrants as 'experts', how can these parents, who are coping with multiple transitions, challenge the ideas of these professionals? Vimpani, Patten and Hayes (2002) discuss the challenges of capacity building within communities and workforces in response to Fukuyama's (1990) 'great disruption', that is, the rapid change from an industrial to an information- and service-based society. They suggest that the professional workforce needs to develop new operational paradigms, such as moving 'from being "the expert" and prescriber of therapeutic action, to facilitator and coach as well as evaluator and interpreter of diverse sources of information' (Vimpani, Patton & Hayes 2002, p. 26). Clear (1999) concurs, suggesting that the structure of the parent/professional relationship is underpinned by inequality and objectivity. Clear goes on to suggest that professional processes are strongly constructed from disciplinary interests that act to decontextualise parents' efforts as carers, and that organisational frameworks act to impede establishment of caring relationships.

A practice example of the professional processes of disciplinary interests can be found in the content of information given to parents about sleeping. In South Australian child and family health practice, independent sleeping has long been promoted as preferred practice (Leeson 1990). This is supported by the National SIDS Council of Australia (2007), who recommend that babies sleep on a separate surface in the same room as their parents until 12 months of age. However, in many cultures, co-sleeping is seen as a natural, nurturing and protective practice for newborns. This approach is supported by evidence that co-sleeping enhances infant maternal attachment, supports infant survival and promotes breastfeeding (McKenna 1995, 1996; McKenna, Mosko & Richard 1997). These positions appear contradictory. The Children, Youth and Women's Health Service has posted on their web site a help topic on sleeping with babies (2007). The information on this site offers evidence for and against co-sleeping, and supports parents to make a collaborative family decision regarding sleep practices. In this way, organisational frameworks support health professionals to move to a position of facilitator and coach.

Parents, however, still often ask for health professionals' opinion on the 'best way' to approach sleep. The authority of child health professionals to speak on these

matters remains privileged within health care discourses. As such, the information communicated by them is often promoted as the preferred and most beneficial way of parenting. When a child health professional takes a definitive position on which way to settle a baby, they advise a definitive way of becoming a 'good' parent against which all other approaches to parenting are measured. When this authority underpins child health practice, it is referred to as the 'expert' model (Davis, Day & Bidmead 2002).

McKenna (2000, p. 125) suggests that 'the choice belongs to fully informed parents, not to advice givers'. This approach reflects current practice changes in communicating and working with parents in Britain (Hall & Elliman 2003). The Parent Adviser Model (PAM) developed by Davis, Day and Bidmead (2002, p. ix) arose from 'parents' concerns about professionals not listening to them, not treating them with respect and not caring for them as individuals, as people with competence of their own'. The model is about engaging parents in a supportive relationship in order to enable them to adapt to and manage problems as they arise. Child and Youth Health in South Australia began training all child health professionals in this model in 2002. These shifts in consumer-focussed care are welcomed. If they are to become more meaningful than 'feel-good' rhetoric and meet the needs of culturally diverse parenting, new ways of understanding the self as a cultural being in the context of professional communication need to be researched in a variety of situations.

An outline of the thesis

In this first chapter, I have introduced the reader to the intersections of culture, communication and child and family health. I have briefly reviewed South Australian Government policy in families and children alongside research evidence reflecting the state of care experienced by consumers of health who are also migrants.

Key arguments from the literature were introduced to support the investigation into how child health professionals communicate with parents who are migrants or new arrivals to Australia, particularly in the area of parenting. These include the pivotal role of parenting in the development of cultural identity for children and the specific challenges of parenting from marginalised positions. Child health professionals are uniquely placed to mitigate these challenges of parenting, yet the experiences of migrant parents in a range of health settings suggest that their health encounters only reinforce a sense of marginalisation. While pedagogies of cultural care and

communication exist in health care education, they seem to leave unattended the cultural positioning of individual child health professionals.

There seems to be little research or evidence regarding the way that health professionals construct their approaches to working with cultural difference, nor how these constructs intersect with everyday practice. The study reported in this thesis is unique in that it turned the focus of investigation away from observing the cultural other as a service recipient to exploring child health professionals' reflections on their cultural positioning and intercultural communication practice.

Theoretical frameworks for investigation are presented in chapter 2. As a critical inquiry, this study was underpinned by a cluster of related theoretical constructs. I began using a criticalist position following Kincheloe and McLaren (2005). This was primarily underpinned by poststructural and feminist understandings. During data collection and analysis, I sought further theoretical positions from which to make sense of emerging participant constructs of identity, knowledge and ideology. Insights from cultural studies and postcolonialism were most useful. Further, following Hodge (2005), I incorporate three body analyses as a strategy to unsettle and challenge the binary progression of theory to practice. The ontological and epistemological positioning of the inquiry is made explicit in this early chapter, as these understandings inform textural deconstruction of pedagogies of child and family health care, intercultural care and communication presented in chapters 3 and 4.

Chapter 3 is the first of two chapters that provide background to the study and situate child and family health practice through an understanding of current and historic socio-political and professional discourses. Presented in two sections, this chapter first critiques the historical context of child and family health. This is followed by a presentation of a situated understanding of contemporary child and family health practice in South Australia.

As a study of culture, historical understandings are required to make sense of the present. Considering Good (2005), I do not use the 'post' discourses as a form of presentism that attempts to decry the ways of the past, replacing them with a new set of better post-modern/cultural/structural understandings. Rather, I explore history to explicitly understand the past as influencing present-day ways of being in the world in an endeavour to find pathways that accommodate both past and present understandings in a multicultural.

Australia as a nation was created as a colony of the United Kingdom. With this history comes a legacy of colonising behaviours towards Indigenous Australians and a precarious middle ground for migrants to Australia of ancestry other than Anglo-Celtic and Anglo-Saxon³. Australia's history of child and family health is entwined with this history of colonisation, as some families experienced health care and others welfare. It seems that those who were non-indigenous and non-white variously inhabited both spaces, but all were placed on a trajectory to normative Anglo-centric cultural parenting standards. There is little available literature that examines historically-influenced cultural aspects of parenting in Australia.

Contemporary constructs of child and family health are presented and discussed in the second section of chapter 3. While child and family health care is enacted by a range of health care professionals, the majority of this care is carried out by child health nurses. This section pays particular attention to nurses' scope of practice in community child health care. The central ideologies of primary health care, partnership and population health are examined regarding their capacity to change health care outcomes in the context of child and family health care.

To finalise the background investigation, Chapter 4 critiques contemporary discourses of cultural care and communication in child and family health practice. The *Parent Advisor Model* or PAM, (Davis, Day & Bidmead 2002) is introduced as a dominant pedagogy within community child health care in South Australia, and transcultural care (Leininger 1997; Leininger & McFarland 2006) is identified as the normative approach to intercultural communication encounters. Using postcolonial feminist textual deconstruction, these discourses are found to represent modernist assumptions of truth and knowledge. While these assumptions generally serve us well in health care, they present potential problems of application of theory to practice within pluralistic intercultural communication encounters.

Ethnographic methods are proposed as most useful to understand participants' taken-for-granted assumptions about their intercultural communication practice. These are described in chapter 5. In order to value and deconstruct both researcher and participant understandings of intercultural communication, data collection methods for this study included participant observation, field interviews, video recording of consultations, and reflective in-depth interviews with participant child

³ Collectively referred to in subsequent chapters as 'Anglo'. Following the Macquarie Dictionary (2008), Anglo is also used to describe 'a white person whose first language is English'.

health professionals following observation of their DVD. In addition to describing how data was managed and analysed, in this chapter I also relate how data is presented in the discussion chapters. The participants are introduced to the reader in chapter 6. Importantly, this brief chapter also describes the service in which participants work and situates their particular health care environments.

The analysis showed that participants in this study created and operated within a system of binaries. These are presented in the findings chapters as a series of collisions where participants seemed to be located at one end or the other and often could not find a place to operate simultaneously at both ends of the binary. As such, these binaries at times restricted and delimited practice, particularly in the pluralist context of intercultural communication about parenting in the multicultural that is Australia. These binaries are referred to as collisions because, within the linear scope of a binary formation, power was perceived by participants as a material object. Relations of power then became force relations. In this way, the authority of white cultural knowledge and ideologies crept out unrecognised and unquestioned into the communication practices of child health professionals.

Data analysis and discussion are presented together in the findings chapters. In each of these chapters, the nature of the binary is described through practice examples alongside discussions deconstructing the multiplicity of meanings inherent in these examples. Three body analysis is used as a reconstructive tool interwoven into discussions inviting the reader to step outside the binary to consider alternate possibilities of meaning.

The first binary construct is presented in chapter 7. It relates to philosophical differences in practice between child health professionals and the organisation for which they work. This resulted in a binary of 'us and them' that operated on two levels. At the structural level, participants understood the changes in service delivery from a comprehensive primary health care model to a population-health based model driven by political and fiscal needs rather than serving the needs of individual parents and their children within communities. Services to parents were experienced by participants as being reduced, particularly services to parents from minority groups. This conflicted with media portrayal of improved services to parents.

An us/them binary was also observed at the individual level of the child health professional during the intercultural consultation. Where the organisation increased practice directives and repetition of tasks, these were experienced by participants to

limit their professional capacity to build relationships with parents and complete ongoing clinical management. These aspects of care were understood as essential components of intercultural communication. The organisational approach conflicted with participants' sense of themselves as agents of care and capacity building in the community.

In chapter 8, I explore how participants constructed identity around the binary of sameness and difference. These opposing positions, conflicting in their ideology, left little room for participants to consider a place where both sameness and difference could mutually exist in the intercultural communication encounter. Without this coexistence, the various subject positions of the parent were denied in the intercultural communication encounter.

Participant understandings of how they developed relationships in the intercultural context are framed in chapter 9. Participants explained that their ability to develop relationships was informed by a complex intersection of individual, family and social constructs, not necessarily through professional learning. Many participants found that the discourses of partnership within the *Parent Advisor Model* (PAM) reinforced their personal approaches to communication.

Partnership and its inherent qualities was assumed as universally applicable across all health care encounters through behaviours learned and understood within Western sociological constructs. At times, participants' ideological positions conflicted with those with whom they were communicating. In these situations learned communication behaviour sets masked participant values and beliefs. Intercultural communication encounters were restricted because learned skill sets were not accompanied by a parallel deconstruction of ideologies on race, gender and class, which were left to creep into communication encounters unnoticed and unquestioned.

To maintain their position as partner in the intercultural communication encounter, participants created and then operated within an expert/partner binary. This binary is explored in chapter 10. Participants explicitly resisted a position of expert superiority. This was executed primarily by attempting to give power to parents.

I argue that modernist understandings of power do not transpose into plural applications of partnership. Where power in a modernist sense is understood to be possessed and given away, it also necessarily flows from top to bottom. In this

study, the flow of power from top to bottom reinforced rather than reduced the authority of the person giving away the power. Problematically, authority was at times given away with power, leaving no room for mutual existence of joint expertise. In this way, power was repressive for both the child health professionals and parents, often despite their best intentions of partnership.

Expert practice crept out unmarked as participants concentrated on attending to important but at times superficial behavioural markers to demonstrate respect and empathy. Attention to behavioural markers distracted participants from paying attention to the relational nature of power. Paternalism also emerged under the cover of empathy within a partnership framework.

The final binary is described in chapter 11 as a collision between authorised public knowledge and the situated constructed knowledge of the child health professional self. In this chapter I explore how lay knowledge is bordered from professional knowledge through a professional ethics of information giving. Premised on deeply personal cultured experiences, lay knowledge is found to slip seamlessly into communication interactions without an equivalent examination of the professional ethics of the culturedness of the information being given.

Summary

Culture implicitly shapes the way we parent, and therefore who we and our children become. Reciprocally, the way we parent our children also shapes culture. In an Australian context, child health professionals influence this molding of culture. For those experiencing parenting for the first time in a new country and who are vulnerable to the dual challenges of parenting and cultural transition, it is essential that we better understand how the cultural self influences practice, particularly the inherent practice of communication.

The findings of this inquiry direct practice development towards a mindfulness of the binaries that contain and constrain intercultural communication, particularly in child and family health. It offers reconstructive strategies using three body analysis that enables the cultural self of the child health professional to enter the consultation in constructive ways alongside an awareness of the ever-present relations of power in health care relationships.

CHAPTER 2

THEORETICAL CONSIDERATIONS

Jeff Lewis on 'theory' (2002 preface, unpaginated): '...an important and exhilarating form of cartography or map making – these maps, however, will always return the reader to the direction of home and the familiar plane of lived experience.'

Framing a methodological approach

The relationship between communication and the cultural self in child health practice is the focus of this study. Communication does not exist in a void: it takes place between individuals within society with multiple and competing dynamics. These dynamics constitute the making of culture.

This chapter begins with an examination of the theoretical perspectives which shaped the approach to this study. These perspectives enabled me to work with participant child health professionals and ask questions about the subject positions taken up in their intercultural communication encounters. Secondly, this chapter maps a framework for deconstructing child health professionals' understandings of their approaches to communicating with parents who are culturally different to themselves. Rather than return without question to familiar planes, the role of this map-making is to make explicit the lived experience of theory.

This study required methodological approaches that reflect current epistemological and ontological views shaping our increasingly global and pluralist societies. In this study of culture and communication, which arose from concerns about practice, it seemed essential that approaches reflected understandings of parenting as value laden, transactional and subjective in the context of a multicultural. Further, it was important that the process of inquiry and analysis reflect the multiple and situated beliefs of both the participants and myself. Approaches to the inquiry therefore needed to provide scope to interpret and understand 'reality' and knowledge as informed by a range of intersecting factors. These include, for example, social, political, cultural, economic and gender considerations, shaped and reshaped over time.

Following these considerations, this study is undertaken under the broad umbrella of critical inquiry. Within critical inquiry, a range of theoretical constructs were employed to variously attend to the emancipatory transformative agenda of the

research, place culture at the centre of the inquiry, attend to the plurality inherent in culture and multiculturalism and engage reflexively with participants.

I began with a broadly criticalist approach, following Kincheloe and McLaren (2005), where critical inquiry is informed by the plurality of the 'post' discourses. During immersion in the field I continued my theoretical exploration, trying to find theories that could help me understand and explain observations and discussions around race, difference and equity that were not easily understood through liberal humanist discourses. I struggled to make sense of these issues and returned frequently to theoretical literature. It was by following findings in the field through to theoretical understandings that I found myself engaged with cultural studies literature, particularly postcolonialism, feminism and whiteness studies. In an attempt to make sense of the observed linear application of theory to practice, without consideration of the cultured context of usage, I introduce the construct of three body analysis. Rather than the familiar plane of lived experience, this map-making brought me to a place of discomfort and disjuncture that questioned my professional role as a child and family health nurse and the culture and theory that has underpinned this role since its beginning.

In the following sections I detail how these various areas of scholarship are understood and taken up in this thesis. I begin by examining the epistemological and ontological understandings inherent within critical inquiry as it is understood and applied in this study, and draw on insights from cultural studies through the intersections of communication and culture within a multiculturalism. From these perspectives, relationships between language, power and culture are privileged. Following this, I describe how I employ key understandings from postcolonial and feminist scholarship.

On being critical

A study of culture is inherently critical, as it encounters questions of power, liberation, identity and resistance. Identity is formed within and around cultural experiences that both allow yet limit subjective positioning of the self. Within this politic of identity, this study examines how child health professionals understand their subjective positioning and how they represent themselves. The questioning examines how child health professionals see and might imagine the effects their positioning has on parents whose culture locates them outside dominant ideology of Western child health practice. A critical model is required to unsettle these dominant

discourses and to interrogate how this dominance is structured, enacted and resisted.

I drew on 17 years of clinical experience to identify the majority of child health professionals working in child and family health in South Australia as middle-class Anglo Celtic women, like myself. The theories that dominate our socialisation might be understood to come from those formulated in western European conditions. These emerge historically from the feudalism of the Middle Ages to the eighteenth-century Enlightenment. The Enlightenment aimed to counter the dominance of religious thought in politics and the economy and develop approaches that were more rational and egalitarian than those of previous centuries. Humanism as a legacy has a proud history of liberating oppressed peoples everywhere. It is from within this tradition that twentieth-century health professionals in South Australia emerge. By highlighting this, I identify that across the globe there are many histories of dominance and suppression from the East to the West and from the North to the South. However, given the location and situated historical construct of the participant group, I critique only the dominant culture of the West in this study.

As a critical inquiry, this study investigates taken-for-granted realities or truth claims that are shaped by social, political, cultural, gender and economic factors embedded in the historic realism (Guba & Lincoln 1998). Health care has traditionally been located in the positivist discourse of science. Agger (1991, p 106) contends that critical studies alongside postmodern inquiry are useful to interrogate 'taken for granted assumptions about the ways in which people write and read science'. This study challenges the assumptions of a singular context and value-free truth in relation to parenting and child-rearing, which thus far in Australian child and family health have been determined through scientific reductionism within health care discourses. Agger asserts that these approaches challenge 'presuppositionless representations' inherent in positivism, arguing that to deny presuppositions is both 'politically undesirable and philosophically impossible' (ibid, p. 106).

Looking closer at the ontological assumptions within critical approaches, I wondered about their relationship to colonisation. Brian Fay, for example, argued that 'critical theorizing promises a way in which intellectual effort might help improve the political situation' (1987, p. 2). I questioned what Fay understood as the nature of intellectual effort, and who was the subject of this intellect. Further, I questioned universalising assumptions of a singular problematic 'political situation', asking which one this might be, and through whose eyes, and in what ways we might we understand the

nature of any improvement to this situation. Kincheloe and McLaren (2005 p. 305), on the other hand, state that critical research is a 'transformative endeavour unembarrassed by the label "political" and unafraid to consummate a relationship with an emancipatory consciousness' In order to clarify the political nature of critical inquiry, the next section explores the underpinning assumptions of various forms critical inquiry.

Critical social science

Fay (1987) demarcates 'critical social science' from the broader term 'critical theory'. He locates critical social science as a science with an immutable 'Basic Scheme' that renders it scientific, critical and practical (ibid pp.27-33). In defining 'scientific', he suggests that research must be reductionist and responsive to empirical evidence. The emancipatory aspect of critical social science is drawn from the self-estrangement theory developed in the modernist period. Fay describes this as an expression of the 'modern humanist spirit' where humans are pictured as fallen creatures who, through analysis and effort, are able to achieve a form of enlightened existence that is 'free and satisfying to them' (ibid, p. 3).

While this notion is sound in the modernist tradition, it does not hold in a pluralist or multicultural global environment. This approach assumes that there is a 'better way'. Maybe there is. In the situation of child health professionals supporting migrant parents to parent in a way that they find fulfilling and respectful to their beliefs, a modernist approach inherently reinforces the idea that there is one singular dominant approach to be discovered and adopted. In this scenario child health professionals are helping the migrant parent to become enlightened to the non-scientifically proven yet dominant methods of industrialised Western parenting. When this idea was applied to the methodology used in this research, it was important for me to find strategies that accommodated difference and diversity. This work was inherently political and emancipatory, but not in a linear singular fashion leading to the oppressed becoming emancipated by access to Western reason.

Discussing the limitations of critical social science, Fay (1987, p.8) suggests a way forward, arguing that 'human individuals are not only active beings ... but are also embodied and traditional creatures'. However, rather than see these aspects as useful in accepting and understanding difference in beliefs and approaches, Fay problematises embodiment and tradition as blocking progression to enlightenment. Ontologically, Fay's notions of enlightenment, empowerment and emancipation remain embedded in a modernist colonial paradigm where problems can be reduced

scientifically by those academics in the dominant group in their patronising approach to analyse and empower the 'sufferers' (ibid, p. 28). In this paradigm, the research may implicitly maintain the traditional relationship between the researcher and the researched. Here, difference is labelled problematic and ownership of this problem is laid squarely with those who are different rather than their dominant oppressors. For liberation to occur in this paradigm, the oppressed need to recognise the particular ways in which they have been duped and make changes, rather than expect the oppressors to examine their own particular approaches. The researcher is positioned as liberator.

Regarding critical theory

Critical theory offers a more reflexive approach. 'As much as critical researchers may claim to see meanings that others miss, critical postmodern research respects the complexity of the social world' (Kincheloe & McLaren 1998, p. 286). It is a respect for complexity that moves this research project to a broader methodological stratagem, one that links a criticalist approach with postmodernism.

Kincheloe and McLaren reframe the principles of enlightenment and emancipation under the influences of the 'post' discourses. On critical enlightenment, they move the focus from the fallen individual seeking the rational dominant truth to an analysis of 'competing power interests between groups and individuals within society' (2005, p. 309). Their approach accounts for a range of areas of privilege such as race, gender, class and sexuality, and does not lay the responsibility for enlightenment or amenability to enlightenment on the one person or group. They see it as a relational activity.

Similarly, with the principle of critical emancipation, Kincheloe and McLaren distance themselves from the notion of emancipation occurring through access to Western reason and the assumption that those from the dominant group have the ability, indeed the right, to emancipate others. Lewis (2002) concurs, stating that notions of freedom relate to something that the individual conceives in relation to and against collective codes, not just in envisioning a false separation from them. Kincheloe and McLaren extend the notion of individual responsibility by stating that emancipation is a joint effort or partnership between the individual seeking power to control their lives and a 'justice oriented community' (2005, p. 308). As with the notion of enlightenment, they do not lay the responsibility with the oppressed individual or group to radically alter their social arrangements and thereby alleviate their suffering, as does Fay (1987, p.28).

These issues are of great importance to the foundation of a research project exploring how child health professionals communicate with parents who are culturally different to themselves. The umbrella of inquiry for this thesis is therefore located as an 'emerging' (Kincheloe & McLaren 2005) or 'new' criticalist approach (Agger 1991). Inherent to this emerging criticalist approach are a range of postmodern considerations. Of particular relevance to this study are postmodern rejections of 'modern assumptions of social coherence and notions of causality in favour of multiplicity, plurality, fragmentation, and indeterminacy' (Best & Kellner 1991, p. 4) and a postmodern challenge of grand narratives along with insights into mechanisms of social control (for example Foucault 1995).

Modernist assumptions of social coherence and linear causality are embodied in the underpinning political philosophy of Western thought, primarily that of liberal humanism. In the following section I present my understandings of liberal humanism and the challenges that universalising assumptions inherent in this paradigm might present for those living in the margins of normative culture. These include parents and children who are marked as culturally different, such as refugees and migrants to Australia.

Liberal humanism

A claim to individual freedom underpins the political philosophy of liberalism, which developed in Europe during the 18th and 19th centuries. Lewis (2002) explains that the task of Enlightenment philosophers such as Immanuel Kant and Rene Descartes was to demonstrate how morality as a command of nature could be explained and maintained through science and art and thus liberate individuals to paths of goodness for the collective benefit of the state. Key to this premise was the humanist belief in the essential goodness of mankind (sic) and a reinvigorated belief in scientific knowledge as truth. While the freedom of the individual was regarded as supreme, how this individuality was constructed was the domain of democracy and democratic institutions (ibid).

Habermas (1981, p.9) summarises that the project of modernity was to develop '...objective science, universal morality and law, and autonomous art according to their inner logic' which would constitute the 'rational organisation of everyday social life'. The way to develop objective science was to claim all knowledge valued by the state as based on nature. Through the Enlightenment, natural scientific laws became irrefutable ideals to which all of society should aspire. Knowledge as scientific truth became universal knowledge and scientific reason; the logical

operation of the mind became the only acceptable way to access this truth. This required separation of the mind from the body so as to keep reason distinct from the emotive messy non-scientific responses of the body. This dualistic Cartesian ontology or binary logic also separates the universal from the specific and culture from nature through hierarchical and oppositional claims. This separation or way of thinking is particularly endemic in health care (Lupton 2003).

Adorno and Horkheimer (1979) claim that Enlightenment rationality is enacted as a logic of domination and oppression. Rationality is inherently instrumental in perpetuating the dominant discourses of Enlightenment that eliminate competing ways of thinking and claims itself as the sole basis for truth (Barker 2003).

Liberation is linked to humanism when the state assumes the role of liberator through democratic politics. Distributing what is claimed as scientific truth to the population through public education and policy, the democracy operates through rational and therefore sanctioned systems (Lewis 2002). Here, dominant discourses claimed as truth are hegemonically authorised, defining and controlling all other meaning systems (Foucault 1980b).

Governmental authority legitimised through liberal humanism and the ideology of democracy paradoxically becomes 'the protector of individual rights and freedoms, even though these freedoms might at any point be forfeited through the greater interests of the state...' (Lewis 2002, p. 21). The *Universal Declaration of Human Rights* is based on this perspective (General Assembly of the United Nations 1948).

Inherent in this perspective is a tension between the individual and the collective society. This individual/collective tension is also present in the concept of personhood in humanist theory. The individual is shaped by liberal humanism within the democracy and, paradoxically, also needs to establish an identity that sets itself apart from this society. Davies (1991) argues that the individual, while socialised through the dominant discourses of the collective, is expected to take up the position of agentic individual working toward self-improvement based on Enlightenment notions of rational and coherent choices. Davies contends that the identity of this individual is 'continuous, unified, rational and coherent' (ibid, p. 43). This self is assumed to possess an essential human nature (Weedon 1997) and uses language to 'dominate those irrational, emotional aspects of self that might otherwise disrupt claims to coherent adult identity' (Davies 1991, p. 43).

Benson (1990) explains that this rational self must make choices that are approved by those powerfully positioned within dominant discourses to enable the individual to continue along the linear path to self fulfilled enlightenment. He therefore questions whether in fact these choices can be claimed as 'free' if indeed they are constrained by those positioned within the dominant discourses.

Intercultural communication in the child and family health setting in Australia is positioned within the dominant discourses of Western culture. Therefore, liberal humanist constructs are likely to be embedded in the personal and professional lives of child health professionals. This thesis asks how these assumptions are present in intercultural communication in the child and family health setting. It further asks in what ways, if at all, the linear progression inherent in liberal humanism may be experienced in providing health care in a multicultural. Where grand narratives of child health practice appear, these are also investigated for their effects within multicultural.

Following Kincheloe and McLaren, this inquiry focuses on relations of power between child health professionals and parents at an individual level of intercultural communication. It does this by looking at what child health professionals say, do and think about their practice.

In the next section I introduce theoretical developments from cultural studies and explain how themes from this field are understood and used in this thesis.

Cultural studies

Culture remains at the heart of this study, particularly in relation to child health professionals' understandings of culture and the self as always cultured, and how they see these ideas playing out in their communication interactions. Lewis (2002, p. 19) cites ideas of diversity rather than commonality as the appropriate subject of cultural studies. Diversity and multiplicity in parenting and multicultural are core components of this study.

Like critical inquiry, cultural studies takes as its project an examination of cultural practices 'from the point of view of their interaction with, and within, relations of power' (Bennett 1992, p. 23). Placed under the umbrella of critical inquiry for this study, cultural studies offers theoretical understandings that focus on critical examination of dominant cultures and mechanisms of resistance of hegemonic control (Henry & Tator 2006). Henry and Tator (2006) summarise that questions of

race, national identity and ethnicity are core to cultural studies, particularly with regard to those who experience social inequities as a result of dominant cultural practices. As such, cultural studies theorists pay attention to conditions of multicultural and diversity in countries that previously understood themselves to enjoy a monocultural existence.

The stability of this supposed monocultural existence was challenged by Edward Said in his landmark critique *Orientalism* (1978). Said challenged the grand narratives of occidental Europe and the notion of essential occidental truth by examining the West's historical construction of the Orient as an oppositional referent to self. The constructed 'other' is seen dually as both essentialised self-reflection and constructed mimesis (Darian-Smith 1996). Discourses of the 'other' within the constructed Orient were shown as critical for European culture to gain identity and strength by 'setting itself off against the Orient as a sort of surrogate and even underground self' (Said 1978, p. 3).

Stuart Hall moved the analysis of self and other from the global to the local and situated context of individual self-analysis. He states that, 'Only when there is an 'Other' can you know who you are' (Hall 1991, p. 16). Hall explains that discovery of this fact unlocks the 'whole enormous history of nationalism and of racism' (ibid). He states that racism 'is a structure of discourse and representation that tried to expel the Other symbolically – blot it out, put it over there in the Third World, at the margin' (1991, p. 16). Core to a critical inquiry of culture, therefore, are ideas of identity representation, racialisation and marginalisation perpetuated through historic colonialisms and neo-colonial discourses, processes and practices. These issues are of great import to exploring child health professionals' understandings of 'self', and the discourses used in working with those who are cultural different to themselves.

The concepts of discourse and deconstruction are central to the cultural studies project. These terms are interpreted variously from differing theoretical positions. In the following sections I explain how discourse and then deconstruction are understood for use in this study.

Considering discourse

In a contemporary context, discourse is central to all forms of critical and cultural inquiry. Following Foucault's (1980b) influential work, discourse has been variously interpreted in relation to language and text. In this study I follow a social construction

of discourse which suggests discourse as language in social use (Davies & Harre 1990; Fiske 1994). Fiske (1994) argues that discourse is marked by a history of domination, subordination and resistance shaped by the social conditions of those who use it. In this way discourse can also refer to the ways in which knowledge is structured and enacted through social practice.

Davis and Harre (1990, p. 45) bring the focus of discourse to the 'institutionalised use of language and language like sign systems'. They suggest that levels of institutionalisation include the disciplinary (for example, child and family health nursing), political (for example, universalising practice directives of neo-liberal governments), cultural (for example, the child health home visitor nurse represented as friendly within dominant discourses of white Australia) and small group levels (for example, individual child health teams) (ibid, p. 45).

Further to this understanding of discourse as located knowledge, Weedon (1987, p. 108) states that discourses "constitute" the nature of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern'. Discourses therefore influence the inherent constitution of individuals as subjects. Weedon continues, stating that:

neither the body, nor thoughts and feelings have meaning outside their discursive articulation, but the ways in which discourse constitutes the minds and bodies of individuals is always part of a wider network of power relations often with institutional bases. (1987, p. 108)

Introducing relations of power to the discursive formation of self, Weedon refers to a Foucauldian interpretation of power. Unlike modernist juridico-discursive interpretations of power, Foucault presents power as not possessed, not necessarily flowing from top to bottom and as a positive force that is not primarily oppressive (Sawicki 1991, p. 20). This understanding is useful as it enables a reframing of power that is not something material, that can be held, but something that is diffuse and dynamic that has material effects at the micro level of intercultural communication.

In this study, discourse is understood as particular uses of language that constitute the nature of self through shifting relations of power. Discourse therefore signifies forms of knowledge and ways of constituting meaning in the world (Jordan & Weedon 1995). Through liberal humanist claims of truth and knowledge as universal

rational and unitary within healthcare, some discourses are sanctioned over others. Rather than engaging pluralistic constructions of truth, Foucault (1980b) demonstrates that dominant discourse limits the acceptance and credibility of other claims to truth and knowledge. Through prioritising the Cartesian dualisms of liberal humanism, McNay (1992, p. 13) argues that modernist thought 'controls the parameters of what constitutes knowledge and monitors the extent and kind of discourses that are allowed to circulate'. Dominant discourses not only limit the possibilities of alternate discourses, they also limit the possibility of reflecting on meaning and assumptions within their own authoritative position, for they takes this position as an incontestable truth.

While not claiming this study as a discourse analysis, I will explore relations of power within language and culture, taking language to be constitutive of culture and of culture as shaping discourses expressed through language. At the individual level, this study aims to recognise 'how people use discourse and how discourse uses people' (Potter & Wetherell 1990, pp. 213-214).

Deconstruction

Cultural studies as an eclectic field of critical inquiry is inherently plural in its ontological composition. As such, this field of study rejects universal structures that seek to express the entirety of meaning and sense, instead suggesting that every structure remains in a process of construction and deconstruction (Van Loon 2001, p. 276). All aspects of culture are viewed as being in a constant state of creation, examination and re-creation. This construction and deconstruction occurs through competing discourses within social power (Jordan & Weedon 1995). Based on the work of Jacques Derrida (1976), deconstruction rejects the unitary subjectivity of humanist discourses. As a process, deconstruction interrogates and breaks down the metaphysical binaries of Western logic (Davies 1993b). For example, deconstruction in feminist inquiry is concerned particularly with unsettling the male/female binary, whereas in postcolonial theorising, deconstruction relates primarily to the binaries of cultural sameness and difference, self and other.

A recent Australian contribution to the cultural studies project of deconstruction is the concept of three body analysis proposed by Hodge (2005). Hodge contends that Western academics are conditioned by a 'metaphysic of asymmetrical binaries' (2005, p. 119) which still exists despite Derridean influences. He takes the idea from the French mathematician Henri Poincare, who analysed a three-body problem posed by Isaac Newton about how to predict the trajectories of the sun, the earth

and the moon. Poincare demonstrated that analysis of three bodies was far more complex and complicated than two (Hodge 2005).

Rather than endlessly trying to locate or identify somewhere along a binary continuum, Hodge invites us to look outside to a third point from which to 'capture dynamic, open-ended complexity' (Hodge & O'Carroll 2006, p. 9). In this way, binaries can be identified and deconstructed. However, rather than proposing an alternate framework which might create a further oppositional binary, a third body complicates and disrupts the binary. I use three body analysis in this thesis to explore the possibilities of how a binary collision can become a kaleidoscope of multiple meanings.

As an analytical tool, deconstruction exposes the values and interests suppressed far beneath the surface of science that both politicise and democratise science, thus allowing readers to engage with and contest science's deep assumptions and surface rhetoric (Agger 1991, 114-115). In this thesis, deconstruction is used in two ways: firstly, to critique psychosocial canons of health care communication that are core to child and family health practice in South Australia, and, secondly, as a tool to analyse communication between child health professionals and parents who are migrants or new arrivals to South Australia. This aspect of deconstruction is detailed in chapter 5.

Many of the discourses central to critical and cultural inquiry are raised and considered in this thesis. These include, for example, issues of selfhood, gender, identity and representation, race, racisms and othering. In the next section, I describe two theoretical frameworks that were useful to make sense of these themes in the research data. These are the areas of feminist and postcolonial scholarship. In the subsequent discussions, I explain how I bring together feminist and postcolonial scholarship and highlight how understandings from these theoretical fields were useful for developing understandings in this study.

Regarding feminist and postcolonial scholarship

Feminist theorists have contributed to critical and cultural studies by exploring 'being female' in a wide variety of cultural contexts (Lewis 2002, p. 185). Rather than trying to understand an essential female self, feminist inquiry focuses on the consequences of women being constituted as belonging to the category of female; of being 'discursively, interactively, and structurally *positioned* as such...' (Davies

1992, p. 56). Analysis becomes a collective task of finding ways to resist the constitution of women inside the male/female dualism (Davies 1990) in a range of cultural settings.

Used most obviously and simplistically, Eve Darian-Smith suggests that postcolonialism demarcates the ‘transition from colonialism to self-determination among formerly colonised nations’ (1996, p. 292). This sense of definition by chronological marker and method of periodisation is contested by Joan Anderson (2002), who purports that postcolonialism, as a discourse from the perspective of the colonised, is framed as a historical condition rather than a chronological marker. Where a marker suggests that a change has occurred, a historical condition signifies an existent set of circumstances. Cathryn McConaghy (2000, p. 268) expands this assertion, stating that these circumstances relate to a ‘notion of working against and beyond colonialism’, referring to issues of power rather than time.

This is of particular importance in the neoliberal climate of Australia, where, as a colonised society, issues of power are perpetuated through discourses, processes and practices of ‘neo’ colonialism. In a neo-colonial environment individuals and groups within previously colonised societies continue to live under the conditions of internal colonisation where dominant⁴ groups dictate social structures and redefine local meanings (Anderson et al. 2003; Browne, Smye, & Varcoe 2005). It is within this set of circumstances that this research was undertaken and from which the tools for analysis were drawn.

Sheryl Reimer Kirkham and Joan Anderson argue the relevance of using a postcolonial frame in examining intercultural health care encounters. They state that ‘a postcolonial framing rests on an overarching mindfulness of how domination and resistance mark intercultural health care encounters at individual, institutional and societal levels’ (2002, p. 10). Inherently political in that it examines the micropolitics and macrodynamics of power, postcolonial scholarship pursues ‘matters of how contemporary constructions of race, ethnicity, and culture continue to rely on colonialist images and patterns of inclusion and exclusion within health care settings’ (Reimer Kirkham & Anderson 2002, p. 10).

Bringing together feminist and postcolonial scholarship

⁴ The notion of ‘dominant’ groups or culture indicates a ‘deeply rooted set of understandings’ experienced as a ‘set of common-sense, taken-for-granted truths’ about society individuals and social relationships (Furniss 1999, p. 14-15).

In examining changing relations between dominant and minority groups, Anderson contends that postcolonial scholarship does not obviously include a gendered analysis (2002). She asserts that such analysis ‘has been “written in” by scholars who have provided the theoretical lens to address issues of gender from the perspective of the post-colonial female subject’ (2002, p. 2). Anderson advocates for a postcolonial feminist analysis which is generated jointly from postcolonial and black⁵ feminist perspectives. Claiming their complementary perspectives, she states:

While the post-colonial project focuses on colonisation, the construction of “race” and racialization, cultural hybridity and the fluidity of identity, black feminist scholars ... provide a lens to address how ‘race’, gender and class relations intersect to shape material existence and the social conditions of women’s everyday lives. (Anderson 2002, p. 3)

Research examining communication practice between predominantly female child health professionals and parents of babies who present predominantly as mothers must write in gender. To not do so would be negligent. However, before ‘writing in’ gender, it is important to consider current theoretical arguments and determine the approach taken by this research in conjoining postcolonial and feminist theories for analysis.

Sandra Harding (1987, p. 3) argues that there are fundamental problems associated with ‘adding women’. In early feminist research, women contributed politically in existing social movements and developed scientific research projects that launched women into the world of men. While these contributions recognised women as agentic, they also left powerful ‘andocentric standards firmly in place’ (ibid, p.4). In these situations, women remained inferior to and in the service of men. While examining white male dominance, political discrimination and institutionalised economic exploitation, feminist research also contributed to constructing discourses of women as essentialised victims (ibid, p. 5). Rather than ‘adding women’ to dominant masculine research discourses as adjunctive or as vitriolic victims, this discussion explores the methodological features a feminist gaze can contribute to postcolonial scholarship.

⁵ Anderson (2002) draws on Ahmad (1993) in explaining that the word ‘black’ is used as a political rather than biological category. In the Australian context, this word is not commonly used by non-Indigenous writers and activists. I have experienced ‘black’ being used as a derogatory term for indigenous people in both NSW and SA. I am therefore not comfortable to use this term other than in citations.

Within feminist inquiries problems are drawn from women's experiences (Gray 1997; Harding 1987; Smith 1974). This does not, however, suggest an essentialised female subject. bell hooks (1984, p. 4) clarifies that 'race and class identity creates differences in quality of life, social status, and lifestyle that take precedence over the common experience that women share'. Harding states that in denying the universal man, the universal essentialised woman disappears. This recognises the plurality of constructed self and further resists the homogenisation of women.

A sidestep to consider class, reveals further notions of homogenisation in traditional Marxist understandings. In Marxist theory, class is 'conceived of as an essential unified identity between a signifier and a specific group of people who share a socio-economic conditions' (Barker 2003, p. 105). A postmodern understanding denies this homogenisation, claiming that rather than being an objective economic fact, class is a 'discursively formed collective subject position' (ibid, p. 105). Class does not disappear when named as discursively produced. Class and class consciousness remain historically specific. Class consciousness is not taken up as a unitary whole, but fragmented by multiple available subject positions of race, gender and age.

While recognising that all women are not the same and that women's experiences are of value in and of themselves, Harding also makes the point that one of the most important methodological features of feminist research is 'studying up' instead of 'studying down' (1987, p. 8). This insists on self-representation rather than enduring the epistemological violence of being studied by and for the benefit of others. McConaghy (2000) reminds us that questions about women that men have traditionally wanted answered have come from desires to pacify, control, exploit or manipulate women. Kirsch summarises that research with a feminist goal is not only 'on women, but also *for* and *by* women' (1999, p. 8).

McConaghy also draws on Harding's feminist challenge to self-represent in 'studying up', relating it to traditional anthropological ways of knowing 'race' (2000, p. 37). Like the category of women, minority groups, and in particular women from minority groups, have traditionally been spoken of and for in traditional ethnographic research. She links this with hook's landmark investigations into the construction of black subjectivity within traditional ethnographic objectification of the racial 'other'.

Rather than 'adding women' to research, Anderson concludes that feminist considerations go to the 'very roots of asking, what is credible social knowledge and

how is knowledge produced and used' (2002, p. 8). For this research, postcolonial and feminist theories are complimentary in their ontological and epistemological approaches, both seeking plural contextualised truths from subjects who have historically been written out and marginalised in dominant discourses. Knowledge from both areas of scholarship is recognised as plural and contextual and questions are drawn from the voices of marginalised subjects and are explored for their own benefit. As a child health nurse and a woman, concerns about communication practice have come from personal experiences in the field. In practice settings I have also listened to the voices of nurses and to the silence of the peripheral other.

During this inquiry, I do not intend to homogenise the gendered concerns of female nurses alongside those of mothers who are migrant 'others'. Clearly, while they intersect ontologically and epistemologically, they remain different. Leila Gandhi (1998, p. 83) draws our attention to aspects of the sometimes 'volatile' and 'tenuous' partnership between postcolonial and feminist theories which may inhibit their joint application. This comprises three intersecting areas of controversy: the issues of identity and representation emerging from 'the debate surrounding the figure of the "third-world woman"'; the problematic history of the 'feminist-as-imperialist'; and finally, the colonialist deployment 'of feminist criteria' to bolster the appeal of the 'civilising mission' (ibid, p. 83). The first two of these issues are of utmost relevance to this thesis. Where Gandhi discusses the theoretical argument between postcolonial and feminist theorists, chapter 8 of this thesis explores the impact of this debate in individual practical terms, where child health nurses explore their own feminisms and how these shape their interactions with migrant 'others'. Of relevance in this section is the potential misuse of feminist methodological criteria.

Gandhi (1998) cites Mohanti (1994) in explaining how in the US and western Europe, colonialist epistemology remains visible through feminist scholars who have appropriated and codified knowledge for and about women in the Third World. She provides an example of this through Spivak's (1987) analysis of Kristeva's (1977) text, *About Chinese Women*. Gandhi summarises that Spivak's reading 'catches the authoritative knower in the act of "epistemic violence" – or authoritarian knowing' (1998, p. 87). Further, she argues that there is the risk of not only homogenising representation of and for Third World women, but also of the homogenisation of the intentions of all Western feminist researchers (ibid).

Feminism's historical complicity with imperialist discourses is also challenged by Gandhi. She claims that feminist scholarship does not attend to the battle for female

individualism, which denies the exclusions and sacrifices of many made for the benefit of a few individual women (ibid, p. 90). This extends Harding's problem of adding women. While Harding recognises that the contribution of individual women to political and scientific pursuits historically left the status quo of societal patriarchal dominance untouched, Gandhi contends that these acts within themselves reinforced colonial racial privilege (1998, p. 90-91).

Given these intense historical epistemological and ontological differences, can feminism and postcolonialism be drawn together for theoretical application? Gandhi states that both have interests in 'the study and defence of marginalised "Others" within repressive structures of domination' (1998, p. 83). McConaghy (2000) argues that feminist theories contribute considerably to understandings of 'race' and racisms alongside postcolonial theories. She notes many key contributions that are relevant for this study. Firstly, drawing on educational research by Roman (1993), McConaghy contends that we are now more aware that racism affects groups of people in different ways and 'better understand the multiple dimensions of oppression in contemporary societies' (2000, p. 36). In addition, our understandings of 'subjectivity formation and the politics of representation in relation to racially-constituted peoples' are greatly enhanced by feminist scholars who have investigated issues of identity, voice and difference (ibid, p. 36).

Of particular interest to this study are the contributions of Bronwyn Davies (1993a) as discussed by McConaghy (2000). Through the work of Davies, McConaghy contends that feminist theory has exposed the problems associated with male/female binaries. Although she suggests that little work has been done to expose the problems of black/white binaries, she states that within feminist theory, binaries are exposed as 'powerful means by which certain knowledges are legitimated and certain subject positions and identities are enshrined' (McConaghy 2000, p. 37). It is this very power base that is challenged by the use of three body analysis within this study. Exploring black/white binaries using a three body analysis contests racist discourses embedded in dominant binary constructs. This addresses the feminist challenge to move beyond identity politics by unmasking and deconstructing binaries (Roman 1993, cited in McConaghy 2000). Anderson (2002) argues that, within postcolonial feminist scholarship, it is essential to engage with and challenge dominant discourses, such as black/white binaries, rather than taking them as a starting point of inquiry. Gandhi reinforces that both feminist and postcolonial theory have welcomed 'the post structuralist invitation to refuse the

binary oppositions upon which patriarchal/colonial authority constructs itself' (1998, p. 83). In this thesis, Hodge's (2005) three body analysis will enable this.

A combined offensive between postcolonial and feminism against 'the aggressive myth of both imperial and nationalist masculinity' is an area of productive possibility (Gandhi 1998, p. 98). To be defined as an offensive against masculinity is perhaps too much of a standpoint for this thesis. It will, however, draw analytically from themes within both postcolonial and feminist scholarship and be guided by the approaches to inquiry within both feminist and postcolonial scholarship. Themes include identity and representation, racism and othering. Approaches to inquiry include the rejection of essentialising and homogenising processes and the use of three body analysis to unsettle oppositional binaries.

This thesis explicitly draws on questions and concerns from women's everyday experiences for the benefit of women and their children. While a child health service isn't everyone's 'everyday', the locations of interaction, including the clinic, the parents' home or a waiting room, have elements of 'everyday' where the work of predominantly women child health professionals intersects with the lives and work of, predominantly, mothers and their children.

Identity, representation and race

Key to this study of culture and multiculturalism are questions of identity, representation, race and ethnicity in Australia as a postcolonial location. In this section, I begin by explaining how selfhood is understood through notions of subjectivity and agency. I then move into application of these considerations in the context of multiculturalism, focussing on issues of race and racism. This is followed by discussions on identity and representation as they are understood in contemporary Australia.

Subjectivity, positioning and agency

Subjectivity is a term used in this study to understand the process through which a person's identity is achieved (Davies 1993b). Davis and Harre (1990, p. 43) posit that an 'individual's "subjectivity" is generated through the learning and use of certain discursive practices'. Discursive practices are 'all the ways in which people actively produce social and psychological realities' (ibid, p. 45), to make sense of ourselves and our place in the world. People are positioned by or position themselves through discursive practices.

While the humanist notion of identity also presents personhood as being achieved through learning, in humanism this learning is most often linear in progression. The rational individual reaches their potential when given the right environment for education and personal development. Considering the self as constructed through multiple discursive practices enables scope for 'theorising contradictions either in our sense of ourselves or in the meaning of our experience' (Jordan & Weedon 1995, p. 16).

Our sense of self is constantly changing through accessing various subject positions made available through discursive practices. Unlike the rational conscious self portrayed in modernist notions of identity, '*subjectivity* encompasses unconscious and subconscious dimensions of the self...' (Jordan & Weedon 1995, p. 14). In discussing the legacy of psychologically constructed personhood, Davies and Harre (1990, p. 46) claim that 'human beings are characterised both by continuous personal identity and by continuous personal diversity'. Rather than denying the rational humanist self, this demonstrates recognition within poststructural theory of the multiplicities of self. Personal identity, while viewed consciously as rational and agentic, sits alongside the self that may be subconsciously positioned in other ways through socially constructed discursive practices. Child health professional understandings of the various discourses of self are examined in his study as they relate to intercultural communication.

Jordan and Weedon (1995, p. 15) unsettle this seemingly agentic self by stating that 'discourses can only be effective if they are able to constitute individuals as subjects, defined positively or negatively in relation to norms which they privilege'. If, for example, the individual does not privilege the norms of liberal humanist self – rational, continuous and unified – they are constrained by the discourses of liberal humanism. Liberal humanist discourses of patriarchy that claim the rational agentic unified self as implicitly male limit subject positions available to women. Women are homogenically positioned as irrational, emotional and non-agentic. While many would consider that women's entry into the public domain of economic production since the 1960s signified a change in this positioning, personal experience in the role of child and family health nurse suggests otherwise. Like the women's liberation movements of the 1960s and 1970s, the assumption of change appears to apply predominantly to women of upper- and middle-class standing. A vast majority of women, it seems, now wear the double burden of responsibility for economic production and responsibility for house and family. Despite this

responsibility, many continue to understand themselves as non-agentic, emotional and irrational.

Davies argues that in becoming a speaking subject, one can agentially discard discourses and take up as one's own more enabling subject positions. This opens up the possibility of seeing the self as 'continually constituted through multiple and contradictory discourses that one takes up as one's own in becoming a speaking subject' (1992, p. 57).

This study explores the existent tensions of the internally constructed cultural 'selves' presented by child health professionals as they are constituted by and constitute a political subject. This multiple self is regarded as 'simultaneously made a speaking subject through discourse and ... is subjected to those discourses' (Bacchi 2005, p. 205). Following Magnusson (2005, p. 154) child health professionals in this study are viewed as 'active co-producers who use (adopt, transform, resist) available understandings of the world and themselves'.

Racism and 'othering'

Racism is constructed by the play of identity and difference (Hall 1992). In this study, where child health professionals were asked to consider personal and professional constructs of identity, they necessarily considered this identity in relation to the difference they perceived in cultural others. While child health professionals would not overtly consider themselves as racist, through examining notions of identity and difference, concepts of racism and othering entered the debate.

Constructed through the play of identity and difference, racism is a complex process involving both the positioning of 'blacks' as inferior alongside 'an inexpressible envy and desire' (Hall 1992, p. 255). Hall elaborates on the confusion of applicability of this constructed categorisation marked by typically binary systems of representation. He draws on Spivak, who examines the 'epistemic violence'⁶ of discourses of the 'Other' (1987 cited in Hall 1992) and suggests that these represent one end of the binary system of belonging and otherness. Hall challenges this strategy of binary reversal or inversion by citing Fanon (1968), who recognises that epistemic violence originates from both outside and within when the other is internalised as self. Hall explains:

⁶ Epistemic violence refers to the process of writing so-called empirical history in the West which has denied the histories of the 'Other'. (Spivak 1995).

Just as masculinity always constructs femininity as double – simultaneously Madonna and Whore – so racism constructs the black subject: noble savage and violent avenger. And in the doubling, fear and desire double for one another and play across the structures of otherness, complicating its politics. (1992, p. 256)

The same can be said of feminist constructions of masculinity as both father and rapist. In this construct, the internal doubling is equally troubling. In rethinking racism, Hodge and O'Carroll (2006) refer to this type of internal doubling as a social process of 'schismogenesis'. They draw from anthropologist Gregory Bateson, who used the term 'schismogenesis' (from Greek *schismos*, a split) 'to refer to the main ways that splits develop in groups, cultures or social systems' (Hodge & O'Carroll 2006, p. 10). Hodge and O'Carroll (2006) propose that racism can be based on 'complementary schismogenesis', where a split is truly based on difference, or 'symmetrical schismogenesis', where problems arise due to the near similarity of groups. Likening this to Hall's internalising of 'other' as 'self', if aspects of the 'other' are too much like the 'self', epistemic violence from internal constructions in the form of racism can occur. Lack of surety of identification of the 'self' due to multiculturalism compounds the anxiety of symmetrical schismogenesis (Darian-Smith 1996). Eve Darian-Smith (ibid p. 295) states that 'what remains is the anguish of not being able to recognise ourselves distinctly'.

In dealing with this anguish and attempts to represent and identify the 'self', the 'other' is assigned an identity by the 'self'. Othering is inherently 'self-ish'. McConaghy (1997, p. 85) states that when we engage in 'othering', we are 'categorising human existence, characterising people on the basis of certain criteria such as world view or similar anthropological construct, and homogenising their experiences'. Categorising itself does not constitute the whole of the problem. In order to understand our world we categorise objects, behaviours and feelings from childhood. Categorisation becomes a problem when it uses world-views or anthropological constructs to construct a category of 'other', where this other is observed to be inferior to the self. In doing this, othering is a form of racism and remains central to colonialism (ibid) and thus identity within a neo-colonial environment.

Identity and representation

To understand the mechanisms of racism in postcolonial discourse, it is important to understand who the subject of racism might be. The subject of representation in postcolonial discourse remains unclear. Is it purely about examining the constructed

oriental or coloured 'other' through contested categories of self, or do considerations of racism include the representation of 'self' when the self is from the dominant white colonising group? Darian-Smith (1996, p. 292) argues that a purely temporal understanding of postcolonialism is explicitly political as it 'involves contested interpretations of what it does and does not represent'. Postcolonial discourses range from representing the symbolic emancipation of new nations embedded in Western institutionalised systems to a representation of subaltern and neo-Marxist interpretation of postcolonialism which are seen as emblematic of an 'often veiled, oppression by the West over the rest of the world' (ibid, p. 292).

The issue of representation is addressed in the nursing literature by Anderson, who contests that postcolonial subjects are 'people of colour whose identities have been constructed within the historical relations of colonialism' (2002, p. 2). It is these voices that are represented in postcolonial scholarship. Bhabha (1994) suggests that we learn our most enduring life lessons from those who have suffered subjugation, domination, diaspora and displacement, legitimising their right to produce knowledge.

Reimer, Kirkham and Anderson clarify that the project of postcolonialism 'centers on theorizing the nature of colonized subjectivity and the various forms of cultural and political resistance' (2002, p. 3). Does this paradoxically seek to reveal a universal coloured colonial subject across nations? Hall (1996) proposes that the only universalising aspect of postcolonialism is that colonisation and decolonisation affect both colonising and colonised societies. It does this, however, in different ways. Postcolonialism as a transnational process is about change occurring in many societies as a historical condition rather than at a moment in time (ibid). For example, the Irish were historically subjugated by a colonising United Kingdom; both parties are white, yet the UK dominated Ireland politically and economically.

The subject of representation as transnational is multiple and conflicting, being both created by a history of colonialism and in the process of seeking new identities in a post- or neocolonial world. Frankenberg and Mani (1993) suggest that postcolonial theorising provides a discursive space which permits a decisive, though not necessarily definitive, shift in identity construction from that of the colonial era, signifying the creation of an agentic subject in a decidedly new postcolonial era. In the Australian context, McConaghy (1998, p. 121) talks of 'a place of multiple identities, interconnecting histories, shifting and diverse material conditions' and a place 'in which new racisms and oppressions are being formed'. Rather than a

'post'-colonial space, McConaghy is describing new or 'neo' colonialism within Australia. While this depiction takes its place within postcolonial discourse, it clearly denotes that the 'post' in postcolonialism refers not to the end of an era but to a merging of forces continuing to constrain the agentic subject position 'mis'-represented as 'post'-colonial.

Locating Australian postcolonial discourses

Susanne Scheck and Jane Haggis (1998, p. 617) assert that, while originally explored by 'intellectuals from colonised cultures as a new location from which to talk back to the imperial centre, postcoloniality has also been claimed by writers within white settler societies as a way of describing their location'. In saying this, they in no way diminish the effects of settlers on the colonised. However, following Frankenberg (1993), they mark in an Australian context, white as a colour and race, that maintains itself through the subjugation of the other.

As indicated by Hall, the transnational character of postcolonialism means that nations will experience, represent and locate postcolonialism in differing ways. Frankenberg and Mani concur, stating that 'cultural time is paced differently according to one's location in relation to systems of domination' (1993, p. 300). In white settler societies such as Australia, political colonisation for the white population did not involve the same structures of racial and cultural domination applied to the indigenous population (Scheck & Haggis 1998, p. 617). As an appendage to Britain, white Australians were responsible for 'implementing these very structures of domination as active colonisers in Australia and, from the early years of this century, in Papua New Guinea' (ibid, p. 618). Can Australia claim to be experiencing the postcolonial, given that race relations between Indigenous and non-Indigenous Australians are far from settled?

Scheck and Haggis (1998) introduce During (1987), who distinguishes between the postcolonised and postcolonisers. During suggests that the postcolonised identify with the culture destroyed by imperialism, while the postcolonisers identify with the original colonising nation. This poses two fundamental problems. Firstly, is this binary scheme of postcoloniser and postcolonised enough to understand the location of postcoloniality, and what of the in-between migrant 'other' who is neither postcoloniser nor postcolonised? Secondly, how do we ascertain if the Australian white postcolonisers are 'post', 'neo' or 'existent' colonisers?

White Australian subjectivity

The first challenge of the binary structure of the postcolonised or postcoloniser is taken up by Nicolacopoulis and Vassilacopoulos. In exploring the onto-pathology of white Australian subjectivity, they contend that dominant white Australia engages in 'a perpetual positioning and repositioning of the foreigner-within as white-non-white or as white-but-not-white-enough' (2004, p. 32). They extrapolate that deep tensions about rightful land ownership exist at an ontological level of our constitution as a nation. This tension is reflected in our ways of being as Australian subjects. As members of the Western liberal order, Australians are encouraged to relate to the world as property-owning identities. Land dispossession has denied this right to be Australian to the Indigenous population. Nicolacopoulis and Vassilacopoulos explain that, for the dominant white Australian to be recognised as rightful owners of property, they need someone to recognise this ownership as non-Australian; indigenous peoples are unable to do this. A suitable 'other' is required. Nicolacopoulis and Vassilacopoulos (2004, p. 33) claim that certain migrant groups are claimed to play this 'dual legitimising and anxiety-relieving role', thus positioned as 'the perpetual foreigners-within'. In this scenario, non-white, non-Aboriginal Australians are neither postcolonised nor postcolonisers; they are in an in-between space where they are simultaneously potential neo-colonisers and colonised individuals.

Frankenberg and Mani's essay on understanding the politics of location is helpful here to understand that, rather than operating on its own, the postcolonial 'is in effect a construct internally differentiated by its intersections with other unfolding relations' (1993, pp. 303-304). These internal relations in the context of Australia as a white settler society include an empirically driven colonisation of indigenous peoples as well as a history of diverse migration. In arguing against the implementation of postcolonial discourses as clear cut binaries, Hall (1996, p. 245) suggests that they can be used to examine conflicts, and reference the shifts of constantly changing relations between dominant and subaltern groups within nations. In Australia, postcolonial discourses will assume their own patterns, dependent on internal political relations, and can be effectively used outside the binary of postcoloniser/postcolonised to examine conflicts between dominant and subaltern groups within the nation. Homi Bhabha (1990, p. 4) describes this as the '*in-between* spaces through which the meanings of cultural and political authority are negotiated'.

Of the contemporary neoliberal Australian context, McConaghy (2000, p. 8) writes that 'it is no longer always useful to present dichotomies of the coloniser and the colonised to illustrate the differential power relations and life experiences of those in colonial contexts ... an important task is to better understand the specific nature of specific oppressions at specific sites: to understand current forms of oppression'. The politics of location calls to order the nature of specific oppressions. In order to contextualise research data from this PhD project, Australian postcolonial discourse needs further consideration.

Scheck and Haggis (1998) contend that white Australia has been ambivalent in redefining its relationship with Britain and in deconstructing its domestic colonising relations. This deeply questions its claim to postcoloniality. Australia's slow disconnect from Britain is seen not as a unified national goal but rather as an abdication by Britain (Hudson 1988, cited in Schech and Haggis, 1998). They draw on Jacobs (1993) to assert that, while Australia moved toward recognising Aboriginal land rights in the 1970s, this resulted in a continuing confinement and control of Aboriginal territoriality rather than a comprehensive return of land control to Aboriginal Australians. The ongoing struggle over land rights and race relations indicates Australia's reticence at releasing its place as coloniser. Schech and Haggis (1998) suggest that Australia is moving towards a position of cultural hybridity rather than entering a 'post'-colonial space.

Cultural hybridity

Bhabha (1994, p. 206) describes cultural hybridity as 'a space of cultural and interpretive undecidability' where cultural differences 'contingently and conflictually touch' (ibid, p. 207). While attending to difference, the notion of hybridity seems confined to a linear plane between coloniser and colonised. Bhabha (ibid, p. 206) further explains a borderline experience opening up '*in-between* coloniser and colonised'. This re-presents the problem of locating the migrant other who is neither colonised nor coloniser in Australia's settler society.

Cultural hybridity is noted as being embedded in racialised discourses of colonialism, marking identity through racial mixing and differentiation (Lomba 1998; Young 1995). Schech and Haggis (1998) also note that due to its use in Australian racist vocabularies as a term, 'cultural hybridity' is unacceptable to many. However, based on the work of Ang and Stratton (1996), they determine hybridity as reference to location is useful in looking at the space between multiple boundaries (Schech &

Haggis 1998). This fits with Bhabha's notion of cultural hybridity as location rather than identity.

Application of three body analysis (Hodge 2005) to the colonial/postcolonial discussion presents the analyst with a more representative explication of location and identity than a two bodied cultural hybridity. Using Homi Bhabha's contention of a borderline experience opening up '*in-between* coloniser and colonised' (1994, p. 206) if a third body is added – such as location identity or ideology, for example – we have the potential for an analysis that reflects the complexity of multiplicity in culture. This multiple interpretation accommodates the coexistence of differential power relations and life experiences within specific oppressions at specific sites, as implored by McConaghy (2000).

Rather than using terms embedded in racialised discourses, such as cultural hybridity, this thesis follows Hodge (2005) in using three body analysis to contend with politics of location and identity within postcolonial discourses. With this strategy, binaries such as racist/antiracist, sameness/difference and black/white all are subject to a third body. This body can be of location, of identity, or of ideology.

Three body analysis usefully draws together Nicolacopoulis and Vassilacopoulos' (2004) presentation of the othering of the perpetual-foreigner-within in the framework of the white Australian coloniser and indigenous colonised. It accommodates Frankenberg and Mani's (1993) contention that postcolonialism unfolds under the influence of external constructs. It provides a framework for Hall's resistance to clear cut binaries and his contention that postcolonial discourse can indeed be used to 'examine conflicts, and reference the shifts of constantly changing relations between dominant and subaltern groups within nations' (1996, p. 245).

Summary

In summarising, I return to Kincheloe and McLaren (1998, p. 263), who state that 'critical theory should not be treated as a universal grammar of revolutionary thought objectified and reduced to discrete formulaic pronouncements or strategies'. As such, I set out in this chapter specific applications of critical inquiry as an umbrella for a range of theoretical frameworks that inform the epistemological and ontological positions of this investigation. Informed by the 'post' discourses, critical theorising uses a transformative agenda to investigate relations of power between individuals and groups. In this way, emancipation is not understood as occurring through

access to Western reason, but as a partnership between individuals and the community within frameworks of justice and equity. While partnership remains a concept of reason, it is reason that values and explores multiple and competing paths rather than the singular linear progression of humanist discourse.

I began this inquiry with a flexible position informed by social justice and liberal humanist beliefs. It was not until I immersed myself in the field during data collection that I recognised how these discourses, in which I was personally embedded, relied on constructs of individualism that could not adequately explain the interrelated relations of race, gender and class. Observations and participant discussions regarding race, difference and equity led me to explore theoretical constructs that could shed light on these issues in ways that enabled exploration of alternate possibilities of meaning.

Through this process, the study became a critical examination of dominant culture and how dominant culture managed diversity and difference, specifically in relation to the local and subjective experiences of child health professionals' intercultural communication. Within the critical paradigm 'perceptions, social and personal truths are always related to culture and social meaning' (Harper and Hartman 1997, p. 37). Culture therefore remains at the centre of this inquiry.

Understandings from the field of cultural studies were extremely useful in this inquiry. Drawing on the broad disciplines of sociology, anthropology and history, cultural studies theory enabled a situated critique of the taken-for-granted aspects of everyday life. In this study I explore the everyday experiences of child health professionals as they work and communicate with parents who are culturally and linguistically different. In this way, I investigate how they use constructs of culture available to them in the social context of child and family health work, and how they reproduce or make culture in their everyday communication practices.

Agger (1992, p. 10) posits that 'cultural studies emphasises that culture is conflict over meaning'. This conflict occurs theoretically, ideologically and in the lived experiences of participants. It is not my intent in this study to engage in binary replacement of one set of theories or ideologies with a newer or better set. Rather, it is to identify existing ways of being and communicating, and the concomitant strengths, limitations and challenges of these approaches as they are experienced in a multicultural. This study therefore explores the meanings that child health professionals make of their world in relation to identity and representation in a

multiculture and how these meanings might be understood to inform intercultural communication in the child and family health setting.

Stolzenberg (2001) contends that the value of culture as a focus of study is that it allows the cultural analyst various metaphysical views or approaches to understanding. Following this notion, I have drawn on postcolonial and feminist scholarship to critique findings of the study so that various metaphysical considerations could be made.

Within an increasingly globalised multiculture, issues such as identity, representation, and the subaltern are important to how we communicate culture through parenting practices within child and family health. These issues are not often or helpfully considered. Alongside nationalism and the political economy these issues are a key focus of postcolonial inquiry (Browne, Smye & Varcoe 2005, 21).

Anderson (2002) argues that feminist scholarship with postcolonialism is more capable of considering power relationships on the axes of gender, together with those of culture, race and class, than either perspective alone. Following this perspective, feminist theories alongside postcolonial were used to inform this study. Feminist scholars have discernibly contributed to cultural studies by examining the lived experience of women (Van Loon 2001), and to challenge a mainstream culture that ignores cultural alternatives (Agger 1992). In all of this looking for meaning, culture is questioned.

The intractable ambiguity of culture is succinctly addressed by Stolzenberg (2001, p. 444) when she suggests that instead of viewing culture as a name for a thing, we might 'come to view it as a place holder for a set of inquiries'. This study is indeed an inquiry into understanding the many meanings of culture, conflict over these meanings, and the various approaches taken to understanding meanings.

CHAPTER 3

CONTEXTS OF CHILD AND FAMILY HEALTH IN SOUTH AUSTRALIA

The past is not past. The past, the present and the future are, as they always are, part of each other, bound together. (Carmel Bird 1998, p. 4 The Stolen Children: Their Stories)

Introduction

Presented in two sections, this chapter situates South Australian child and family health practice historically, politically and within contemporary clinical practice. In the first section I critique the historical context of child and family health. As a study of culture, historical understandings are explored and critiqued to make sense of the present and look for opportunities to move into the future. This is followed in section 2 with a review and critique of contemporary child and family health practice in South Australia. In this second section I pay particular attention to child and family health nursing practice, as nurses deliver the majority of *well* child and family health care. Clinical governance of child and family health practice for nurses suggests core tenets of primary health care, partnership and population health. These are examined for their capacity to support nurses to effect change in South Australian child and family health care.

In Australia, child health professionals have responded to recognised community needs since colonisation. The agenda for care has been debated politically and taken up by dedicated individuals, community advocacy groups and governments. Child health practice has developed and changed in response to these ongoing debates, which set the agenda for care relating to current perceived needs, national and global events and available evidence. This chapter explores some of the agendas underpinning care as it developed historically and the current approaches to care, and also describes how care is manifest through nursing competency standards.

Section 1: Historical contexts of child and family health in Australia

While there are historical accounts of the development of infant and maternal health services across Australia, there is little available descriptive or analytical literature about the development of community health nursing across Australia (Keleher 2000, p. 18). Historical accounts attend primarily to infant and maternal health care offered to white settlers and an alternate agenda of welfare for indigenous children. It seems that community child health nurses did not publicly attend to the specific need of mothers and children who were culturally and linguistically different to the English-speaking women of the colony of Australia.

In this chapter I present a brief historic account of events that have shaped contemporary child and family practice in Australia. I describe the impact of national and state agendas on the concept and delivery of care to children and their families. Following Bird (1998) and Wright Mills (1970), I hold that to understand the present we must have an understanding of the past. This reflection enables the reader to conceptualise the political drivers that have shaped assumptions of universal health care and notions of welfare within community child health practice in Australia. This highlights Australia's history of colonisation and the impact that is still felt today. In many ways this history shapes the very core assumptions and beliefs that underpin intercultural communication in contemporary, community child and family health.

Since Australia was colonised in 1778, approaches to the health and welfare of children has differed depending on racial identification. The most obvious difference was between agendas for the care of indigenous children and non-indigenous British settler children. For non-indigenous white settler 'Australians', infant maternal health *care* began predominantly with health concerns about survival of new arrivals to the colony of Australia (Lake 1993; Mein Smith 1997; Smith 1978). Non-indigenous, non-white settlers were rendered invisible through policies of assimilation and integration. Their history of infant and maternal health care in Australia is one of omission in public policy (see, for example, Mein Smith 1997; Sheridan 2000). Following colonisation, *care* for Indigenous children and families was experienced nationally as an attempt to destroy cultural connections by forcibly removing babies and children from family and community through agendas of assimilation and child welfare (Bird 1998; Human Rights and Equal Opportunity Commission 1997). I begin with a focus on indigenous children.

Welfare for Indigenous children

'The fact is, if I did meet someone, I don't want to have children, cos I'm frightened that the welfare system would come back and take my children.' (confidential evidence number 528 cited in Bird 1998, p. 13)

In Australia, *care* for indigenous children was enacted under a welfare agenda underpinned by a goal of assimilation rather than an agenda for health. Control of the physical and moral welfare of Indigenous Australians in newly colonised Australia was violently taken from indigenous communities by the government of the day. This taking over was accomplished through a succession of legislative Acts that decreased Indigenous peoples' control over their families and communities and increased control of the nation-state over their lives. For Indigenous Australians, their homeland became an imposed welfare state where the government or church took primary responsibility for health, housing, education and economy. Lived indigenous experiences of 'welfare' from early colonisation do not equate in any way to commonly held notions of 'wellbeing' (Bird 1998), nor did welfare provided for Aboriginal communities approximate to that provided in the wider Australian context (Human Rights and Equal Opportunity Commission 2007).

A national perspective on indigenous child welfare

Without exception, all states and territories in Australia initially undertook strategies to change indigenous Australians to become like their colonists. These protectionist policies led to dislocation from homeland and loss of cultural knowledge, resulting in malnutrition and disease. Governments of the time attributed this genocide to social Darwinism or the survival of the fittest, where only the strongest or most adept to survival (in terms of white Western ways) survived. With the prospect of the Indigenous population becoming extinct, attempts were made to 'merge' and then 'assimilate' mixed heritage Indigenous Australians into colonial ways of life (Human Rights and Equal Opportunity Commission 1997, pp. 27-37 & 119-128). Part of this strategy was to control reproduction of Indigenous peoples and ensure assimilation and acculturation of Indigenous children into the cultural practices of their colonisers.

Nationally, 'between one in three and one in ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970' (Human Rights and Equal Opportunity Commission 1997, p. 37). 'In that time not one Indigenous family has escaped the effects of forcible removal' (ibid, p.

37). These infants and children were compulsorily taken into government or missionary institutions far from their families and communities. These children were often told that their parents were dead or didn't want them. Children within families were often separated within institutions. Children were often renamed and forbidden to speak in their own language (Bird 1998).

In the 1950s and 1960s, greater numbers of Indigenous children were removed from their families despite international recognition of the work of John Bowlby on the devastating effects of maternal deprivation. During this time, child welfare legislation alongside a continuing national agenda of assimilation sanctioned the ongoing forced removal of Aboriginal children into non-Indigenous families and institutions. 1972 saw the beginning of a decline in forced removal of Indigenous children. This was due to the election of the Whitlam Labor Government on, amongst other things, a platform of Aboriginal self-determination. This meant that funds began to be directed to Indigenous organisations to lobby against the high removal rates of Indigenous children. We began to see a national approach to Aboriginal affairs within a context of international civil rights movements.

Aboriginal child welfare in South Australia

South Australia's history of forced removal under the guises of protection, welfare and assimilation mirror those of the nation. Australia is governed by a combination of both state and federal laws, and marginal differences therefore exist between the respective states and territories in relation to time frames and the nature of laws used to enforce removal of children from their families.

Until 1881, the 'protection' of Indigenous peoples in South Australia was left entirely to missionaries. While the government did not itself remove children from families during this time, it was complicit through inaction over the common practice of pastoralists removing children from families to put them into service as stockmen and servants. From this time until 1908, children were removed as boarders into government schools aimed at distancing them from family and community influences and forcing them into the service of colonisers. From 1908, the *State Children's Act 1895* was used as justification to remove Indigenous children from their families and communities on the grounds of 'destitution' or 'neglect'. At this time, all children of mixed descent were regarded as neglected. Over time, this task moved from primarily the role of police to that of social workers acting on the social welfare agenda for Indigenous children.

In 1967, while still being removed from their birth families, Indigenous children began to be fostered by Indigenous families. Changes to legislation were made. These included the *Community Welfare Act 1972* and the creation of the Aboriginal child placement principle through the South Australian Aboriginal Child Care Agency in 1983. Despite these changes, in 1983 there 'were still more Indigenous children in non-Indigenous foster placements than in Indigenous placements' (Human Rights and Equal Opportunity Commission 1997, p. 128).

This inheritance and lived experience of the stolen generations informs parenting and child health services today. This legacy engenders child health nurses to position themselves distinctly as health workers not social workers to avoid being implicated in the forced removal of children. Social workers bring with them their history of taking children away from family, community and cultural heritage. Child health professionals were and are careful to bring with them an agenda of nurturing child growth and development.

A health care agenda for children of colonisers

The current child and family health platform of child growth and development began with a concern for infant survival. The first decade of the 1900s saw a political strategy to preserve Australia's 'best immigrants', that is, those who were born in Australia and descended from early colonisers (Mein Smith 1997; Smith 1978). Infant mortality and morbidity of the colonising peoples drove a health and welfare agenda in mainstream Australia. A fall in Australia's annual rate of population growth from three percent to 1.07 between the 1870s to 1890s sparked a debate around the best ways to increase Australia's population. During this population debate, a moral approach was taken to public health (de Vries 1963). This approach, underpinned by social Darwinism, acted to maintain normative Western standards of civilisation. For example, medical practitioners of the time attributed the increase in infant mortality to the moral degeneracy of women and their subsequent inability to care for children (Smith 1978). Thus defined as a moral issue pertaining to women, there remained no public health responsibility for infant mortality. It followed that unless women raised themselves out of moral decay, their children would continue to die.

Locating South Australian infant and maternal health

The development of the School for Mothers in South Australia from 1909 marked a change in the nature of child health services. Dr Helen Mayo promoted an argument

that, rather than moral issues, it was the economic situation that was the cause of the rise in infant mortality, as it forced working-class mothers to find employment in industry. Drs Mayo and Borthwick considered lobbying for broad legislative change to remove women from the workforce during pre- and postnatal periods, but determined that this may have compounded issues of poverty and maternal health through concealment. That is, mothers might have concealed their pregnancies to maintain their paid employment. Instead, they advocated for a freely available infant welfare service to all mothers (Smith 1978). Modelled on Saint Pancras in London, South Australia's School for Mothers saw the beginning of an ongoing service to support mothers. The school's aim was 'to promote the education of the MOTHER in all that concerns the physical, mental and moral development of herself and her offspring (Mothers and Babies Health Association undated see Appendix 1 for an example of promotional material).

Education was used as a pedagogic tool to ensure that the service was not seen as charitable: 'The work of the association will be WHOLLY EDUCATIONAL, as distinguished from Charitable, and in no way to overlap [with] that done by already existing charitable agencies' (ibid, emphasis in original). The School for Mothers distanced itself from state government and municipal societies, but worked alongside existing charitable agencies (Smith 1978). Giving education was perceived differently to the giving of a gift⁷ as in a charitable organisation. Both, however, are giving: one of education, and one of material goods. In giving education, a socialist underpinning based on theories of enlightenment and justice prevailed.

In Adelaide, the School for Mothers partially addressed issues of gifting by deeming that necessary items such as clothing would be sold, not gifted, to mothers. Items 'sent in by committee members and friends' were sold through a jumble sale along with cups of tea (Mothers' and Babies' Health Association 1959). The act of purchasing, even though the items were donated and sold at minimal prices, mitigated some of the sense of power and control. In purchasing, an agreement of worth is made and paid, and obligation is distanced by one step. This arrangement, however, did not apply to education.

To understand the notion of charity, the idea of gift-giving needs to be explored further. Gift-giving in both charitable and educational terms involves relations of

⁷'Gift' is defined as 'the power or right of giving' (*Macquarie Dictionary* 2008).

power. In a charitable organisation, relations of power are obvious: the giver is always in a position of control over what they give and how they give it. The receiver has control only in as much as they can refuse to accept the gift. Managing the needs of motherhood in a state of poverty made taking up a position of resistance difficult and conflicting. In many ways, the receiver is dependent on the charity of the giver. In calling on education as a tool for enlightenment, relations of power are similarly conflicting, although perhaps not quite in the same position of moral dependency.

In giving and receiving 'education', the imbalance of power between adult women may have been perceived as mitigated by the sense of empowerment⁸ experienced by mothers. The directive to give education rather than charity to mothers embodies constructs of a deserving poor compared to that of an undeserving poor. The notion of a deserving poor has its roots in the history of welfare and ideas of the rational agentic self who strives for self-improvement. For example, the deserving poor are prepared to work, through education, to raise themselves above their current situation, whereas the undeserving poor are positioned as reprobate in squandering any assistance given to them. The concept of a deserving poor is based on an understanding that these mothers present of their own free will; that they want to be enlightened and that they will necessarily have more control over their own life through education. That mothers take up this position is not surprising given the threat of high infant mortality. This challenges any perception that mothers might enter an educational setting on their own individual, free, objective and rational terms.

Enlightenment constructs assume an understanding that an individual taking up an educational opportunity, in this case a mother, is a rational agentic being (Davies 1991), unfettered by the sociological constructs that shape her world. The subject positions available to mothers were, however, shaped by conditions of poverty, such as working in substandard factory environments and high rates of infant mortality (Smith 1978). There is a double tension here. Firstly, at the heart of Enlightenment constructs is the positioning of women as irrational and dependent (Davies 1991). Through the mothers and babies movement, we see a resistance to Enlightenment as women were offered an opportunity to assume a position normally only available to males. Indeed, medical professionals at the time scoffed at this strategy, claiming

⁸ 'In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health' (World Health Organisation 1998).

that mothering was a natural instinct (Mothers' and Babies' Health Association 1959; Smith 1978). However, the very mechanism used to raise women to rationality inherently denied the influences of the socioeconomic circumstances of working-class poverty and infant mortality, as if to be educated ameliorated these social conditions.

It seems that there was a trade off if women were prepared to accept and follow instructions. Through a pedagogy of middle-class expertise, whose episteme was developed around paternalistic constructs of morality and medical science, they might be accepted as 'rational' human beings, a position at the time only available to men. In doing this, however, they traded their numerous available subject positions, including historic women's ways of knowing about birth and child rearing. By following modernist ideas of linear progression in becoming enlightened to moral and medical approaches to mothering, mothers were forever bound. They could never progress freely in a linear fashion, as their lives continually contended with the multiple social conditions of poverty and economic dependence.

Mein Smith (1997) suggested that, by the 1930s, *most* mothers adopted the definitive strategies of infant welfare movements. In this way they were noted as good mothers. How, then, were women positioned who were not able to take up education and enlightenment? One of the major causes of infant death in Australia at this time was diarrhoea. Infant welfare organisations attributed the death of infants from diarrhoea to a failure to regularly attend baby health centres. This was noted by authorities of the time as bad mothering. Terms such as 'bad home conditions' (Mein Smith 1997 p. 167) were used to denote deprivation due to overcrowding, poor access to food and a lack of sanitation. In this way, bad mothering was recorded of those who neglected 'clean orderly habits' (Mein Smith 1997 p. 169).

Despite contemporary critique, gaining knowledge about how to parent well and prevent the death of an infant remained a powerful motivator for attending child health services and attempting to change parenting behaviour. Indeed, access to this knowledge was empowering for many parents of the time and, alongside improvements in public health, led to a decrease in infant mortality in South Australia until the depression in the late 1930s. Hygiene and nutrition remain at the heart of public health movements (Baum 1998a).

By the mid-1940s, welfare concerns regarding suitability of environments for raising children became more prominent with the increasing removal of white children from homes into institutions and foster care. Dominant scientific medical discourses generally dictated child and family health practice until the 1970s, when ideas about health and welfare began to change in response to the Alma Ata Declaration (World Health Organisation 1978).

Infant and maternal health for non-white, non-indigenous Australians

The archives of the Mothers and Babies Health Association hold a wonderful historic collection of photographs. Reviewing these, I observed mothers and babies who appeared to be of primarily Anglo-Celtic or Anglo-Saxon origins, even though Dr Mayo argued that the service should be available to all mothers free of charge. These images raise questions about who the service was implicitly intended for: families who were white, or assumed to be white.

In addressing this question, I return to the beginnings of the mothers and babies movement in the early 1900s. In colonial Australia, the nation's wealth was measured by the size of its white population (Lake 1993). Ways therefore needed to be found to increase the white population. Australia was perceived as vulnerable due to its extensive coastline and vast open spaces, where whiteness was threatened by Aboriginals and 'non-British' migrants. White native-born babies were considered the nation's best weapon against the impending 'racial decay' (Mein Smith 1997, p. 2). To support this strategy, in 1912 a maternity allowance of five pounds for each viable infant was introduced by the Labor Prime Minister Fisher (Lake 1993; Mein Smith 1997). This was the equivalent of three to four weeks wages for a female factory worker (Lake 1993). This baby bonus, however, was only paid to white women or women who could be assumed to be white; 'women who were Asiatics, Aboriginal natives of Australia, Papua or the islands of the Pacific' were not given this maternal support (ibid, p.379). It seems that the mothers and babies movement may have been part of a well-orchestrated strategy to exclude non-white migrants from a national identity that was Australian.

There does not seem to be a parallel visible recording of how non-white migrant women were supported in parenting or childrearing. This is demonstrated through historic migration policies. For example, Lara Palombo (1998) explored the experienced of Italian migrant women. She explained that until the 1870s, national

census data did not differentiate male from female migrants. Italian migrants were categorised as 'other Europeans'. Palombo argues that despite Italian women's dominant stereotype of 'mother', they were never identified as reproducers of the white race. They were thus denied assimilation into the dominant British-Australian order. Post-war immigration policy of the 1950s reinforced this invisibility, in which women were not categorised as migrant workers in their own right but as dependants of males (Sheridan 2000). Migrant women were intended as wives and mothers, to settle the social disruptiveness of migrant 'rogue males' (ibid, p. 125).

A further indication of the ongoing invisibility of non-white migrants in Australia's history of child and family health was the development of Lady Gowrie Child Centres. Lady Gowrie Centres began as health centres for preschool children combined with nursery school kindergartens for comprehensive early childhood care. Established in each state of Australia in working-class areas, the purpose of the centres was contradictory. Begun to improve the health of children living in poverty, they soon evolved into demonstration projects, the purpose of which was to establish and test the best standards of early childhood care. Core to this was the collection of data on the 'normal' child and 'optimum' child growth and development (Mein Smith 1997, pp. 227-228). As the White Australia Policy remained central to Australianness, those children accepted as a measure of normality into Lady Gowrie Centres were Australian-born of Australian-born parents. Aborigines and migrants were excluded (ibid). Again, women and children who were non-white remained invisible.

Returning to the photographs in the Mothers and Babies Health Association, it was not until the 1970s that photographs of nurses working with families with skin colour other than white began to appear. These were of Indigenous families and those of Vietnamese heritage. This reflects the changing national approach to Aboriginal affairs and the introduction of policies of multiculturalism.

Drawing the past into the present

Contemporary child and family health practice is situated in this historical context. As Carmel Bird (1998) said, the past, present and future are always bound, although they are not necessarily linear. Key aspects of this history remain of interest for this study of culture and communication in contemporary child and family health practice.

Australia began as a colony of Britain. This position means that, historically, child and family health care was divided into infant and maternal care to ensure the survival of the colonisers and welfare control of Indigenous peoples. The outcome for indigenous peoples was the systematic destruction of cultures through the separation of infants and children from their families' communities and heritage. Mothers who were either 'colonisers' or 'migrants' but whose infants experienced health inequities due to conditions of poverty were entreated to maintain a moral and civilised superiority over indigenous mothers. While continuing to follow modernist aspirations of enlightenment, in South Australia concerns moved in the early 1900s from morality to education on infant and maternal health. Given the high rates of infant mortality, this approach was understandable, but in accepting the status quo of enlightenment approaches the complex situated intersections of poverty and the histories of women's ways of knowing were left unattended.

What is most interesting in this survey is that there was little reference in the literature about child and family health care provision to families who were neither white nor Indigenous. Australia has been host to migration from Asian and European countries since colonisation, but little is written about where migrants other than those from an Anglo background were situated. From an Indigenous perspective, all peoples other than Indigenous Australians were 'migrants'. From the perspective of Australian governments, Australia was settled by peoples of Anglo descent, and all other arrivals were 'migrants'. It seems mothers and babies who migrated to Australia who were not white, or not white enough, were not given political or actual recognition of the multiplicity of their cultures. The assimilation policies meant that they had to become 'like us' as quickly as possible, leaving behind their culture, language and customs. Perhaps they, alongside working-class white women, were also offered an enlightenment opportunity to join with normative white Western parenting practices, thus placing non-white migrants in the same camp as colonising white settlers. Visual and documented histories, however, show little record of this.

In all of these histories of childrearing, mothers, infants and children were subject unquestioningly to dominant modernist ontologies of the importance of a paternalistic Western morality and normative standards of birthing and motherhood constructed within rational scientific principles of health and illness. For indigenous peoples, entire tracts of cultural heritage were negated through welfare legislation within policies of protection and assimilation.

Historically, child and family health practice has always been enmeshed in relations of power. From indigenous experiences, relations of power were explicit in the complete and unequivocal removal of control from families and communities over raising their children, and thus over continuing cultural knowledges. For the children and families of colonisers, these relations of power were more subtle, operating through the use of a modernist agenda of enlightenment where mothers traded multiple subject positions for a scientifically endorsed rational approach to motherhood. Mothers who were migrants are imagined as also experiencing a trade-off for accepting normative rational standards of practice, including loss of traditional mothering practices. This reflection also highlights the tensions in child and family health between constructs of welfare as damaging where relations of power are more often explicit and child and family health as health promoting universal services where relations of power are more implicit. The next chapter builds on this historical context to explore constructs of child and family health in contemporary practice.

In summary

In this chapter I have explored some of the ways that the health of infants and children has been enacted in the colonial history of Australia. This history is dominated by the impact of British settlement and constructs of white Australian nationhood. New white Australians brought with them an agenda to care for the health of white Australian-born children in the colony. They enacted a paternalistic approach towards Indigenous infants and children, with policies stating that, ultimately, if indigenous culture could not be erased, indigenous peoples should assimilate into white colonising cultural practice.

Families who migrated to Australia with other than Anglo origins seemed to be written out of Australia's narrative of child and family health until the 1970s, their histories rendered invisible. This was achieved through policies that legitimised nationhood only through whiteness or assumed whiteness. We are left to imagine the possibilities of how child and family health services intersected with these legitimate but not white migrants to Australia.

I began this historical review to contextualise child health practice as it is experienced today. In this way I hope to better understand child health professionals' critique of their intercultural communication encounters and enrich my own analysis of intercultural communication practice. I did not intend to inculcate the

past as a substitute for trying to understand it, as Good purports to be the role of postcolonial critique (2005, p. 293). As noted by Good, Western culture is not alone in its guilty history of racism, sexism, homophobia, ecocide and imperialism (ibid). In this study, I do not look for the problems of history to flagellate colonists. However, as Australia's history is one of colonisation, this needs to be noted as an explicit contributor to current-day behaviours and attitudes. Good suggests that postcolonial critique argues that the past is 'guilty of not being present' (2005, p. 293). The past, however, is not the subject of this investigation. I have accounted for the past, to understand the present.

In the following section I shift the focus to contemporary child and family health practice and critique current governmental and disciplinary discourses of care.

Section 2: Contemporary contexts of child and family health in Australia

In Australia, models of child and family health service delivery vary from state to state. While national health policies go some way to influencing consistency in practice goals and outcomes, differing state legislation and differing codes of nursing practice mean that there is understandably little uniformity in child health services offered to families. However, the unifying feature is that child health practice operates within a public health paradigm. In this paradigm, the aim is illness prevention and health promotion through primary health care, community development, and surveillance (Keleher 2000). Child health nurses work with families and their well infants and young children through child health centres, community activities and home visiting programs. Nurses are the largest professional group in child and family health. They collaborate with and refer families to other professionals, such as social workers, psychologists, physiotherapists and medical officers, who represent a smaller proportion of the child health workforce.

Because nurses undertake the majority of service provision in child health services, child health nursing practice is the focus of the following section. There are two national professional bodies for child health nurses. The Australian Confederation of Paediatric and Child Health Nurses, established in 1992 (ACPCHN 2007), has membership in every state and territory of Australia. The Australian Association of Maternal, Child and Family Health Nurses (AAMCFHN) began in 1996. Following the inclusion of the South Australian Child and Family Health Nurses Association

(SA CaFHNA) in 2006, the AAMCFHN has representation in all states and territories.

Due to the disparity between states and professional organisations, there are a range of child health nursing competency standards directing practice. These include the ACPCHN's 'Competencies for the specialist paediatric and child health nurse' (2000), the Australian Nursing Federation's (ANF) 'Competency standards for the advanced nurse' (1997), the New South Wales, Child and Family Health Nurses Association's (CAFHNA) 'National competency standards for the child and family health nurse' (2000) and, most recently the Government of South Australia's 'Clinical competencies for child and family health nurses' (2006). These are in addition to the Australian Nursing and Midwifery Council's 'National competency standards for the registered nurse' (2005), 'Code of professional conduct for nurses in Australia' (2003) and 'Code of ethics for nurses in Australia' (2002). While this indeed represents a professional hotchpotch, it also has the potential to account for the differences between state populations.

The unifying factor of all child and family health competencies is that they specifically direct practice from a primary health care approach. In addition, the ACPCHN and the Government of South Australia competencies include a focus on partnership with the child and their family. The use of a population health approach is included in the Government of South Australia's competencies. As this study was undertaken in South Australia, the underpinning principles of primary health care, partnership and population health will be examined. Further, the tensions inherent in enacting these principles in the current political climate will be considered. In this chapter, current nursing competency standards are analysed to determine nurses' scope of practice to work in communities with infant and children and their families.

Primary health care

The principles of primary health care underpin all community health practice in Australia. Following the International Conference on Primary Health Care in Alma Ata, initiated by the World Health Organisation (WHO) in 1978, governments from around the world were called to action to take responsibility for striving for health for all peoples by the year 2000 (1978). In the spirit of social justice, primary health care was claimed as key to reaching this target (ibid).

Primary health care was defined in the *Declaration of Alma-Ata* (1978) as 'essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable' (WHO 1998, p. 3). Central to this definition is equity in access to community-based organisations with recognition of the need for all government and non-government sectors traditionally outside of health to become involved. This included an increase in health education and health promotion as preventative health measures (ibid, p. 2). In Australia, for example, this call was taken up in the area of child health through early childhood injury prevention and skin cancer prevention programs. The early childhood injury prevention program was implemented in South Australia in 1985, augmented by the Child Accident Prevention Foundation of Australia, which developed into the Child Accident Prevention Foundation of Australia, Kidsafe (2007). In 1981, the prevention of skin cancer was highlighted through the 'Slip Slop Slap' campaign that became a national slogan (The Cancer Council Australia 2007).

Baum and Sanders (1995), however, suggest that the centrality of these key aspects was discarded by many developed nations as they developed a more selective approach to primary health care that stressed medically and behaviourally defined goals that could be measured. They argue that the term 'primary health care' was used more to describe primary care, or first point of contact, for example, through general medical practice, than to set agendas for collaborative intersectorial health promotion (Baum & Sanders 1995).

The imperative for intersectorial collaboration within primary health care was strengthened through the development of the Ottawa Charter for Health Promotion at the First International Conference on Health Promotion (WHO 1986). The charter presented a health promotion agenda to achieve the goal of 'health for all by the year 2000'. The charter includes prerequisites for health such as 'peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity' (WHO 1986, p. 1) that would require collaboration outside traditional medically-modelled health portfolios. According to Baum (1990), the principles of the charter have become a public health mantra. The principles are that health promotion action requires building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills, reorienting health services and 'moving into the future' (WHO 1986). To do this requires mediation, advocacy and the capacity to enable people to achieve their health potential (ibid). Following this, signatory nations such as Australia responded

by developing strategic goals and targets to prevent illness through health promotion activities on both an individual and community basis.

Australian Government implementation of Health for All

In Australia, the *Health For All* report identified the following priorities for action: ‘the control of blood pressure, improved nutrition, injury prevention, the health of older people, the primary prevention of lung and skin cancer, and the secondary prevention of breast and cervical cancer’ (Health Targets and Implementation *Health For All* Committee 1988).

Baum and Saunders (1995, p. 150) assert that while setting a health reform agenda for some countries, the interpretation of the charter by governments was ‘reductionist and supportive of the *status quo*’. A shift from comprehensive to selective primary health care emerged when targets were related to disease, biological or behavioural risk factors rather than wide-ranging social and environmental factors (ibid). It seems that this may also be the way primary health care has been enacted by the national government of Australia. For example, in searching the Australian Government Department of Health and Aging (2007c) web site, I entered primary health care as a search word. This returned a site from which one could choose hospitals or screening services. When looking for publications within primary health care, a summary of ten publications from 2001 until 2006 was presented, all of which related to increasing after-hours medical services (2007b). Further attempts to find comprehensive primary health care approaches were made by entering the search term ‘early childhood’. The first 20 references returned related to immunisation (2007b). While these are important aspects of ensuring access to medical care, they clearly fall within a selective approach to primary health care. Developments in immunisation are extremely important in increasing the health status of the population; however, these approaches have not been proven to reduce health care inequities arising from the social determinants of health.

It seems that health care targets remain medicalised. For example, the Department of Health and Ageing web page for health priorities (2007a) states that ‘the National Health Priority Areas are; cancer control, injury prevention and control, cardiovascular health, diabetes mellitus, mental health, asthma, and arthritis and musculoskeletal conditions’. I explored the health priority area of asthma, as it links to early childhood. Rather than addressing the social determinants that contribute to the increasing incidence of asthma, such as poverty, the strategy to address this health priority area is to relieve the ‘significant burden that asthma places on the

Australian community in terms of health, social, economic and emotional costs' (Australian Government Department of Health and Ageing 2007). It could be suggested from this that individuals, predominantly children, who experience the condition of asthma are attributed blame in the form of a cost burden to the Australian community. While this is an important fiscal consideration on its own, it does not address the social determinants of health that contribute to disease production in the first instance.

Where organisations refer to economic measurements of illness to the community, Baum suggests that this reflects an underlying assumption that economic productivity is paramount (Baum 1998b). This suggests that government economic activity is privileged over social determinants of health. Poor health status attributed to low economic productivity is worthy of intervention rather than the driver being the state of the nation's health.

Moving away from the Department of Health and Ageing to the Department of Families Community Services and Indigenous Affairs (2007b), there is a notable shift to a collaborative approach between departments in the stronger families and communities strategy.

This is also the case in the area of early childhood in Australia, where health targets have been subsumed into an *agenda* for early childhood. This is in response to national and international attention on early childhood development (see for example McCain & Mustard 2002; Phipps 1999; Young 2002). The very recognition of early childhood as a health agenda based on stage of life rather than medicalised health factors is significant. Rather than setting targets, the Department of Families Community Services and Indigenous Affairs' *Communities for Children: Early Childhood Intervention* (2007a, p. 2) is presented as 'a "roadmap" to guide collaborative and national investment in early childhood'. This national agenda for early childhood responds to risks that are identified as leading to poor outcomes in broad areas, such as 'drug dependency, school failure, welfare dependency, poor health and criminal behaviour' (ibid, p. 1). In this approach, risk factors are identified rather than outcome targets.

According to Labonte (1992), the use of language in primary health care discourses is significant. Labonte suggests that a 'target' is incompatible with the notion of primary health care, noting that a target is stationary and shot at (ibid). While some targets may indeed be identified as *moving targets*, reducing health needs to such

definitive and measurable goals is incompatible with a mandate to recognise social, political and economic complexities of health and illness. Following the global failure of meeting the targets of the *Health for All* report, we see a shift from health targets within narrowly defined medical terms to agendas and outcomes. These agendas attempt to cross the borders of health, welfare and education. This is indeed a helpful step for an individual nation and nation state to meet the needs of its population based on the principles of *Declaration of Alma-Ata* and the *Ottawa Charter*.

South Australian implementation of primary health care principles

In South Australia three separate reviews into health, welfare and early childhood education addressed similar issues within the state. The reviews resulted in the following reports:

Better Choices Better Health. Final Report of the South Australian Generational Health Review (Department of Human Services & Menadue 2003)

Our Best Investment: A State Plan to Protect and Advance the Interests of Children, also known as the 'Layton Report' (Department of Human Services & Layton 2003)

The Virtual Village: Raising a Child in the New Millennium. Report of the Inquiry into Early Childhood Services (Department of Education and Children's Services & Wright 2005)

Uniquely these reports all promoted the need for a unified approach to early childhood services within the state. These reports were complimented in the specific area of early childhood by *Every Chance for Every Child-Making the Early Years Count. A Framework for Early Childhood Services in South Australia* (Department of Human Services 2003a) In the following section I detail the points of collaboration in these and the ensuing operational frameworks.

The *Generational Health Review* (GHR) was the first whole of service health review in South Australia for twenty five years. It identified a number of key themes to deliver a health reform agenda that would address health inequalities and ensure 'safe, accessible, efficient and effective health care' (Department of Human Services & Menadue 2003, p. iii) . These included 'promoting a population health approach, promoting primary health care, accountability and transparency, workforce development, health inequalities and health as a human right' (ibid, p. iii). *First Steps Forward, South Australian Health Reform*, was the Department of Human Services'

(2003b) response to the Generational Health Review. It proposed plans to reorient health services towards a primary health care agenda through better governance, better systems and better services.

In line with these recommendations, *Every Chance for Every Child* (ECEC) promoted 'the health, development, safety and learning of all children in South Australia' with a goal to enhancing 'the quality of early childhood for children who are disadvantaged by their early childhood experiences' and to 'increase the equity of outcomes between groups of South Australian children' (Department of Human Services 2003a, p. 4). To achieve these goals ECEC proposed a range of primary health care strategies. These included antenatal support, universal and sustained home visiting programs, strengthening early childhood development, learning and care, strengthening the capacity of communities to be more supportive of families and providing more effective, better coordinated programs and services for children and families (Department of Human Services 2003a).

The Layton Report (2003) called for similar interventions. These included:

a state-wide nurse home visiting service

the development of parenting skills and parental capacity through a variety of programs and delivery methods

further improvements to ensure accessibility particularly to those with high needs of culturally appropriate services (Department of Human Services & Layton 2003, recommendations; 7, 15 & 16) .

Finally, the *Report of the Inquiry into Early Childhood Services* recommended strengthening and integrating universal services from birth to eight years through a joint approach such as a new whole of government framework for early childhood services (Department of Education and Children's Services & Wright 2005).

In direct response, to recommendations from these health, welfare and early childhood education sectors, the Government of South Australia implemented an inter-ministerial committee on Early Childhood Services. This committee is a joint sitting of representatives from the portfolios of education health and welfare. It oversaw the implementation of 'family friendly' Early Childhood Centres (Department of Health 2004). This committee remains active in 2007 and has seen the implementation of seven *Children's Centres for Early Childhood Development and*

Parenting across metropolitan and rural South Australia (Government of South Australia 2007).

Of targets agendas and frameworks

In analysing use of language in national and state early childhood agendas, following the style of Labonte (2001), one notices the use of words such as 'investment'. While investment may be interpreted in many ways, in this document investment refers to monetary considerations. Evidence given to support the agenda is driven by fiscal concerns of a greater need to tackle the increasing cost burden to society of social and health issues such as, criminality, drug use and mental health. It is not until a cost benefit analysis of providing early childhood care reflects returns that are greater than the original investment that governments begin to take notice of early childhood lobbying (see for example Karoly et al. 1998; Stanley 2001). Evidence for a collaborative approach to investing in the early years is underpinned by financial in addition to developmental evidence.

In accordance with the goals of the Ottawa Charter, evidence that informed the early years agenda also includes confirmation that siloed medicalised approaches to health promotion have done little to contribute to the growing disparities in health in Australia (Stanley 2001). Further a government focusing on economic growth rather than economic disparities fails to recognise that increasing social gradients have poorer developmental health than those with more equal distribution of wealth (Keating & Hertzman 1999). Cass (2002) states that Australia's social gradient is increasing which is likely to be affecting Australia's children.

Australian national and state government efforts to improve early childhood development from developmental, economic and sociological perspectives clearly align with a reconsidered interpretation of the *Ottawa Charter for Health Promotion*. State Government initiatives take the approach further by placing the early childhood agenda across the portfolios of health, welfare and education (Department of Health 2004). Two questions remain. Is it possible in an environment of economic rationalism and increasing managerialism to meet these comprehensive rather than selective goals of primary health care? Secondly how do health professionals negotiate a comprehensive primary health care agenda in light of current health care policy?

From the specific perspective of community child and family health nurses, consideration of these questions is further conflated by the historic positioning of

nursing within a broadly biomedical system which privileges an illness model in nursing education and service provision (Keleher 2000). Labonte (2001, p. 105) suggests we may be seeing a re-medicalisation of society that privileges discourse of ‘the “new” genetics and the explosion in technical therapeutics’. These two observations present tensions to community health nurses who are also obliged to work within a primary health care approach. In this context the following section considers the prevalence of primary health care discourse within Australian nursing practice standards in attempting to understand dominant approaches guiding nursing practice.

Primary health care in standards of nursing practice

Knowledge of primary health care, health promotion, continuity of care and the ability to incorporate these concepts into practice are clearly featured within the standards for child and family health nurses in the ACPCHN competencies (2000, p. 22) and the CAFHNA standards (2000, p. 23). Both these child health specific standards of practice include the words ‘primary health care’, and present competencies relating to a broad social justice approach of primary health care, and the delivery of primary care.

The Children Youth and Women’s Health Service (CYWHS) *Clinical Competencies for Child and Family Health Nurses* (2006a) defines child and family health nursing within the context of a primary health care approach. The first competency unit focuses on ‘promoting infant/child and family health and wellbeing’ (ibid, p. 10). Within this unit, are the competencies of ‘knowledge of infant/child/family, health and wellbeing’ (ibid), ‘knowledge, attitude and skills for the promotion of maternal health and wellbeing’ (ibid, p. 13), and engaging with fathers ‘or significant others to enable them to enhance the infant/child/family health and wellbeing’ (ibid, p. 14).

The ANMC *Standards for the Registered Midwife* (2006) notably name one of the four domains as ‘midwifery as primary health care’ (insert page number). A similar explicit inclusion of primary health care principles and practice is lacking in the ANMC *National Competency Standards for the Registered Nurse* (2005) and *Nurse Practitioner* (2006), and the Australian Nursing Federation *Competency Standards for the Advanced Nurse* (1997).

While the CYWHS clinical competencies claim a primary health care approach and include terms such as promoting health and enabling, in my experience there is little scope for primary health care practice other than the delivery of primary care. Take

for example nurses involved in the Universal Contact Visiting program. Primary care as a point of first contact is argued by Wass (2000) as fundamentally different to primary health care. Keleher (2000) concurs suggesting that 'primary care' as a first point of contact with a health system originates from and perpetuates a medical, illness based model. Wass (2000) however suggests that primary care as first point of contact can be legitimised as primary health care, when this contact is part of integrated collaborative care, and when a primary health care philosophy underpins service goals.

The professional pathway followed by nurses who work in community child and family health nursing involves firstly education and practice in general nursing. While there are many aspects of care involved in general nursing, the broad focus is on caring for individuals who are unwell, generally located in acute care settings. To contextualise how primary health care is understood more generally in nursing practice I critiqued the ANMC *Standards for the Registered Nurse and Nurse Practitioner* and also the ANF *Standards for the Advanced Nurse*. Of most import are the ANMC *Standards for the Registered Nurse* because in South Australia all nursing work is underpinned by these standards.

From a primary health care perspective there appeared to be a number of omissions in these standards. To begin, there were no statements defining underpinning global or national imperatives for practice in the introductions of any of these statements. There was minimal reference to the principles of primary health care or health promotion in the ANCM *Standards for the Registered Nurse*, and the *Nurse Practitioner*, or the ANF *Standards for the Advanced Nurse*. An initial impression was that these standards did not value primary health care principles. To qualify this impression I scanned the documents for embedded primary health language, looking for use of root words such as promotion, advocacy, enable, mediate or collaborate. Following this the question was asked of each competency domain, could they be interpreted as applying to a group/community or population of people in addition to the individual.

The ANMC standards for the registered nurse comprise four domains which cover a total of 44 elements of practice. One of the 44 elements asserted the need to recognise 'that membership and roles within health care teams and service providers will vary depending on individual/group's needs and health care setting'. Within this element, one of four indicator suggests the need to recognise 'the impact and role of population, primary health and partnership health care models' (ANMC

2005, p. 7). As each of the elements contains between 2 and 14 indicators this is a small overall representation of primary health care. Of the 44 elements only one contained the word 'advocate' (ANMC 2005, p. 3) and three used the word 'promote' (ibid, pp. 6-7). The fourth Domain refers to 'collaborative practice' as do a further 5 elements. However the majority of these refer to collaboration within the health care team or negotiation and referral to other health service providers. The use of these primary health care words did not always fit with primary health care approaches as articulated in theoretical understandings, or contained in policy statements at state or national levels. For example, element 7.8 suggests using 'health care resources effectively and efficiently to *promote* optimal nursing and health care' (ANMC 2005, p. 6). The word *promote* was used in relation to use of resources.

The ANMC (2006) Standards for the Nurse practitioner build on those for the registered nurse, and assume a goal of meeting the unique needs of 'specific client/patient populations' (ibid, p. 38). While primary health care, health promotion, or population health approaches are not explicitly mentioned, a few elements may be attributed to their underpinning principles. There are three main standards which overlay a total of nine competencies within the document. Within the nine competencies there are a total of 43 performance indicators.

Within competency 1.3 a single performance indicator refers to public health in suggesting the nurse 'actively engages community/public health assessment information to inform interventions, referrals and coordination of care', and in doing so one element of 43 suggests using 'critical judgement to vary practice according to contextual and cultural influences' (ANMC 2006, p. 39). Another one of the nine competencies relates to a systems approach suggesting that the nurse 'engages in and leads an informed critique and influence at the systems level of health care' (ibid, p. 40). A single performance indicator in this area suggests that the nurse 'evaluates the impact of social factors (such as literacy, poverty, domestic violence and racial attitudes) on the health of individuals and communities and acts to moderate the influence of these factors on the specific population/individual. While collaboration was mentioned eight times it was used in the same way as in the registered nurse standards, within health care systems for example 'clinical collaboration' and in establishing 'therapeutic links' (ANMC 2006, pp. 40 & 39). The word 'promote' was used once only. This was in the context of promoting the nurse practitioner role (ANMC 2006). This represents a marginal proportion of the entire

document which is otherwise dedicated to supporting individualised one to one primary care approach to client/patient care.

The ANF *Standards for the Advanced Registered Nurse* comprised 12 standards and 58 elements (ANF 1997). There is very little embedded primary health care discourse. Standard 2 for example talks of managing the care of individuals and groups however it confusingly proceeds to state that 'practice of the advanced registered nurse is consistently client centred' (ANF 1997, p. 7). In this critique I initially understood the 'client' to be an individual, however if the client was understood to be a group or other health professional, this would expand the scope of practice. Collaboration is mentioned in Standard 3. However, like the previously discussed standards these primarily relate to collaboration within health care teams. Advocacy is notably mentioned in Standard 7 which claims the need to advocate and protect the right of individuals or groups. Promotion is mentioned in two areas one for promoting continuity of care (2.5) and another promoting learning of colleagues and others (4.7).

While collaboration was mentioned through out all three of these documents it was only for collaboration *within* health care practice. Promotion, also used in all, often related to promotion of aspects of nursing practice. All three talked of working with individuals and groups; however, the expression of care was primarily for the individual or group already with a health problem.

From this analysis, the commitment to primary health care practice, as stated in core competency standards, is ambiguous and at times appears to be limited to a selective approach. The specific *Clinical Competencies for Child and Family Health Nurses* (CYWHS 2006a) and the *Competencies for the Specialist Paediatric and Child Health Nurse* (ACPCHN 2000) have a greater attention to discourses of primary health care embedded in the standards. It appears to be within nurses' scope of practice to work with communities to identify needs such as social isolation for new arrivals, and to work with these communities to build supportive environments. There seems however little evidence in the Australian competency standards previewed to support this level of primary health care. How principles of primary health care, primarily within specialist competency standards are enacted, as nurses' work with ideas of culture and communication in their everyday work will be considered throughout this thesis.

Population health

The call for a population health approach to care is present in South Australian Governmental reports and professional clinical standards. *Better Choices Better Health* (Department of Human Services & Menadue 2003) for example, recommends a fundamental shift in perspectives and priorities from individual health service priorities to a collectively focussed population health strategy . The report specifically notes the challenge to promote cohesion, improve coordination and integration ‘without losing the ability to remain responsive to local and regional communities’ (ibid, p. 7). As population health features prominently in policy documents relating to child and family health, understanding what it means and how it is operationalised is important. In the next section I explore what constitutes a population approach to care and how population health approaches might be seen in the child and family health workplace environment.

While no clear definition of a population approach to health is offered in *Better Choices Better Health*, four strategies are given to promote a greater focus on population health in the South Australian health system (ibid). These are ‘planning for defined geographical population, a population approach to health funding, population service planning and population based health governance’ (ibid, p. 8). It seems that planning and funding is based on population needs assessments using indicators of health service needs within regions. Governance of population based health suggests the need for a principle governing body for central control, direction and responsiveness. However, this also requires the ‘dissolution of incorporation of all health units and the integration of their management into regional health services’ (ibid, p. 8). This has the potential to erode strongly founded community capacity for those communities who have invested in their local health services. There is a risk that in seeking centrality of control of a ‘population’, the locus of control for smaller regional communities may be lost, along with their pre-existing social capital.

Population approaches, in this sense, appear concerned with equity of service delivery and access to funding among the population and identification of health needs within communities. This is confirmed in *First Steps Forward* (Department of Human Services 2003b) where a population approach is associated with a funding model that will be determined by needs and priorities identified through both regional and state-wide analysis .

Every Chance for Every Child (Department of Human Services 2003a) clarifies that a population health approach is one underpinned by a view of health that is more than the absence of disease. As a primary health care strategy, ECEC advocates for universal services that address the entire range of individual and collective factors that determine health (ibid). It follows the *Canadian Population Health Template*, which, describes a population approach as improving the status of health of the entire population as well as reducing inequalities between population groups (Health Canada Population and Public Health Branch 2001).

The CYWHS *Clinical Competencies for Child and Family Health Nurses* (2006) also draw from Health Canada's (2001) definition of population health. The clinical competency standards further detail that population health is underpinned by the key determinants of health that impact on a population's wellbeing. These determinants include housing, education, social and economic security, cultural connectedness and safe environments. This is linked to the CYWHS 2005 Strategic Plan 2005-2010 (2005a) and underpinned by four key principles of a population health approach outlined by Baum (1998a). These are; a focus on the determinants of health, on health outcomes and equality of health outcomes, on a whole of life span approach to health, and a recognition of health as a human right (ibid).

As fundamental to public health, population approaches consider the health of all not just the individuals within the population (Baum 1998b). From the epidemiological work of Rose, a population based strategy 'seeks to control the determinants of incidence in the population as a whole' rather than a preventative strategy that simply 'seeks to identify high-risk susceptible individuals and to offer them protection' (2001, p. 993). A population based strategy destabilises the dichotomous terms dominant in medical thinking such as 'sick' or 'healthy' which proposes that an individual simply either has a disease or does not (Rose 1992).

Rose argues that 'the idea of a sharp distinction between health and disease is a medical artifact for which nature, if consulted, provides no support' (1992, p. 6). He continues asserting rather that there is a continuum of disease and risk that occur within the context of a whole society. Using social and medical problems Rose explains that the 'average' predicts the 'deviant'. Calculating, for example, a populations' average weight will indicate the prevalence of obesity. Through this Rose shows that 'deviants are simply the tail of the populations own distribution; they belong to each other and society is one, whether it likes it or not' (ibid, p. 64). This argument proposes that the marginal tail enders are a part of a society whole

therefore responsibility of their care is placed alongside the care of all. It removes the notion of charity to those less fortunate or deviant, as the 'problem' groups are inseparable from the rest of society.

Given the benefits to the whole of society from a population approach Labonte et al. (2005) present a key criticism, that the model does not interrogate why differences in social stratification come into being, and further, how these differences and subsequent social inequities and health disparities relate to capitalism. They summarise that it is not enough to describe inequalities. It is rather necessary to look for root causes of poverty within these groups. They present arguments that suggest there is a greater need for theory to understand social and economic relations. Methodologically they claim the primarily quantitative data driving epidemiological research strips the sociological context and leads to a continuing dominance of risk factor rather than root cause epidemiology. A compounding problem is that human agency remains absent. The organisational means through which people can and do influence their health care outcomes can be considered. A final point is that the neo-liberal context of health care delivery in most OECD countries undermines a population health approach through reduced social spending on health education and welfare (ibid).

From this analysis it seems that South Australia has begun to turn toward a population approach both to reduce the economic burden of disease on the community as a whole, and to increase a focus on the early developmental environment. Collaboration between health education and welfare within a neo liberal government is a positive step. Highlighting the need for population approaches in policy demonstrates commitment to the approach.

The approach to child health in South Australia is population based; a universal approach to access, and then referral into sustained programs for those families identified as being at risk but with potential to change. The focus of the child health nurse is individualized within this population model. As individualized, it has context and recognises and supports the development of human agency. The challenge is to see how the individualized clinical focus works within a population approach, in an intercultural context.

Partnership

The CYWHS competencies for the child and family health nurse situate practice within the context of family partnerships (Children Youth and Women's Health Service 2006a). They specifically refer to the Family Partnership Model, otherwise known as the Parent Advisor Model (PAM) (Davis, Day & Bidmead 2002). The competencies expressly refer to a focus on building relationships with families, and moving from 'expert' to 'partner' (CYWHS 2006a, p. 5). They clarify that partnership involves the family taking an active role in the therapeutic relationship and in problem solving (ibid). While there is a dearth of literature relating to partnership approaches between organisations and within communities in the context of primary health care⁹ the CYWHS approach clearly relates to the relationship formed through clinical practice with individuals and families.

The ACPCHN standards of practice incorporate a broader approach to an 'undisputed ideal...of partnership-in-care' (2000, p. 6). This approach is articulated as important to establish the fundamental notion of caring in relationships that supports cultural diversity and safety. Partnership in these competencies relates to working with 'families, children, young people and communities to provide optimal opportunities for improved health outcomes' (ibid, p. 6). Unlike the CYWHS standards, where definition is confined to the family taking an active role in care and problem solving, the ACPCHN standards offer a definition of the notion of partnership-in-care.

In a concept analysis of partnership with clients, Bidmead and Cowley (2005a) suggest that an antecedent to the establishment of partnership in care is a model of health visiting that explicitly frames the client/professional relationship. The CYWHS competency standards appear to set a partnership model of client/professional relationships for the explicit purposes of health visiting. The ACPCHN standards compliment the CYWHS standards by framing the partnership of interpersonal relationships, within the wider context of communities.

A further point of interest in the CYWHS competencies is that partnership is invoked as a way forward in problem solving identified issues. This perhaps, is based on the assumption that there will always be problems to solve. A premise of a primary health care approach is that universal primary health services support, maintain and

⁹ For example, in a health promotion context a partnership is 'a voluntary agreement between one or more partners to work cooperatively towards a set of shared health outcomes' (World Health Organisation 1998, p. 17)

promote health across the whole population. Unlike a medical model, people who are well are entitled to preventative access and care. In a wellness situation there may not always be problems to be solved.

Robinson cautions that a 'problem oriented' approach such as developmental screening is based on a medical model (1982) returns practice to an expert approach that may limit power sharing. Given that the primary task of child health nurses in a South Australian Universal Contact Visit is infant developmental screening, assessment of infant maternal attachment and assessment of parental psychosocial issues, this problem oriented approach may impact on the delivery of partnership in care, purportedly within a primary health approach. The intended purpose of the contact may conflict with the underpinning contexts of primary health care, population health and partnership

Bidmead and Cowley identified that a negotiated agenda is central to a partnership approach (2005a). They further suggested that a top down agenda can potentially prevent the establishment of a partnership based relationship. This presents a potential barrier or conflict for nurses working in universal screening programs such as a Universal Contact Visiting program.

These considerations create a paradox where health screening is routinely undertaken as a major preventative primary health strategy. Perhaps individual client and population outcomes, depend on how partnership is approached. This consideration makes it vitally important to investigate how child health professionals communicate about parenting, particularly when this communication is with those from vulnerable groups such as women and children who are migrants or refugees in South Australia.

In summary

In this section I have described current approaches to child and family health in South Australia particularly as they relate to child and family health nursing. This practice is framed by both National and State government policy directives that have responded to global trends in health promotion. Recent national and state inquiries into the health, education and welfare of children have resulted in moves towards population based approaches to care. These approaches, aiming to address health inequities across the life span have given particular attention to the years of early childhood. There remains, however, some conflict around how these approaches

intersect with constructs of comprehensive primary health care within service provision.

Child and family health practice is also informed by various competency standards that appear at times to attend primarily to a focus on care of those who are ill rather than maintenance of those who are well. Critique of the competency standards suggests three key themes of relevance to this study. They are the areas of primary health care, population health and partnership.

Analysis in this chapter suggests that the child and family health nurse in South Australia has a role within primary health care that relates to individualised health care, promotion and intervention in the context of community. Care is determined through a population based strategy that calls for universal care through universal contact and targeted health interventions. Partnership as a term is used to mean different things in the various competency standards. Where CYWHS standards focus on a shift away from expert based practice to a partnership model at an individual interpersonal level, the ACPCHN standards contextualise partnership in care across populations and communities. The way partnership is interpreted and enacted appears to have the potential to influence individual and population based health outcomes.

CHAPTER 4

CULTURE AND COMMUNICATION

Introduction

Following the bombing of the World Trade Centre in New York on September the 11th 2001, there has been extensive media and community attention to difference associated with migrants and refugees. In particular, prejudice against Muslims has been on the ascendancy. In Australia, this prejudice was made public during the 2005 Cronulla riots. During this time there was keen media commentary on constructs of multiculturalism, citizenship and being Australian. In this climate, it seems more urgent than before that the effects of communication and culture are better understood in the everyday workings of health care. In this chapter I situate current understandings and applications of culture and communication in the health care workplace and explain how notions of culture and communication are used and applied in this thesis. In doing this, I demonstrate how relations of language, power and culture are inherently entwined and are central to all health care relationships.

Making sense of the term 'culture'

The concept of culture has evolved historically in relation to dominant world views of the time. Professional disciplines have always had a range of competing definitions of culture in reference to dominant epistemologies. In the West, it seems that until the 1970s there were mostly 'grand truths' about culture which were assumed as universal. Professional disciplines have embraced and promulgated these 'grand truths' through education programs and professional competencies. Western interpretations of culture are, however, built on an Anglocentric tradition of continued acknowledgment and validation of paternalistic white male supremacy.

Raymond Williams, a prominent theorist and researcher of culture, states that 'culture is one of the two or three most complicated words in the English language' (1976, p. 76). In common twentieth-century usage, *culture* generally refers to different cultural groups, where *culture* in the anthropological sense represents a particular way of life, as in, for example, an ethnic group.

In Australia, nationhood is represented through concepts of multiculturalism and multiculturalism, where culture is understood to represent different ethnic groups and associated ways of life. While this concept has been useful to value the range of

cultural identities within the nation, it is at times problematic, as it does not account for the fluid and hybrid nature of disparate cultural groups. Neither does it account for relations of power inherent when minority groups are collectively relegated to the margins of nationhood. The majority of Australia's population, from Anglo-Celtic and Anglo-Saxon decendency, do not locate themselves at the margins, and thus have little vested interest in multiculturalism (Hodge & O'Carroll 2006). Multiculturalism is, therefore, often viewed as only relevant to the 'cultural other'. Bourdieu and Wacquant (2001, p. 3) argue that multiculturalism is a 'screen discourse' and threatens the dominant culture's middle and upper classes' access to instruments of (re-) producing their own normative cultural standards (ibid 1999, p. 42).

Williams (1976, pp. 90-91) laid the platform for considering class in structuring understandings of culture that increased the complexity and scope of the term. Feminist theorists realised the category of gender in cultural debates (see, for example, Cunneen & Stubbs 1997; Martin 1996), where postcolonial theorists expanded understandings to explore ideas of dominance and marginality (see, for example, Fanon 1968; Hall 1992, 1997b). Categories such as ethnicity or race, class and gender are intrinsic to the concept of culture. How these categories are constructed in a community is dependent on the interplay of power relations between dominant and marginal interest groups.

In other definitions, 'culture' can be possessed. Through a process of intellectual, spiritual and aesthetic development, one can become 'cultured'. In this way, culture can be named as high art, such as works and practices of intellectual and artistic activity. Emerging from eighteenth-century sensibilities, these applications saw culture as 'the best that has been thought and said in the world' (Arnold 1979, p. 6).

This approach is also problematic, as it assumes that there is a singular position of 'best' to be achieved or owned. These perceptions originated from Western systems of scientific reason and ideas of grand or universal truths. Problems also arise from who was able to determine the nature of these truths. Applying this concept of culture to class struggles between the aristocracy and the burgeoning democracy of the masses, Arnold (1979) suggested that the only way for the masses to become equal with the aristocracy was through the pursuit of perfection. This perfection would be achieved by exposing them to high art, the cultural domain of the elite. Arnold saw culture as a means to an enlightened end, not as a construct of and within itself. This belief was supported by British political and philosophical views of

the time, that is, the belief that 'primitive' people were living replicas of more civilised Westerners, but further down the great chain of humanity.

This pursuit of enlightenment can be traced to fifteenth and sixteenth-century philosophers who troubled over how to represent human beings discovered in non-occidental Europe. By linking this discovery to the story of creation in Christian grand narratives, Auguste Comte developed a theory of the 'great chain of being'. Vidich and Lyman (1998, p. 50) explain that this chain was built on three stages wherein '...human societies moved from conditions of primitive culture to those of modern civilization'. In 1911, Gray suggested that anthropologists could work towards affecting the conditions of the life of natives in the colonies in order to advance them culturally. By addressing humanitarian concerns for those perceived as less fortunate than themselves, they were also paradoxically fortifying the conquering nations' position of superiority in a global context.

Artifacts, biological samples and primitive people themselves were appropriated under the moral legitimisation of Charles Darwin's theory of evolution, where only the fittest or strongest were believed to survive. For the human population, survival was contextualised within modern Anglo terms.

In social Darwinist theories, individuals and groups were categorised through identification with particular social or ethnic groups established by unfounded biological determinism. Cultural determinism, as an associated logic, was measured as the level of an individual's attendant 'civilisation' (Lewis 2002, p. 189). The impact of these historical interpretations of culture continues to be felt in the multicultural that is Australia today, through discourses of assimilation and acculturation. (see, for example, Attwood & Markus 2007; Markus 2001; Neill 2002).

From contemporary cultural studies, Williams also defines culture as 'the signifying system through which necessarily (though among other means) a social order is communicated, reproduced, experienced and explored' (1981, p. 13). Jordan and Weedon explain that this approach to culture incorporates economic, social and political spheres; that 'culture is a set of material practices which constitute meanings, values and subjectivities' in particular contexts (1995, p. 8). In this final definition, clear links are made to understandings applicable to this research study. In seeking to understand culture, this study looks to understand how we, as a diverse group of child health professionals, make meaning of our world, and how

those meanings both constitute and are constituted by our values, beliefs and assumptions.

Contemporary considerations of culture or being cultured are not predicated on relationships to dominant groups, but understood in the context of the relations of power between these groups. The significant question for this study is how child health professionals make meanings of their world, and how these meanings might shape intercultural communication.

Socially constructed understandings of culture are drawn from anthropology, where Clifford Geertz defines culture as 'an historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by meaning of which men (sic) communicate, perpetuate, and develop their knowledge about attitudes towards life' (1973, p. 89). Lewis, from more recent approaches in cultural studies, extends this definition by suggesting that 'culture is an assemblage of imaginings and meanings that may be consonant, disjunctive, overlapping, contentious, continuous or discontinuous. These assemblages may operate through a wide variety of human social groupings and social practices' (2002, p. 13). Where Geertz presents culture as a system of inherited conceptions, Lewis suggests that the meanings and imaginings of culture are fluid and changing and often conflict within particular cultural groups. These ideas of multiple and competing realities align with poststructural and postmodern world-views. Within this domain there are no absolute truths; symbolism replaces materialism, and the micro-dynamics of power are traceable.

The approach to understanding culture in this research is based on contemporary ethnographic interpretations of culture as material practices that constitute meanings, values and belief systems. Culture is about the meanings people make of their everyday experiences in the world; how they negotiate cultural formations and experiences. Following a critical cultural approach, I foreground an understanding that power dynamics operate at both the micro level of the interpersonal relationship and the macro level of structural social order. Both micro and macro social constructions at times act to constrain individual action and at others to provide opportunities (Lynam et al. 2007). Culture is thus constructed and reconstructed, remaining fluid, and always negotiated within relations of power.

Cultural competence and other competing terms

There are a multitude of theories and terms used by professional disciplines to talk about their particular approaches to providing culturally appropriate care. Terms such as cultural competence, cultural sensitivity, cultural awareness, transcultural nursing, and cultural safety are used to describe the approaches taken to meeting the needs of people who are culturally different to those within the mainstream population. In Australia, Eisenbruch et al. refer to an 'explosion of cultural competence theory in health' (2002, p. 127). They state that theories of cultural competence are applied across many health care disciplines to areas of medicine and health science. These areas include clinical matters such as diabetes education, developmental and life cycle areas, antisocial behaviours, health consumer satisfaction, medical ethics and refugee health, primary care and public health. Despite the seemingly wide application of theories of cultural competence in health, the lack of consistency in definitions and approaches is disconcerting. The terms are often used interchangeably and therefore remain poorly defined in their application. This suggests a fundamental confusion in understanding the nature of culture and role of the health professional as a cultural being.

In this section I explore the notion of cultural competence in the Australian health care arena and consider the meanings of culture embedded in these approaches. Following this, I consider how self-awareness is understood as part of cultural competency. I reflect on how this relates to models of cultural safety within historic context of transcultural nursing. As the majority of participants for this study are nurses, I draw mostly from nursing literature. However, as child and family health care is a multidisciplinary endeavour, I also refer to relevant literature from medicine and allied health.

Cultural competence

In Australia the National Health and Medical Research Council (2005) responded to the need to embed cultural competency into Australia's health care system by producing a guide for policy makers, managers, professionals and individuals. They follow Cross et al. (1989) in defining cultural competence as:

a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross cultural situations. (National Health and Medical Research Council 2005, p. 7)

Core to this model is valuing diversity, cultural self-assessment, awareness of intercultural dynamics, and institutionalisation of cultural knowledge. Following the Australian Indigenous Doctors Association (Royal Australasian College of Physicians 2004) adaptation of service delivery, it reflects 'an understanding of diversity between and within cultures' (NHMRC 2005, p. 7).

Models of cultural competence based on multiculturalism are criticised for increasing distances between cultures (Andersen & Collins 1998), thwarting cultural acceptance and integration (Iyer 2000), marginalising cultural concerns to those outside the dominant white majority (Hodge & O'Carroll 2006), reinforcing middle class normative positions (Bourdieu & Wacquant 1999, 2001) and racial superiority (Swendson & Windsor 1995). In framing cultural competence, the NHMRC attended to these arguments by clearly stating that 'achieving culturally competent health care is everybody's responsibility', and that cultural competence can only be achieved through partnership and participation (2005, p. 3). This position of social inclusion and reciprocity is further reinforced by the repeated use of the term *cultural diversity* rather than multiculturalism.

Having framed a pluralist, inclusive approach to cultural competence, the guide surprisingly does not attend to definitions of culture. Culture is perhaps assumed. Cultural and linguistic diversity is a phrase used in the guide to describe the range of cultural groups that make up Australia's population. The historical complexity of this diversity is reinforced as stemming from Australia's pre-settlement indigenous populations and various waves of migration beginning with convict settlement. However, the term 'culturally and linguistically diverse (CALD) background' is used throughout the document to represent people who are not from mainstream white Anglo backgrounds. In this way, 'culture' appears to be held by those who are ethnically different to those from Anglo backgrounds.

This is reinforced in the competency tables for professional specifications (NHMRC 2005, p. 37), where health professionals are suggested to engage in self-reflection. However, this self-reflection refers specifically to understanding the cultural and linguistic backgrounds of clients and reflection on their adaptation to cross-cultural situations. Information requirements are specific to knowledge of CALD communities and services for CALD clients (ibid, p. 38).

Within the nursing profession, cultural competence is cited as a recognised approach by the International Council of Nurses (2005). Cultural competence is

described as 'a practitioner's or institution's [attitudes], understanding and sensitivity to the cultural background and primary language of the patients in any component of service delivery' (ibid, p. 13). The Australian Nursing and Midwifery Council (2006) only use the term cultural competence in *Competency Standards for the Nurse Practitioner* (ibid, p. 39). The *Competency Standards for the Registered Nurse* suggest that the nurse 'recognises that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual's responses to, and beliefs about, health and illness' (ANMC 2006, p. 3) and, further, that the nurse 'accepts individuals/groups regardless of race, culture, religion, age, gender, sexual preference, physical or mental state' (ibid, p. 4).

Specific to child and family health nursing in South Australia, the *Clinical Competencies for Child and Family Health Nurses* (Children Youth and Women's Health Service 2006a) do not use the term cultural competence, referring instead to cultural respect (ibid, p. 19). Like the NHMRC professional specifications, cues for achieving this competence rest on understanding specific health issues and working collaboratively with clients from Aboriginal and CALD communities. These competencies do, however, specify the need for clinical reflection which includes self awareness.

While these documents recognise the importance of sensitivity to patient/clients' cultural backgrounds, there remains no definition of what constitutes culture or to whom it applies. One is left to assume that culture is something that only patients or clients have. Indeed, the ANMC competency standards' position of equity and fairness extends to accepting people *regardless of*, or without regard to culture. Culture within cultural competence and cultural respect appears to be articulated within narrow margins of ethnicity and difference, aligning it with the culturalist approach embedded in discourses of multiculturalism.

In the allied health literature, the problem of disparity in understanding culture and cultural competent practice led to the Intercultural Interaction Project, commenced in 1992 in the School of Occupational Therapy at the University of Sydney (Fitzgerald, Williamson & Mullavey-O'Byrne 1998). Through an exploration of culture and communication issues in practice, the project identified that 'therapists and other health professionals appear to enter into interactions with clients with a limited understanding of the concept of culture and it's potential effects on the interaction' (Fitzgerald, Williamson & Mullavey-O'Byrne 1998, p. 61). Ongoing work with this

project also identified a need to better understand how culture influences ideas about families and how to work with them (Fitzgerald 2004).

It seems that, while engaging with and theorising the term cultural competency is a useful way forward for intercultural health care, without explicit consideration of the nature of culture, practices advocated to promote cultural competence, remain uncritically culturalist, that is, embedded in and reinforcing notions of anthropologically based disparity.

Self-awareness – self-reflection

Self-awareness and reflection appears to be a central component of cultural competency in Australia. How this is represented varies between models of care aimed at reducing health care inequities. All models of culturally competent care specified through national and professional bodies incorporate a consideration of self-reflection. This was also found in nursing, medical and allied health literature (see for example Campina-Bacote 2003; Eisenbruch 2003; Fitzgerald, Williamson & Mullavey-O'Byrne 1998; Smith 1998).

The change towards self-reflection is replicated in the USA report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, where there is a call for more research to explore social cognitive processes that influence 'patients' and providers' conscious and unconscious perceptions of each other' and how they 'affect the structure, processes, and outcomes of care' (Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care 2002, p. 237). While all health disciplines are moving towards more explicit attention to the primary need for self-awareness in developing cultural competence, it is questionable whether this is sufficiently robust on its own to support change in practice.

Cultural safety

To understand the process of self-awareness from a perspective that resists culturalist interpretations of competent care, I turn to Irihapeti Ramsden, a Maori nurse academic. Within the framework of providing culturally safe care, Ramsden situates self-awareness within the context of historical social political understandings of self. Self-awareness is the first of a three-step process of becoming a culturally safe practitioner (Ramsden 1992). Following this, the nurse moves through cultural sensitivity towards cultural safety. The Nursing Council of New Zealand (NCNZ)

adopted Ramsden's work as a national guide for nurses. The NCNZ define cultural safety as:

the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognizes the impact of the nurse's culture on own nursing practice. (2005, p. 4)

Attitudinal change is the goal of self-reflection whereby the nurse is involved in a four stage process:

The first stage involves finding out what you have, the second stage is to dismantle it, the third stage is to put something else in its place and lastly, the fourth stage is translating the changes into action. (Ramsden 2002)

Cultural safety therefore refers to the provision of health care by clinicians who recognise the self as a cultural being, the rights of others and the legitimacy of diversity and difference (NCNZ 2005).

Cultural safety takes social justice as its starting point. In combining with critical approaches to culture, it is constructed as much more than cultural practice. Education is focussed on developing knowledge of the self as a cultural being who also understands that social privilege is attached to race and ethnicity, and that social privilege is unequally distributed in our society. It does not attempt to learn about other cultural groups as a separate activity from this awareness. This is based on the premise that 'a nurse who can understand his or her own culture and the theory of power relations can be culturally safe in any context' (ibid, p. 4).

Conceptualised in the bicultural context of New Zealand, cultural safety makes explicit the relationship between individuals and power and race relations in a postcolonial context. Ramsden (2002) developed the theory of cultural safety because of what she saw as the inherent inadequacies of culturalist approaches to intercultural care. These were mostly predicated on the transcultural approach to nursing created in North America by Madeleine Leininger.

Transcultural nursing theory, adopted widely throughout Western nations, is underpinned by an ontological assumption of culture from a traditional anthropological perspective (see, for example, Leininger 1997; Leininger & McFarland 2006). In this understanding, groups or 'cultures' are distinguished by common customs and ways of being in the world, informed by a national or common

'spirit' (Jordan & Weedon 1995). Leininger also embraced the humanistic ideology of the 1970s to argue that, despite difference, there is an underlying unifying humanity that binds people whereby all people are fundamentally the same.

This approach, while contested in the literature, remains visible in current-day practice. For example, the present-day Australian Nursing and Midwifery Council (2006) *Competencies for the Registered Nurse* continue to direct nurses to act *regardless* of cultural differences. Almost two decades ago, Ramsden (1990, p. 1) argued:

The idea of the nurse ignoring the way in which people measure and define their humanity is unrealistic and inappropriate ... People are still prepared to die in order to maintain their cultural, religious and territorial integrity. It is not the place of the nursing service to attempt to deny the vital differences between people, however altruistic the rationale may be.

Cultural safety therefore requires that individuals receive care that accounts for 'all that makes them unique', rather than having these differences disregarded (NCNZ 2005, p. 5).

Debate in the nursing literature over the past two decades has been polarised around the epistemological and ontological positions of transcultural nursing theories and cultural safety. These are well described and documented (see, for example, Bruni 1988; Cooney 1994; Coup 1996; Gustafson 2005; Papps 2002; Ramsden 2002; Ramsden & Spoonley 1994). In the next section I summarise key points from these debates that illuminate underlying assumptions of meanings and ownership of culture, central to this inquiry.

Locating culture in transcultural practice and cultural safety

Transcultural nursing theory, Ramsden argues is based on multicultural assumptions which assert the value and rights to difference of all cultural groupings. It does this without recognition of the cultural dislocation and devastation that have resulted from the ongoing effects of social power in established race relations between non-indigenous and indigenous peoples and between the dominant cultural group and linguistically diverse immigrants to the country. This multicultural approach similarly leads to health inequities for people who are migrants or new arrivals to a normative Western society. This approach ignores the differences in power among ethnic groups and ultimately manifests in racism that often leads to inequalities in health care (Polaschek 1998). Polaschek contends that cultural risk is

not isolated to being indigenous but is associated with 'being in a minority culture that is oppressed by a dominant group in society' (ibid, p. 454).

Although cultural safety was designed in the bicultural context of New Zealand, it is a useful lens through which to work with peoples from all populations who experience marginalisation due to their 'cultural' differences.

In Leininger's transcultural framework, the health professional always premises their ability to work with culture on the strength of their understandings of those who are marked as different to themselves. By seeking always to understand those who are different to the self, the complicity of the self within a history of colonisation is ignored. Gustafson, a Canadian community health researcher, argues that transcultural approaches to care 'reinforce rather than transform, the social practices and relations that are embedded in, and mediated by, the hierarchically ranked social order both within and beyond nursing (2005, p. 3). This approach leaves unattended historic and situated issues of gender, race and socioeconomic inequalities. In transcultural approaches, the intersections of gender, race and socioeconomic inequalities are played down in order to construct and problematise difference according to classical ideas of 'cultural' and ethnic affiliations (Culley 1996; McConaghy 2000; Mulholland 1995).

Cultural safety as a theory and practice for nurses and midwives to work with culture is mandated in New Zealand (NCNZ 2005), In Australia, cultural safety is employed at the level of policy and educational direction for nursing practice (see for example Australian Nursing and Midwifery Council 2007; Congress of Aboriginal and Torres Strait Islander Nurses 2007) and as a component of broader guidelines for culturally competent health care (National Health and Medical Research Council 2005). The NHMRC guide also uniquely articulates cultural competence as a relationship between the person being helped and the helper which necessitates an awareness of both cultures

It seems, however, that when cultural safety is integrated into models of cultural competence, recommendations for implementation continue to focus on understanding the culture of others without similar attention given to the culture of the health professional. The core ontological position of valuing multiple cultural truths and the historic sociopolitical impacts of relationship between these truths remain unattended. While reflection on practice is recommended, this reflection continues to focus on the health experiences of the cultural other rather than, as

directed in a culturally safe model, on the cultural identity of the health professional and the impact of this identity on the health experiences of those for whom they are caring.

Strategies for implementation continue to focus on the core epistemological position of cultural safety as an outcome experienced by health consumers in response to health professionals' reflection on their own cultural identity. It seems, however, that when cultural safety is absorbed as part of a strategy, it is mainly used at the level of recommendations for professional education. While it has been taken up in some instances in working with people from indigenous populations (see, for example, Australian Indigenous Doctors Association & The Royal Australasian College of Physicians 2004), it has not been taken up for broad use within nursing to include all populations who experience discrimination because of social and economic inequities. Richardson (2003, p. 35) argues that 'the concept of cultural safety provides for the formal recognition of power relations within health care interactions'. It enables an exploration into assumptions underlying practice and is effective on personal, professional and institutional levels of enquiry (ibid).

For this study, a position of cultural safety is an essential lens through which to critique intercultural communication in the child and family health setting. It enables an analysis of communication practices that does not separate the communicator from the context of historical knowledges of social, cultural and political influences on parenting. This context is seen as integral in the formation of the parenting support practices where service providers construct information and the therapeutic approaches for their everyday work with parents.

Communication: a therapeutic approach to care

Communication is the central therapeutic tool that underpins all health relationships and interactions. Particularly in the area of child health and parenting, we know from the work of Hilton Davis, Crispin Day and Christine Bidmead (2002) that parental support is determined not only by what potential helpers do, but by the characteristics of the people providing the services and the relationships they develop with parents (Davis & Spurr 1998), that is, how they communicate and form relationships.

As discussed in chapter 1, communication is also one of the major barriers to health care for consumers from minority groups. These barriers lead to health inequalities

and poorer health outcomes for some adult consumers and their children. In South Australia, this group includes parents and children who are migrants or new arrivals to South Australia. They are identified by the SA Generational Health Review as being at risk of health inequalities (Department of Human Services & Menadue 2003).

A complicating problem is that the health care literature is not always explicit about how and what it is helpful for child health professionals to communicate. As discussed in chapter 1, for example, literature on the 'best ways' to settle a baby to sleep is conflicting. How, for example, does the health professional support a parent accustomed to co-sleeping when the preferred practice in industrialised Western culture is to place a baby in a cot in a separate room from the mother where they experience sleep as an independent activity?

To foreground the context of communication for child health professionals in this study, this section explores the underpinning assumptions embedded in approaches to communication privileged within the Child and Family Division of the Children Youth and Women's Health Service, where this research took place.

Organisationally sanctioned communication

The Parent Advisor Model¹⁰ (PAM) devised by Davis et al. (2002) was adopted in 2002 as a state-wide approach to care in the Child and Family Division of the Children Youth and Women's Health Service in South Australia. Developed in the United Kingdom, the PAM draws on the work of George Kelly (1955), Carl Rogers (1959) and Gerard Egan (1990). As a universal pedagogic tool, the PAM has a role in shaping and reshaping cultural production within child health practice.

Using a textual feminist and postcolonial analysis, this section explores culture and multiculturalism in the PAM, particularly how the model can be understood and worked with in communities that may not share with the dominant cultural group the same assumptions about 'self' and 'other', about knowledge, and about the universality of particular truths.

While the PAM may be very useful, its intended universal application is problematic (Grant & Luxford forthcoming). To understand issues of culture within the Parent Advisor Model, postcolonial and feminist discourses bring a potent challenge to the

¹⁰ Also referred to as the Family Partnerships Model.

assumptions embedded in liberal humanism as the core belief system that underpins policy and practice related to multiculturalism in Australia.

The Parent Advisor Model

Based on the concept of Socratic questioning (H Davis, discussion following presentation, 30 March 2006), the Parent Advisor Model offers a well-intentioned and helpful systematic problem-solving approach for working with parents. The notion of shared responsibility is flagged early, when it is noted as a vehicle to effectively deliver professional expertise 'while maximizing the parent's contribution to the specific problem area' (Davis, Day & Bidmead 2002, p. x). The role of the professional in this shared approach is described both in terms of advice giving and enabling, stressing the value of listening as it 'accords respect, dignity and belief in parents' (ibid, p. xii).

The PAM was developed in response to a number of concerns. These included the need for a universal system of psychosocial support for parents which otherwise was dependent on the hit-and-miss approach of the personal interest of particular health professionals (Davis, Day & Bidmead 2002). Research by Davis et al. into the help-seeking behaviours of parents found no indication that parents who most needed help would necessarily seek it (see, for example, Attride-Stirling et al. 2001; Davis, Day & Bidmead 2002; Offord et al. 1987). The PAM was developed as a universal psychosocial approach to engage with parents and enable joint problem-solving and the development of parental self-efficacy.

This model was implemented in South Australia by the Child and Family Division of the Children, Youth and Women's Health Service in preparation for the implementation of a 'universal home visiting program' (Children Youth and Women's Health Service 2005, p. 6). Implemented in 2003, universal home visiting is a key action area of the South Australian *Framework for Early Childhood Services* (Department of Human Services 2003a, p. 14). As part of this framework, every family is offered a home visit within the first few weeks of their baby's birth for a health check and an assessment regarding follow-up service needs.

The PAM as presented by Davis et al. (2002) is articulated as an integral part of a systematic tiered approach to providing parental support. The approach has four coordinated service tiers, with universality of parental contact decreasing from the generalist service of the first tier to the specialist service of the fourth. They are tier one: all child health workers, tier two: solo child mental health specialists, tier three:

a generic child mental health team and tier four: a specialist multidisciplinary team. In the two community settings where the research was conducted, only level one services were provided. All participants were generalist child health workers, predominantly nurses, but social workers and medical officers were also included.

Within the PAM, Davis et al. recommend a number of key conditions. Firstly, 'individual workers should be selected for the qualities and skills needed to relate to and communicate effectively, as well as the technical expertise associated with their specific profession' (Davis, Day & Bidmead 2002, p. 7). They go on to state the need for 'managerial permission and the time to work in this way, but also on-going supervision to maintain and enhance their skills and motivation and support them under all circumstances' (ibid, p. 7).

Epistemological and ontological positioning of the Parent Advisor Model

Davis et al. utilise psychotherapy and counselling theory in the development of the Parent Advisor Model (2002), in particular 'George Kelly (1991) on how people adapt to their particular circumstances, Carl Rogers (1959) in terms of the fundamental characteristics of helpers, and Gerard Egan (1990), who has presented a systematic understanding of the helping process and skills involved' (2002, p. 10). What Davis et al. have not considered and addressed is the contemporary relevance of understandings of truth, knowledge and selfhood assumed from the modernist theories employed by Kelly, Egan, and Rogers in the 1950s. The currency of their application is tacitly held as being as relevant in today's globalised multiculturalism as it was historically. This section will apply epistemological and ontological understandings from postcolonial and feminist scholarship to question the twenty-first-century relevance of these assumptions.

Founding fathers of counselling

Kelly's seminal work *The Psychology of Personal Constructs*, originally published in 1955, presents a clear position on the nature of self, knowledge, truth and reality, and agency. These positions are embedded in the liberal humanist belief systems of the time. The 'self' is presented as universal and male (1955, p. 107, 110, 113). In validating his theory of personal constructs, Kelly uses mechanistic and scientific analogies, likening the human mind to that of a machine. He contends that as dichotomous constructs are useful in the scientific world, they are therefore equally useful in psychological theorising (ibid, p. 110).

These assumptions of 'self' confine and define the self to liberal Western constructs of normality, that is, an essential, universal self that is rational, white and male. In constructing this self, bodies other than white and male are 'othered', and race, gender and class are denied or represented as problematic. The self is also separated from the body and thus dehumanised. The body is viewed, in Locke's terms, 'as a mechanism to be adjusted, repaired and reprogrammed' (1986, p. ii) .

Considering assumptions about 'self' and 'other', Michelle Fine draws our attention to the need to work the hyphen, that is, to 'unpack notions of scientific neutrality' and 'universal truths' (1998, p. 131). This is similar to the in-between spaces in Bhabha's (1990) work, and the three-body analysis of Hodge, introduced in chapter 2. The theory of personal constructs is an explanation for how people make sense of information and create personal knowledge. These constructs operate as a binary system called constructive alternativism (Kelly 1955, p. 105-107) along a linear continuum (ibid, p. 128). The process of constructive alternativism is 'embedded in the traditions of rationalism' and 'conforms to the basic tenet of modern scientific experimentalism' (ibid, p. 122). Ontologically, this means there is a singular truth to be discovered along the binary continuum. Individuals who do not make rational choices are potentially 'faulty or lacking in some essential part of their humanness' (Davies 1991, p. 3). Therefore, a client who parents in a way that is different to the dominant normative approach might be considered 'faulty' or 'lacking' in their humanness. This process of othering is thus ideologically sanctioned as a deficit model of care. The goal, then, of child health professionals is to assimilate the 'other' into the dominant culture's truths and 'rational' knowledge. They do this in ordinary, taken-for-granted mechanisms of communication.

I now turn to the work of Rogers and Egan. While they continue to leave unchallenged the dominance of the white middle-class male 'self', their ability to allow us to be generous in care dissolves resistance to these assumptions. Rogers contextualises the authority of white male knowledge, arguing that his theory of therapy, personality, and interpersonal relationships is created from both scientific rationalism and experiences of self and other within practice (1959, p. 185-189). He disregards grand theories of truth, preferring to view them as stimuli for creative thinking. However, he continues to regard truth as unitary and therefore singular and universal (ibid, p. 190-191). This is confused by a rejection of objective truths and the claim that 'man lives in his own personal and subjective world' (1959, p. 191). He identifies a stance against universal truths, preferring individualism within a

humanistic framework. In these terms, the individual is understood within a pervading individual/collective dualism (Davies 1991). Despite this tension, Rogers claims universality of application. In doing so, he ignores the effects of class, gender, race or ideology. Rogers claims fluidity in construction through perceptions of self, perceptions of relations between self and others and various aspects of life 'together with the values attached to these perceptions' (1959, p. 200). Davies contests that this personal development is 'denied to those not constituted as agentic, such as women, children, natives (to borrow a term from Trinh-ha) and the insane' (1991, p. 4).

As child health professionals, we tend not to dislodge our sense of comfort with the canonical texts of Kelly, Rogers and Egan as they appeal to our sense of equity and fairness through notions of unconditional positive regard and empathy. Such comfort with these canons is reproduced by their failure to take account of other world-views. How we enact practices of equity and fairness, however, is dependent on our contextual understandings of 'self' and 'other' as classed, raced and gendered. Contemporary child health practice is guided by the social imperatives of equality and equity in service delivery. However, the pre-existence of taken-for-granted views of self and other in the metatheories of Kelly, Rogers, and Egan continue to impact on practice, thus reinforcing neo-colonial practices despite a doctrine of equality and equity in service delivery. Construing 'self' and 'other' along a tightly framed binary inherently reinforces difference as oppositional. So how do Davis et al. account for and contend with the humanistic assumptions within the models of their forebears?

Application of historical assumptions in contemporary practice

Problematic assumptions about the nature of universal care are noted when Davis et al. state that this system of care is for all families 'whether or not their children have problems and regardless of the nature of their difficulties' (Davis, Day & Bidmead 2002, p. 5). Claiming care regardless of the nature of difficulties suggests of the authors that they act 'without regard to', pay no attention to and do not consider the nature of the difficulties of parents or children (*Macquarie Dictionary* 2008). This is contrary to the intent of the PAM. While the model appeals to the moral and ethical sensibilities of universalising healthcare discourses, we ask how using the term 'regardless', which is purported to be a unifying discourse within a universal system of care, contributes to the nature of care provided to parents who are migrants or refugees.

Discourses of liberal humanism are confusing when applied to perceptions of doing 'good' in universal terms. They espouse the notion of the individual freedom of the unified rational agentic being, freedom to express one's subject position. When agency is denied in the public sphere through non-recognition of 'the nature of difficulties' (Davis, Day & Bidmead 2002, p. 5), the rational agentic self is denied. From a postcolonial perspective, liberal humanist discourses appear available only when difference is manifested as 'sameness'.

In trying to treat everyone the same, community nurses subsume the needs of 'minority ethnic patients within the overall needs of a white majority population' (Gerrish 2000, p. 96). Practice that is irrespective of ethnicity is embedded in discourses of fairness and equity (ibid). Kate Gerrish found that health professionals positioning themselves in passive apolitical discourses of equity resulted in some minority ethnic patients being disadvantaged (ibid). If the idea of providing a universal service is to be more fruitfully and fairly provided, these discourses need to be challenged to prevent continued disadvantage of minority groups within health care.

Analysis of the PAM suggests a similar underpinning of apolitical humanist discourse resulting in the use and acceptance of negligent words such as 'irrespective' and 'regardless' and their attendant actions. The universal self is essentialised and notions of truth are internally constructed within an individual/collective dualism rather than discursively constructed in response to multiple available subject positions.

If multiple subject positions are denied through universalising discourses, I wondered how relations of power might be understood and enacted within Davis et al's construct of partnership, particularly in intercultural communication contexts.

Partnership and power

Partnership is the central philosophical tenet within the Parent Advisor Model. So central is partnership that the model has been renamed since data collection in 2004, as the 'Family Partnership Model' (Harcourt Assessment Inc 2007). Davis explained that the change in title occurred gradually in the international context following a request by Western Australian users of the model. The authors suggest that they are not sure about the new title but are disinclined to change as they can find not suitable alternative (H Davis, email communication 29 March 2008). Despite this debate, health professionals using the model remain known as 'Parent Advisors'

(Harcourt Assessment Inc 2007). While this may appear semantic, I suggest that this signifies participant confusion about the conflicting nature of expertise and partnership within the model and how it is to be enacted. An advisor gives advice. Naming the health professional as advisor immediately signals their position of authority within a relationship. This conflicts with the intended nature of partnership where expertise is explicitly shared and parents 'lead all interactions' (Davis, Day & Bidmead 2002, p. 50).

According to Davis et al. partnership

assumes that if parents and helpers can work together as partners, combining both sets of expertise, then there will be increased benefits for the parents, their children, their families, and for the helpers. (2002 p. 51)

While this premise is sound, some of the ingredients of partnership described by Davis et al. leave room for confusion in practice. This is primarily because they are drawn from modernist interpretations of the function of power within communication encounters. These confusions call up epistemological schisms in how power is enacted. For example, there may well be an appearance of shared power, yet the hierarchical nature of the relationship between parent and professional is not acknowledged.

Davis et al. (2002) argue that power sharing is an important element of partnership. They state that in partnership

we assume that neither partner is in overall control, and that they both have power, that they share decision making, and that they attempt to work by consensus wherever possible. (ibid p. 51-52)

To critique this construct of power I draw on the work of Jana Sawicki (1991) who applied feminist critique to Foucault's analysis of a 'juridico-discursive' model of power. Davis et al. appear to use power in the 'juridico-discursive' sense, which is akin to liberal humanist interpretations, used predominantly in health care literature.

Juridico- discursive use of power involves three basic assumptions. Firstly that 'power is possessed', secondly that 'power flows from a centralised source from top to bottom' and thirdly that 'power is primarily repressive in its exercise' (Sawicki 1991, p. 20). From a Foucauldian perspective this represents only one form of

power; one that does not centralise relations of power at the micro level of society such as those in intercultural communication interaction in child health.

When Davis et al. flag the notion of power sharing they suggest that power can be possessed and owned. This construct is reinforced when they state that both parents and professionals *have* power. Sawicki suggests that this form of thinking has led to a 'preoccupation with questions of legitimacy, consent and rights' (1991, p. 21). Following the modernist assumption that power flows from top to bottom then it becomes easier to see how ideas about power, such as, who has it, who does not, and what happens with it, can become confused in ideas about partnership and child health encounters. It then becomes difficult to see or acknowledge how, when partnership is enacted, power can also flow from the decentralised location of the parents.

Finally the third juridico-discursive premise of power is that it necessarily repressive in its exercise. Why would such an understanding of power be employed in child and family health when the goal of the working with parents is empowerment? This seems contradictory when power in this sense relates primarily to prohibitions backed by sanctions. Given that neo liberalism is the dominant discourse that governs our lives in western countries, this is just the approach of much child and family health policy. While parenting practices are not officially prohibited, child health professionals might act to deter parents from some practices and reinforce others. In examining data in this thesis I look to understand how and why specific forms of information might be legitimised against others.

In a sense by applying a modernist understanding of power health professionals implicitly and/or explicitly have their disciplinary power reinforced. Foucault (1995) explains that disciplinary power has arisen historically with the human sciences. It demonstrates how power can be productive rather than predominantly repressive. Through the human sciences certain forms of knowledge and methods of examination and surveillance have emerged as disciplinary techniques. These ways of knowing about individuals are equated with ways of exercising power over individuals.

Sawicki (1991) notes the contradiction that disciplinary power exercised on the body and soul of individuals increases the power of individuals as the same time as rendering them more docile. So where participant child health professionals focus on power as something that can be given away it is instead constructed as

reproducing their own power and has the effect of rendering parents docile. This is of particular import for parents who are culturally different to participant child health professionals. Disciplinary power is exercised as a mechanism to reinforce binaries of illness/health sane/mad same/different as a means of normalisation and social control. As such divisions of cultural difference are reinforced.

A modernist understanding of power as possessed seems to conflict with a predominantly postmodern act of partnership. How participants manage this ontological difficulty, is explored in this thesis.

Kay Aranda (Aranda 2005, p. 136) implores practitioners and educationalist to engage actively in 'postmodern discourses of subjectivity, diversity and power in order to identify how subject positions are shaped by and are shaping discourses of equality'. Anderson et al. (2003) agree that plural transformative subject positions are urgently required in health care. This study of communication and child health practice was undertaken to ask questions about taken for granted assumptions about how child health professionals work with parents who come from cultures that are different to their own.

Linking communication to culture

Interpretations from cultural studies offer constructions of communication that explicitly link culture and communication. Using a system of both internal and external representations, communication is viewed not as separate to but as constitutive of the formation of culture. Stuart Hall's (Hall 1997a) system of representation is briefly described as an alternate understanding of how meaning is produced through language.

Hall first articulates a 'system by which all sorts of objects, people and events are correlated with a set of concepts or mental representations' (1997a, p. 17). Meaning therefore depends on how these concepts are organised to represent meaning for the individual through conceptual mapping. Language is the second system of representation involved in the construction of meaning. Language here relates to all words, sounds, or images that carry meaning. These signs are organised into language. It is the relationship between these two systems of representation, between concepts and signs that produces meaning in language (ibid). Language is the privileged medium in which we 'make sense' of things, in which meaning is produced and exchanged. Meanings can only be shared through our common

access to language. Language is therefore central to meaning and culture and has always been regarded as the key repository of cultural values and meanings. Culture is nothing without language; language is the way in which we communicate culture.

Summary

Deeply historical Western interpretations of culture remain centred on Anglocentric traditions. Within these traditions, culture is often understood from an anthropological sense where it accounts for biological and culturalist understandings of groups of people within a discrete population. It is this understanding of culture that is promulgated through transcultural approaches to nursing care. Problematically, within a multicultural this approach does not account for the fluid and hybrid nature of disparate cultural groups. Neither does it account for relations of power inherent when minority groups are collectively relegated to the margins of nationhood. This approach has also led to violent acquisition of cultural artifacts from minority groups by dominant nations through which the dominant groups have reinforced their position of superiority. Social Darwinism stands out as an historic example, the impact of which is alive and well in contemporary Australian debates on assimilation and acculturation.

Present-day approaches to culture and communication in health care leave unattended the constructed contextual and fluid nature of the individual as cultured. The move to self-awareness in the cultural care literature offers some hope in contending with current culturalist approaches entrenched in health care. On the forefront, cultural safety offers an approach that explicitly recognises the need to deconstruct the historic situated construct of the health professional self and recognise the embeddedness of relations of power in health care communications. Approaches to health care communications remain entrenched in essentialised approaches that implore health professionals to treat people the same regardless of difference, to separate any aspect of a cultured understanding of self from the health issues at hand. This assumes that all consumers of health care aspire to a common goal within normative Western constructs.

Through a cultural studies lens, communication and culture are explicitly linked. Stuart Hall's system of representation frames understandings in this study of how culture is represented by and through culture and culture is represented by and through language; the two are inextricably linked and constantly evolving. By

foregrounding this understanding as a critique of historical culturalist and essentialist understandings, this study sets out to investigate how child health professionals make sense of culture and communication in their everyday practice working with people who come from cultures that are different to their own.

So far this thesis has identified problems of inequities in child and family health practice that implicate contemporary approaches to culture and communication. Child and family health practice has been situated historically, contextualising current-day practice. Ontological and epistemological arguments have been made for a critical inquiry using primarily postcolonial and feminist theorising. This chapter provided a context and critique of contemporary pedagogy of culture and communication in the child and family health care in Australia today. The following chapter describes the methods chosen to investigate the complexity of communication interactions that constitute cultural care in community child and family health in South Australia.

CHAPTER 5

METHODS

Introduction

This chapter presents the methods chosen to explore how a group of child and family health professionals in the workplace of the Child and Family Health division of the Children, Youth and Women's health Service, communicate with parents who are culturally different to themselves. Ethnography is presented as the selected method, as it holds the capacity to meet the dual criteria of taking culture as its starting point and aligning with emerging criticalist inquiry. In this chapter I describe how this research was undertaken within and with the participant organisation, and how gate-keepers and participants were engaged in the process. Justification is made for data collection through a three-phase strategy of participant observation, video recording of consultations between child health professionals and parents from cultures that are different to their own, and in-depth interviews following reflective viewing of video data with participant child health professionals. Ethical issues are examined together with rigour and credibility. The logistics of managing and analysing large volumes of data are discussed. The participants and their work environments are introduced to the reader in chapter 6.

Ethnography

The study of culture is usually undertaken through ethnographic methods. Traditional ethnography involves study with a given group, where knowledge is derived for the purpose of description. The researcher speaks of and for the subjects. It was this approach to anthropology that informed the well-known transcultural nursing theory of Madeleine Leininger (2006). Unlike that approach, this study has an underpinning epistemological position not to engage in further epistemic violence through representing the other through the eyes of self (see discussion in chapter 2). In this light, the following discussion details how ethnography is used within a postcolonial framework.

Developments in anthropology from the mid-1980s have 'legitimated new objects, new styles of research and writing, and a shift in the historic purpose of anthropological research towards its long-standing, but underdeveloped, project of cultural critique' (Marcus 1998, p. 386). Within the project of cultural critique, this

study uses ethnography with its sense of living-in-the world of inquiry examining taken-for-granted assumptions of participants within this world. The world being examined in this study is that of the participant child health professionals – not that of the cultural other.

This study turns the gaze on to the child health professional self. As a practicing child health nurse, I position myself within the professional group being examined, and am therefore both insider and outside researcher. This brings with it particular professional influences. I also bring to this research influences from other experiences in my life that shape my positioning as researcher in this study. I am conflicted as I notice the following parable invading my thoughts:

Why do you see the speck that is in your brother's eye, but do not notice the log that is in your own eye? Or how can you say to your brother, 'Brother, let me take out the speck that is in your eye,' when you yourself do not see the log that is in your own eye? You hypocrite, first take the log out of your own eye, and then you will see clearly to take out the speck that is in your brother's eye. (Luke 6:39-42)

As a professional woman educated to focus on the rational and objective accumulation of reasoning, and aware of the vast epistemological damage undertaken in the name of religion, I want to deny this influence. However, by recognising and reflecting on this influence, I sustain a process of self-reflexivity within the research process. I asked participants to reflect on themselves as cultured beings and therefore apply the same ongoing critique to myself. I came to ethnography questioning my own taken-for-granted assumptions of child health practice and working with the cultural other. This was an ongoing process as I walked with participants through their everyday work experiences.

Ethnography in health care

Ethnography is a widely respected qualitative research approach that has a strong tradition within hospitals and primary health care settings. It has been particularly useful for developing an understanding of the interactions and relationships between professionals and clients. Strong's (1979) landmark study into paediatric medical practice in London in the 1970s paved the way for ethnography exploring health care encounters. Hunt and Symonds (1995) used ethnography with social feminist theory to explore the rhetoric and reality of life in labour wards in the United Kingdom in the 1980s and 1990s. More recently, Hunt (2004) used ethnography in a postmodern feminist framework to investigate how pregnant women who live in

material poverty experience life and the health care system. These studies demonstrated the potential for ethnography to be rigorous, systematic, organised and purposeful while maintaining sensitive engagement with participants. Hunt (2004) tells of how she was compelled by participants to reconsider her understandings of poor women. This was particularly around issues of identity, following the women's capacity to articulate a powerful critique of the assumptions held by health care professionals and the services with which they engage.

In Canada, Browne and Fiske (2001) used ethnography in a postcolonial feminist framework to explore first nations women's encounters with mainstream health care services. This study demonstrated the historical, political and economic situatedness of women's lives as they encountered health care services (Browne & Fiske 2001). These examples demonstrate the capacity of ethnography to utilise a range of theoretical frameworks to understand how people are situated within particular health care cultures that shape experiences of health care encounters.

Theorising ethnography

Ethnography as a discursive method of inquiry and writing within anthropology, sociology, and feminism has become synonymous with the post 'post' project of cultural studies (Marcus 1998). Ethnography in this sense, as deeply reflexive cultural translation is understood to never fully assimilate difference. A discussion on ethnography is intrinsically an ideological discussion from within anthropology and the ensuing cultural project. The following section will endeavour to account for the current ideological theoretical and methodological debates informing the approach to ethnography adopted in this study.

Ethnography is a way of gathering 'thick description' (Geertz 1973). It is generally gathered by participant observation and semi structured interviews over a period of time, in a particular setting. This enables the researcher to understand wider aspects of culture that go beyond issues of race and ethnicity. One of the strengths developed in ethnography, as a research approach, is that it helps us to understand that culture and ethnicity are not the same. It enables an investigation into culture that recognises and values the many dimensions of culture as the making-of-meaning in the world, thus ensuring that culture is not treated as homogenous.

Ethnography, based on Geertz's approach of symbolic interactionism, has been useful for its qualities of 'heuristic flexibility' and its 'democratic and relativist' approach to culture (Lewis 2002, p. 70). While Geertz pays attention to the social

disharmonies in a social group, his work tends to 'privilege notions of social order and systematically constituted social values within a culture' (Lewis 2002, p. 71). In doing this he contributes to the ideology of the nation state as a central organising unit in the modern world. The nation state is identified by its unifying common culture. In this process Geertz and others are implicated not only in analysis of society but also in the production, promotion and maintenance of culture as homogenous. While his contribution to developments and understandings of ethnography are vast, a symbolic interactionist approach is unhelpful when using ethnography to explore issues of language, power and cultural diversity.

The theoretical underpinnings of ethnography have been debated for decades within the human sciences (see, for example, Marcus & Fischer 1986), and many of the concepts remain relevant to this inquiry. Summarised by Lewis (2002), the main considerations for using ethnography in contemporary contexts are issues of symbolic and social order, social homogeneity, imposed authority and ideology, and the anthropological approach of speaking for others. While these issues were considered in chapter 2, the following section specifically addresses issues relating to the use of ethnography as a method for this research.

Symbolic and social order

Postmodern theorists have critically challenged the notion of social order. In these paradigms, language and culture are highly unstable and meaning is constantly shifting and deferred (Lewis 2002). In this changeable context, the notion of a stable social order cannot exist. Social homogeneity is seen as an antiquated notion based on a social order that subjugates the interests of individuals and minority groups by privileging the systematic functioning of the nation state. Postmodernism and cultural theory argues that this diminishes the intrinsic diversity of social groupings. Key to this project is the recognition and valuing of this very diversity. As such, the integrated processes of field work and analysis will work with child health professionals to understand how they construct and manage diversity within the child health workplace.

Colonial anthropology

When ethnography is examined as a method we are reminded that '... culture as the object of ethnography is predicated on the notion that the difference of others can be fully *consumed* ...' (Marcus 1998, p. 398). There is always a surplus of difference that remains when attempting to explain or interpret another cultural subject (Marcus 1998). The idea of a radical surplus of difference contends that difference can never

be fully 'consumed conquered or experienced' (ibid p. 389). Difference will continue to exist despite historic attempts at homogeneity and consumption of the other. For this study, the approach to ethnography is not to consume, conquer or experience the culture of the other, but to examine the cultured positioning of the child health professional. I do this by exploring how this cultured self manages difference and perhaps the surplus of difference within practice. Indeed, even in my emic position of child health professional, there remains a surplus of difference between my interpretations and readings of how participants construct themselves as cultured. This follows a postmodern consideration that any interpretation is only ever partial and never fully resolved.

Through historic colonial anthropology, the cultures of minority groups have been subsumed into that of the dominant group, thereby subjugating the interests of the minority groups. In this way the dominant group continues their goal of social order and homogeneity. This study subjects participants from the dominant group to a reflexive ethnographic process to enable them to consider if their own practices might take up a colonising agenda.

Marcus (1998) clarifies that it is not the practice of ethnography itself but the validation of traditional ethnographic authority that is challenged. Marcus and Fischer (1986) refer to this as a crisis of representation where research and writing has responded by becoming more reflexive, accounting for issues of gender, race and class, as it counters anthropology's classic norms of 'objectivism, complicity with colonialism, social life structured by fixed rituals and customs, ethnographies as fixed monuments to culture' (Denzin & Lincoln 1998, p. 19). While drawing on ethnographic methods, this study explores the multiple conflicting and situated subject positions of participants. It recognises culture as a fluid reciprocal production of meanings, practices, values and subjectivities. This approach to ethnography is recognised as never being fully resolved or a defining statement of truth. As such, it counters traditional colonial authority.

Research design

The following section describes the research methods and design. The underpinning principles and credibility of this design as 'research as praxis' (Lather 1986) within a postcolonial framework are interwoven throughout the discussion.

Outline

Consistent with ethnographic inquiry, I employed three stages of fieldwork in this study. These are:

Stage 1 participant observation

Stage 2 video recording consultations between child health professionals and parents from a variety of cultural backgrounds in a range of clinical settings

Stage 3 in-depth interviews with participant child health professionals following independent and joint viewing of their video recordings.

Conceptualising the study: working with a reference group

Having conceptualised this project as an ethnography study, I consulted with key stakeholders in the field. A key informants' group was established to ensure that the project was ethically and logistically sound, useful within the practice field and reflexive in engaging and working with relevant industry groups.

The rationale for this strategy was based on the current political and economic climates of neo-liberalism and economic rationalisation that set an essential goal for research to be explicitly linked to the needs of industry and community. From a research perspective, linking research with the needs of practice lays a platform to engage with and consider structural and professional systems that shape practice. From the perspective of practice development, linking with industry supports validity of research constructs and scope for future implementation of practice change.

Informants with a range of practice, management and research positions were invited to attend from key child and family health and migrant health organisations in South Australia. organisations included the Children's, Youth and Women's Health Service, the Migrant Health Service, the Parenting Network and the Migrant Resource Centre (see appendix 2). Eight individuals agreed to attend meetings and contribute to the study design. The first meeting was held in June 2004. Participants were offered a background to the study proposal and contextualisation of the study as research for doctoral candidature. We discussed the expectations of key informants and the proposed methods for data collection. With the permission of the key informants, the meeting was audio-recorded and transcribed as minutes. Discussions from this meeting shaped the ethics proposal for the study.

A second meeting was held in November 2004. Key informants were given an update on the ethics application and research progress. At this meeting it was decided that key informants would no longer meet as a group but could be contacted on an individual basis throughout the research process if the need arose, and that a report would be provided to informants at the end of the study. Key informants have been sent brief updates regarding research progress, and a report will be offered when the thesis is complete.

In order to grasp an understanding of national trends in the field of culture and child health, I spoke with a range of experts in these areas of research and practice (appendix 3). Following suggestions from the key informants group, I travelled to Sydney in July 2004, where greater diversity in the population has driven more extensive practice and research developments in areas of culture and health. During this exploration I refined methods of data collection and analysis. Importantly, these discussions with clinical and research experts validated the need for further research into this area and contextualised the study within a national framework.

An application was made to undertake the research in two sites of the Child and Family Health division of the Children's, Youth and Women's Health Service in South Australia. This is a state-wide service that attends to the well-being and development of South Australian children and families through a range of universal and targeted child health and parenting services.

Gaining ethics approval

The research design was approved by two ethics committees: the Flinders University Social and Behavioural Research Ethics Committee, and the Children Youth and Women's Health Service Ethics Committee (appendices 4A and 4B).

Gaining ethics approval was not straightforward. One committee initially refused approval due to concerns that the research was attempting to attribute problems of intercultural communication to the particular ethnicities of parent participants. This confusion occurred because the committee interpreted the term 'culture' to mean ethnicity. Further, they suggested that ethnography was not robust enough to address my research question. While this response was disappointing, it strengthened my resolve to argue for a boarder understanding of culture, and of ethnography as a rigorous method of enquiry in health care. I was encouraged by

the literature to challenge the institutional dominance over accepted interpretations or meanings of concepts relevant to practice and research.

I made a time with the chair of the committee to discuss my concerns. It was helpful to understand, in more detail, the nature of the committee's concerns, and how I might usefully address them. My ethics application together with a letter detailing my understandings and application of the concept – culture, informing this particular study, and an argument based on the well respected international use of ethnography in health care research was submitted. After two further submissions, approval was granted.

Ethical safeguards

Ethical safeguards were put in place to ensure that all participants only engaged in the research in a voluntary way and that the research interests were explicit and transparent. Written consent was asked of health professional participants, parent participants and administrative workers (see Appendices 5A & 5B). Information in the letters of introduction for participants (see appendices 6A and 6B) and information brochures for participants (see appendices 7A, 7B and 7C) invited participation and detailed the processes involved. Participants were supported to refuse to take part in the research or to withdraw at any time. In addition, child health professional participants were reassured that their decision to participate in the research was in no way linked to performance appraisal

An initial strategy to ensure confidentiality and anonymity was the use of pseudonyms. Throughout data collection this was changed to an alpha-numerical representation (for example, Participant 4 or P 4) because pseudonyms appeared to have the potential to misrepresent issues of class, gender and socioeconomic status. This observation was confirmed in Hodge and O'Carroll's (2006, p. 53) discussion on the representational 'tricks' employed by of Hage (2000), where pseudonyms became socio-cultural markers.

Potential risks were identified for parent participants, the majority of whom identified as coming from a cultural background that located them within minority groups in the Australian context. Particular attention was given to the concerns that might have influenced parent participants' ability to consent voluntarily, such as potential fear of governments and government organisations due to past experiences, belief that refusal to participate may impact negatively on themselves or their family, fear that, through participation, information gained from the video tape may be used

inappropriately or to their detriment and fear that refusal to participate might affect their ability to access ongoing services from CYWHS. I addressed these issues in the following ways.

All documentation for parent participants was translated into the four most commonly used languages across Sites A and B. Parent participants were also offered the opportunity to have material read out to them by interpreters or cultural consultants to address potential issues of illiteracy in participants' spoken language. Time was offered to answer questions and clarify issues. Participants were also offered the opportunity to have family members review consent forms.

Entering the field: recruiting participants

Following ethics approval, I attended a meeting of nurse managers from the state-wide Child and Family Health Services (CFHS), within the Children, Youth and Women's Health Service (CYWHS). I explained the project and asked the managers to recommend sites for research. They collaboratively identified two service delivery sites that had the largest attendance of families from cultural and linguistically diverse backgrounds in metropolitan Adelaide. I then met individually with managers and team leaders from these sites to discuss the study and seek their support to undertake the project in their services. I answered questions and addressed the concerns they raised.

For example, one service delivery site (Site B, detailed in chapter 6, 'People and Place') had recently moved to a new building in a new location. In addition, they recently had another researcher collecting data for another project (field note 050520). Clinicians were not yet settled in their new site and had found the previous researcher's approach invasive and non-collaborative. Rather than collect data from both sites simultaneously, we agreed that I would attend the other service delivery site (Site A) first. This would give clinicians from Site B time to settle into their new environment and offer a reprieve from research activities. I also hoped that reports on the collegial approach to data collection might filter out from Site A to Site B, reassuring potential participants of its less didactic approach.

Managers and team leaders then arranged times for me to attend clinical team meetings at the sites, to invite clinicians to take part in the research. I attended a team meeting at Site A in June 2005. The team leader led the introduction, saying

'Julian is here to meet us and talk about her research. I'll let her introduce herself, have a chat, and then we'll have morning tea. Julian has brought a cake'. There was some discussion about it being home made. She then said, 'Maybe before Julian starts we can go around and introduce ourselves to Julian and tell us something special about what you do'. (Field note 050601)

Realising I risked labels of bribery and coercion within research; I followed my insider knowledge of morning tea rituals at team meetings and took a cake. It provided a non-threatening introductory focus for conversation and indicated my capacity to work with them from an inside position. The introductions were relaxed and informal.

Of the ten people present, I recognised that I knew, in a professional capacity, three people at the meeting. One I had met ten years prior when I was working as a child and family health nurse, and she had sat in on and observed my practice. I had not worked with her since. One I had worked with in the same team for approximately two months, nine years ago. I also knew the Aboriginal cultural consultant well, having worked with her on a collaborative project 18 months previously. I noted that people at the meeting seemed interested in the study. As I was explaining my background and research interests, there was lots of nodding and sighs of agreement. One participant (P7) said

they just don't see migrants as important any more, we are expected to do the same job but without the support. They don't listen to us when we say they need more. (Field note 050601)

During the meeting I gave out letters of introduction and information sheets, described the research and answered questions. I invited participants to let me know, at any time, if they were interested in being part of the study, at which point I would give them consent forms. All child health professionals present that day asked for one immediately. I handed them out and they were returned during morning tea.

I had some trepidation about gaining the consent of child health professionals, particularly their consent to video recording intercultural communication and subjecting this practice to scrutiny. I was surprised by the alacrity with which these clinicians agreed to participate. They spoke about their lack of opportunity to reflect on practice and looked forward to the opportunity to see how they were going.

During the meeting, one of the concerns raised by participants was that I had not expressly asked for ethical approval to observe child health consultations in the

participant observation stage of data collection. In the original study design, I had only planned to sit in on consultations to video them. Team members were most concerned that I would not get enough of a sense of what they did unless I sat in on and observed consultations before asking for consent to video consultations. From this brief introduction, participants had begun to work with me to ensure that I described accurately the context of their work environment, what happened in their work setting and how they behaved in this context. Following this response, I requested an amendment to my original ethics proposal to enable me to sit in on and observe consultations (see appendix 8).

Discussions over morning tea confirmed participant interest in the study. For example, Participant 5, one of the participants whom I had not previously known, said that I was supported '100 %' in doing the study. Speaking on behalf of the group, P5 said that the group thought that what I was doing was really important and that they would help in any way they could (field note 050601). By the end of morning tea I had been invited to return that afternoon to observe a parent education session.

Even though coming into the field in Site B was delayed, engaging staff members as participants still seemed more challenging. When I attended this site to introduce myself and the study, a number of conditions differed to those in Site A. The meeting was held in the afternoon, and all attendees appeared tired and drawn. They sat in a large circle hugging the walls of the meeting room, unlike at Site A where they seemed to be sitting on top of each other around a large table covered with food. There was no sense of enjoyment in the coming together to share food and conversation as there was in Site A.

I was scheduled into a 20-minute time allocation on the meeting agenda, leaving little time for staff to engage with me or the project. Senior clinical team members were absent from the group and the regional manager was present. There were a number of new contract staff members, and I was told of staff shortages. Participants were uncertain if they were required to take part in the study or if they had choice. I explained as much as possible within the time constraints, drawing on experiences and examples from Site A. I invited staff members to complete a consent form and leave it in my pigeon hole if they were interested, and left.

Even though I was initially told that my time would merge into afternoon tea time and had brought a bun to share, a decision was made to continue with the agenda, as

they had a lot to get through. Despite this less than ideal start, on returning to the field to begin participant observation, I was recognised by two new staff members who recalled my presentation to the team meeting. They both said they were looking forward to my beginning work at their site. I had met one of these participants two years earlier when she had been a student and I was working as a child and family health nurse at another site in the organisation. She had sat in on and observed my practice on a number of occasions.

To my surprise, I found many completed consent forms in my pigeon hole on this return visit to Site B. I was also reassured by interest shown by another staff member, as this field note excerpt demonstrates. She came to me and said:

'I just want to let you know that I'm sorry I haven't put my form in yet. I would really like to take part in your research, but I just haven't had time to get the form back to you'. I was very reassured and said, 'Thank you so much for even considering it'. I explained that there was no problem with the timing of the forms, and that I had realised that she may not be interested because of the risk of being observed and being identifiable as one of [a professional group with a small number of members in the field]. She said, 'No that's absolutely fine I have thought a lot about it'. (Field note 050811)

I spent the rest of this first field visit listening to participants tell me about themselves and their work, filing and tidying and trying to be helpful and unobtrusive. I used my insider status to assist me to get alongside the participants. I left feeling reassured that, while it might take more time to engage with this team, it was a possibility. My initial impressions of asking potential participants to engage with me in research at Site B appeared to have been distorted by organisational pressures of understaffing and change.

In summary, participants who were involved in the study are as follows:

Stage 1

Participants involved in participant observation included:

child health professionals such as:

child and family health nurses working at professional levels 1 and 2

mothercraft nurses¹¹

social workers

medical officers, and

cultural consultants

interpreters, and

administrative staff.

Stage 2

Participants involved in video recording consultations included:

parent participants and their infants

child health professional participants, predominantly child health nurses and medical officers

interpreters, and

cultural consultants.

Stage 3

Participants involved in in-depth interviews following independent and joint viewing of their video recordings included child health professionals from stage 2 as above.

Field notes were recorded throughout the research period. Field notes, videos and transcripts of audio-recorded interviews provided data for analysis. In addition, media reportage during the research period was subject to textural analysis.

Rigour and credibility

In designing the study, particular care was taken to ensure that methods followed both an emancipatory agenda of critical inquiry (Lather 1986) and the strong historically situated research-theory dialectic of feminist and postcolonial inquiry (Reimer Kirkham & Anderson 2002). The notion of research as praxis presented

¹¹ Mothercraft nurses in South Australia are second level nurses with specific skills in feeding and settling who work under the supervision of a registered nurse. While they still refer to themselves as mothercraft nurses, they are formally classified as enrolled nurses.

criteria for ensuring that the research was undertaken in a democratised manner characterised by negotiation, reciprocity and empowerment (Lather 1986). These considerations are used to critique how research methods enabled understandings of the situated context of life and analysis of 'how gender, race, class, and historical positioning intersect at any given moment to organise experience in the here and now' (Reimer Kirkham & Anderson 2002, p. 15).

Reciprocity involves mutual negotiation of meaning and power (Lather 1986). Similarly, reflexivity encompasses the co-constitution of research material between the researcher and the researched (Marcus 1998). Both consider historically situated politics of location and positioning. Understanding the making of meaning and how meaning is contextualised and enacted is key to this research, as is understanding relations of power within health care encounters. Methods for this study draw on a range of critical, feminist and postcolonial approaches where reciprocity and reflexivity are visible (see for example, Blackford & Street 2002; Browne & Fiske 2001; Hunt & Symonds 1995). For this study, reciprocity is seen as the give and take between participants and researcher, and reflexivity relates more to 'ongoing self critique and self appraisal' (Koch & Harrington 1998, p. 882).

Reciprocity

Following Lather (1986), this study was designed to incorporate reciprocity at two points of intersection; between researcher and participant and between data and theory. For reciprocity to occur, certain conditions must be met before it can be enacted. Throughout all stages of data collection I worked towards establishing an environment of trust and genuineness in the relations of the research process, and encounters with participants and stakeholders. I carried this approach through the analysis stage of the study. It also informed how I represented the participants and what they shared with me, when I have given conference presentations.

The co-construction of interview data

It was important to each stage of this research process that I stayed close to the life-world of participants. The way I chose to do this during the participant observation phase, the phase of video recording and in-depth interviews was similar to the approaches to interviews I learned in my practice as a child and family health nurse. This process of interviewing was integral to all stages of data collection. For this reason, I paid particular attention to the ways in which interviews were constructed and enacted.

Clinical interviews are co-constituted through attempts to gain a shared understanding of the world of the client (Minichiello et al. 2000). Similarly, research interviews proceeded as a dialectical process (Lather 1986). This means that each step depended on the previous one, and both the researcher and participants contributed actively in the process. In this way, I was able to engage a process of ‘filtering’ or checking back with the participants to ensure the reliability of interpretations as they presented (Minichiello et al. 2000, p. 253). The following excerpt from an interview with P10 demonstrates this process.

R: Can you tell me about what’s happening here in this bit?

P10: Just getting to know each other, it’s kind of a warming up I guess, try and make her feel comfortable, trying to let her talk, like if she wanted to talk, let her say what she wanted to say, just listening and try and let her know that I was listening to what she was saying.

R: It sounds like it’s important to you that you do that warming up and establish that relationship.

P10: Yeah, yep.

R: And why is that? (Interview 10 051128)

Once the intent of the participant was clear, I was able to proceed to the next level of understanding of why the participant held this belief. Demonstrated in the above example, the research descriptor of ‘filtering’ is synonymous with the clinical practice of ‘reflective listening’ (Bolton 1986).

Undertaking inquiry in the criticalist paradigm informed by feminist and postcolonial scholarship, I was mindful that data collection, deconstruction and reconstruction are all shaped by the various subject positions I take up as a cultured being. Gubrium and Holstein contend that the active subject behind the interviewer:

becomes a necessary, practical counterpart to the active subject behind the respondent. Interviewer and, ultimately, researcher, contributions to the information produced in interviews are not viewed as incidental or immaterial. Nor is interviewer participation considered in terms of contamination. Rather, the subject behind the interviewer is seen as actively and unavoidably engaged in the interactional co-construction of the interview’s content. (2003, p. 33)

I therefore expressly attempted to recognise and understand my own role in activating the interview subject and co-constituting data throughout all stages of data collection. I asked and answered questions from a range of subject positions and attempted to be explicit in this process. At other times, I introduced concepts to participants to develop theoretical discussions or deconstruct ideas.

In an example from the field, while observing a parent education session, a child health professional participant deferred to me in my role of clinician even though I had expressly asked her to involve me only as an observer/researcher. A parent asked P9 if she should buy a thermometer:

P9 deferred to me. I said, 'I have always had a thermometer in the house since I have had babies. I find it useful to be able to monitor the temperature at home so that I am more confident about my decision whether to go to the doctor or not'. (Field note 050719)

I recognised through P9's response that she continued to view my presence as that of a clinician and refer to my expertise. I chose an alternate and compatible position of mother from which to answer the question. While this was my overt response, my multiple positioning necessarily includes that of clinician, which is inextricably linked to how I enact my role as mother. In this way, group members received an answer that was both private and professional. As a researcher, I felt obliged to provide a response to the question to maintain a relationship with P9.

Transparency

To maintain trusting relationships, I needed to be explicit about my approach to gathering, understanding and interpreting the information participants gave me. For example, sitting in front of the DVD with P10, I explained my approach to viewing the DVD and our intended discussion:

I've looked at the video trying to be more of an outsider than an insider, so, trying to forget that I've been a child health nurse and ... can look at what you do and say 'I know exactly why you do that'. What I'm trying to do is put on a researcher hat and say 'can you help me understand why that bit happens?' (Interview 10 051128)

I attempted to explain why I would be asking the questions I did and how I had viewed the DVD with an ethnographic curiosity. In this way I hoped to bring the participants along with me in the process of inquiry. In all interviews, participants were asked if they had any questions regarding the intent of the research. Participants, being interviewed while reflecting on a DVD of their practice, were also

invited to raise any sections of the DVD for discussion or their own concerns of considerations regarding the intersections of culture and communication.

In another example, a month into participant observation, I was sitting in the kitchen in Site A when P 34 asked what I was finding:

I said, 'I thought initial impressions were about the challenges of when to give information, such as "this is so" or "that is so", or when to use a more pluralistic approach'. P34 said, 'I wonder if it is more to do with the general approach of the individual nurse and whether they are [set] in one approach or that they have the approach that [presents] all the options together'. I said, 'Yes, and that was what I was most interested in; looking at how the child health professionals saw their approach, and where their approach came from'. (Field note 050719)

In these ways, I was actively involved in co-constituting the data as an activated interviewer. Gubrium and Holstein (2003) explain that an activated interviewer acknowledges their contribution in the production of knowledge in the research process, rather than attempting to deny, or relegate it to the margins. Additionally, these approaches indicate the transparency of the research process, and the investigation of research themes and concepts.

Researcher and participants in the ethnographic process were construed as activated productive sources of knowledge rather than repositories of information and opinions (Gubrium & Holstein 2003). Participants determined what information to offer, whether I was in a mode of inactive observation or active inquiry. As such, by the very process of offering their life experiences and reflections on practice, they constructively shaped the content, scope and process of research data. Following Gubrium and Holstein, data is attributed value through both its meaning and how meanings were actively co-constituted.

In the following sections, I detail how the research was undertaken in the field, how I engaged with participants' recorded data and how I reflected on and developed meanings with participants. While data analysis explicitly followed data collection in the early stages of the research, as time progressed these phases overlapped and interlinked. I would, for example, be reflecting on previous data collected to inform the focus of observations in the field or questions asked in an interview. Very often, analysis was occurring as I watched and discussed intercultural communication with participants. The following sections detail how I collected data across the three phases and explain how I critiqued and analysed the data along the way.

Throughout these sections, I demonstrate reflexivity through ongoing self-critique and self-appraisal, giving the research shape through a politics of location and positioning (Koch & Harrington 1998, p. 882). I demonstrate genuineness, building trusting relationships, enabling participants to be active contributors in the research and show evidence of catalytic validity.

Data collection and analysis 1: listening, talking and taking notes

Atkinson and Hammersley (1998, p. 111) describe participant observation as 'not a particular research technique but a mode of being-in-the-world characteristic of researchers'. The aim of participant observation in this study was to be-in-the-world of participants to gather an understanding of the cultural context of communication within the practice field.

In studying culture, ethnographers look for cultural knowledge, cultural behaviour and cultural artifacts (Spradley 1980). I looked for these things in the world of child health practice. Cultural artifacts are 'the things people shape or make from natural resources' (Spradley 1980, p.5). In child health practice, these might be a tape measure, weighing scales, or paperwork. Cultural behaviour is what people do; in child health practice this might be assessing an infant or counseling a parent. Cultural knowledge is what we need to do these things. It is used constantly to 'generate behaviour and interpret our experience' (ibid , p. 6). Spradley goes on to suggest that cultural knowledge can be simply referred to as 'culture'. In this definition, culture is defined as 'the acquired knowledge people use to interpret experience and generate behaviour' (ibid, p. 6).

During participant observation, and indeed throughout the ensuing data analysis, culture was considered not as a separate sphere, 'but a dimension of all institutions – economic, social and political' (Jordan & Weedon 1995, p. 8). I followed Jordan and Weedon in viewing culture as 'a set of material practices which constitute meanings, values and subjectivities' (ibid, p. 8). In recording ethnographic data, I also followed Willis in considering that:

symbolic activity brings some sense of wider positionality and outside formation of the self: an awareness of causation, axis or support of cultural being and consciousness located somewhere other than at the geometric centre of the self. (2000, p. 5)

In this study, I particularly looked at constructs of culture viewed through the actions and reflections of child health professional communications. To do this, I observed and discussed the practices, routines and experiences of consenting child and family health professionals across two service delivery sites over a period of seven and a half months. During this time I sat in on, observed and engaged with daily activities and lunch room discussions, consultations in a range of settings, parent education sessions, case conferences and team meetings.

These observations ranged in time from approximately one hour to around four hours. In each site, field visits were initially organised so that observations could be made of the range of participant activities and to develop genuine trusting relationships with participants. I was invited to attend activities with participants such as observing open sessions, sitting in on child health centre consultations, attending home visits and observing case conferences or parent education sessions. As the study progressed, field visits were organised to coincide with times when participants were most likely to be available to talk over lunch times.

In addition, I worked towards building a rapport with participants during field visits. While this is an explicit goal of ethnographic approaches, I found building a rapport comfortable and in keeping with my personal and professional ways of being-in-the-world. Participants were peers, and I was genuine in my interest and desire to enhance practice by understanding and critiquing aspects of practice with them. Oakley states that there is no intimacy without reciprocity (1995 p. 49). I used this underlying principle to shape my actions in working with participants to develop rapport. I made many cups of tea, tidied waiting rooms, cuddled crying babies, washed dishes, filed and fetched. Having worked as a clinician in similar positions in the field, I was able to use my emic position of understanding the various pressures of work to support participants in their daily work. In these ways I naturalised my position in the field through immersion.

In Site A, I also offered assistance in professional ways. For example, I looked up information for a participant who was consulting with a parent and needed information on interstate immunisation protocols (field note 050622). I also helped in logistical matters, such as setting up the group room prior to a Getting to Know Your Baby group (field note 050728) and supported staff with minor computer problems (field note 050614). In Site B, I spent much time in the filing room putting files away and finding files for participants (field note 050811). I had the benefit of time to trawl

through looking for misplaced files. Working in this room, I was also visible and open for discussion, as this field note extract demonstrates:

...by being there I was seen to be working in a way that they recognised as contributing and I was in a location where people could talk discreetly, as it was an enclosed room in a venue that was often crowded and open. I had inadvertently placed myself in the line of flow of traffic. I was genuinely interested in helping out. (Field note 050811)

As a child health professional by training and experience, I was conscious of the potential to blur the boundaries. I therefore took particular care to maintain my position as researcher. On a number of occasions I was asked by staff to support them in clinical ways that I believed were not appropriate. In these instances I explained that, as a researcher, it was not ethical for me to take on clinical roles and, perhaps more importantly, that I was not legally covered to take on work of a clinical nature. These situations included being asked to relieve for short periods when staff were sick, and to support staff who were taking on new roles. For example, as I walked into the nurses' room one lunch time, P9 said, 'Oh great, you can help me with a new parent group' (field note 050614). P9 had said she felt uncertain about her skills in running groups and was looking forward to having my support in a group she was running that afternoon. I explained that I wasn't really there in a clinical role but as an observer:

P9 said, 'Sorry about asking you, I didn't mean for you to actually help with doing the group'. I said, 'I didn't think that was what you meant. I'd love to help, like I helped P4 the other day'. I looked at P4, who was also in the room, and she smiled confirmation. I said, 'I'd also love to sit in and observe if you're OK with that and if you are happy to ask the parents if they are happy for me to be there'. P9 said, 'OK, yes that's OK'. (Field note 050614)

While it might have been more comfortable for both of us if I had just said 'yes, I'd love to help you', this response would have left room for misconstruing my role in the room. Following this, we discussed, and clearly framed, what I could and could not ethically contribute given my role as researcher. I helped with name tags, setting up the room and preparing afternoon tea. The delineation of my role as clinician and researcher was at times confusing for staff who knew that, while I was there as researcher, I also worked casually in a clinical capacity at other worksites.

Participant observation provided a discursive context for understanding and analysis of participant perceptions of themselves and their actions at individual, organisational and societal level. I asked participants about their understandings of what they did and why they did what they did. I used everyday discussions to ask participants about their understandings of practice and communication. Central to these discussions were child health professionals' views about culture, how they came to learn about it, how they managed it, and how they viewed its contribution to practice.

Data was mostly written onto note pads in the field. I did this quite publicly in open spaces such as a kitchen, nurses' room, waiting area or consultation room. Field notes included descriptions of the field and the people present in the field. Notes recorded what they were doing, how they behaved and how they interacted with others. Notes also included verbatim records of sections of conversations and summaries of conversation themes. I attempted to be transparent in doing this. However, at times I made assumptions about participant understandings, as the following field example demonstrates. P4 and I were discussing dates in the tea room when I asked if I could just write them down so I wouldn't forget. I got out my note pad:

P4 said with surprise, 'You're writing down our conversations as well'. I said, 'Only the important bits so that I can understand everything better'. I wondered what did she think I was writing down all this time? I showed her what I had written from the [observation of the parent] group. (Field note 050622)

I had mistakenly assumed that because I was sitting in public spaces openly writing that participants would understand the depth of my note-taking. Following this experience, I offered to show participants the notes I had recorded more often and continued to ask participants to tell me if they didn't want discussions recorded. Many participants took up this offer. At other times participants came back to me a few days after a conversation to clarify what they were comfortable to have included and what they wanted excluded, an example of which is in field note 050707. Discussions that were most often requested to be excluded were those relating to specific individuals in leadership positions or those relating to professional conflicts of interest with organisational directions and practices.

I also kept a running analytical field journal. In this I reflected on methods, approaches and developing ideas. All of these notes were transcribed into Microsoft Word documents and catalogued using the American numerical date system, as this ensured that documents remained in chronological order on the personal computer (PC). For example, 'Field note 050614' refers to participant observation on the 14th of June 2005. These notes were then imported into an NVivo program to assist with managing the large volumes of data. Shortly after commencing participant observation I began using a voice recognition program, Dragon Naturally Speaking. This enabled me to sit in the car after a field visit, talk into a microphone and record field notes directly into a Word document linked directly into NVivo.

Organising and analysing the data

The large volumes of ethnographic data were managed using the software program QRS NVivo Version 2.1. From participant observation I generated 43 field notes that comprised the following data sets:

21 episodes of daily activities and lunch time discussions

nine consultations in a range of settings

seven parent education sessions

four case conferences, and

two team meetings.

As I read and reread these documents, I tried to absorb and make sense of the situated work-world of participants. I asked many questions about how they went about their work and why. I considered what participants mostly talked about at lunch times and between consultations and what they discussed with me, and asked why that might have been. I also asked of the data questions about how participants talked about culture and what they said. As I read, I also considered how participants talked about parents who came from cultures different to their own, and whether they gave consideration to themselves as cultured. I tried to make sense of the discursive frameworks that participants used to talk about their communication practices. From field notes of consultations, I asked how participants engaged parents, how they went about making sense of parental needs, and what barriers seemed to be at play. During this questioning of participant behaviours, thoughts

and feelings, following Willis (2000), I began to formulate possibilities of meaning that I was able to return to the field with and talk over with participants.

I recorded this first stage of analysis through an integrated process of coding and memo writing. Using an inductive process, I recorded all minor nuances and concepts as free nodes. These usually constituted a line or paragraph of text. I reflected on these ideas, recording my thoughts in memos that were tagged to the field note and labeled with the same date as the field note along with the word 'memo'. For example, 'field note 050801' matched 'field note 050801 memo'. When I recorded memos, I also coded them with the node/s that I had used in the field note. In this way, when I recalled a node, I retrieved not only the highlighted section in the field note but also my preliminary analysis in the memo. For example, in field note 050801, I recorded a lunchtime conversation with a group of participants. The following excerpt describes what P20 talked about:

P20 seems to think that the universal approach is a waste of resources. She talked about the fact that we don't all need universal home visiting; [that] there are many parents who are confident and comfortable to come to the child health centre of their own accord. She talked about it looking great for South Australia's statistics to say that every family is offered a home visit, but it seems from her perspective that this is a terrible waste of resources. (Field note 050801)

P20 went on to describe the type of administrators that she believed existed in the organisation and then said, *'The politicians don't have a clue what we do, and they'll never find out with our administrators'* (field note 050801).

Reflecting the tone of the conversation, I noded this section with the descriptive nodes 'universal approach a political scam', 'real work will remain hidden', and the general node 'UHV'¹². I tagged this section of the field note to denote that I had linked a comment. In the memo I wrote:

Belief that UHV is just a scam so that the organisation can say that they see all families and 'look' good. Belief that this is not a sound use of services. I wonder what might be? Belief in the agency of parents to look after their own children and make their way to seek services if they need to. I wonder where these strong beliefs come from. Seems to be a social justice agenda, is it from experience of [this system] not working, or something else?

¹² The term 'universal home visit' was changed during the research period to 'universal contact visit' (UCV) and 'family home visit' (FHV).

P20 seems cynical about the type of people who manage or administer our organisation; that they serve their own agenda before the clients. She also sees that politicians are shielded from the reality of practice to protect administrators and managers.

I coded this section with the same nodes as the field note. During data collection, participants spoke a lot about the changes in service delivery. This comment, however, marked the first time a participant had expressed a broader political concern related to these changes. Following this critique, I asked P20 during interview about the beliefs that might have underpinned her thoughts. I also felt comfortable to ask more questions of other participants about how they felt about the effectiveness of UHV as a strategy. Following Stynes (2000), this inductive approach continued throughout the research process.

I had accumulated 933 free nodes after analysing data sets relating to daily activities and lunch time discussions, observations of consultations and team meetings. These free nodes were then clustered into thematic groups and subgroups, referred to as 'trees' in NVivo. As a visual thinker, I printed off all the nodes, cut them out, then used large sheets of butchers' paper to cluster the nodes into thematic groupings. I then named these thematic groups. Some nodes were placed in more than one thematic group, while others were put aside with their relevance and association not yet established. Six general areas took shape: analysis of methods, organisational context, communication practices, participant beliefs underpinning practices, participant self-reflections and migrant work. For example, the node 'universal approach a political scam' was first clustered into a group labelled 'participant beliefs re organisation', which was then clustered into the larger theme 'organisational context'.

The remaining participant observation data sets were coded using a combination of forming more free nodes and placing new nodes into existing subgroups or trees. In response to this inductive process, field observations moved to more specific recordings of the constructs of culture and communications in response to existent field notes. This included keener observation of participant perceptions, beliefs, values and attitudes relating to culture and communication. At times these were clearly stated by the child health professionals, while at other times I continued to explore and document 'possible' meanings (Willis 2000, 115).

While all field notes were transcribed or uploaded through Dragon Naturally Speaking within 24 hours of collection, analysis of data took between 24 hours and three weeks. This was because video recording commenced seven weeks after the commencement of participant observation. Video recording required another set of pre- and post-video field notes. When I completed analysis of all field observations, a further two general categories had formed. These were impact of beliefs on practice and other CHP issues.

Changes to research design

This stage of data collection also provided time for reflection on the research design. The research design was originally conceptualised to include in-depth interviews with a small group of participant parents, following video recording. In the field, doing participant observation, I reviewed why this had been included. Two factors reinforced a decision to remove this aspect of data collection; the literature and logistics. Firstly there was a dearth of literature confirming negative health care experiences of migrants or new arrivals attributed to the challenges of communication and culture. The research question was based around an absence of data on how health professionals managed concepts of culture in intercultural communication encounters. Further as the project also needed to be contained within the context and scope of doctoral research frameworks, and I had already added observation of consultations into participant observation, I decided that post-video in-depth interviews with child health professionals would be more helpful in answering the research question. Parent participant experiences of health professional communication could be explored in future research projects.

This presented minor challenges, as I had already submitted information for parent participants to be translated and printed. Rather than change the written documents, I explained to parent participants that this aspect of the research design had changed. I also brought this change to the attention of the ethics committees in the annual review process.

Data collection and analysis 2: making visual recordings of practice

The next stage of data collection was video recording consultations between consenting child health professionals and parents who were marked as culturally different to the health professional. Video recording was used as a strategy to enable examination of the intersection between the thoughts and feelings that shape

intercultural communication and the practice of intercultural communication, that is, to examine the intersection between beliefs, ways of knowing and doing.

In a study of communication and culture, it is essential that the complex and situated nature of communication encounters is accounted for. Given the notion that spoken words account for only seven percent of a communication encounter, where both participants speak and understand the same language (Mehrabian 1972), it was considered essential in this research design to find ways to reflect on multiple aspects of communication. Video methods enabled this reflection.

In traditional ethnographic approaches, field observations are often linked with in-depth interviews carried out in the field. These in-depth interviews rely on memory recall for the interpretation of events and also perhaps professional rhetoric that may not have transformed into practice. That is, there may well be differences between what people say they do and what they actually do. In an interview setting, participants can reflect on the thoughts and feelings that surround and shape their practice. When a visual recording of practice is added to the tools of reflection, opportunities are opened for participants to observe and consider how these thoughts and feelings might play out in practice. Visual recording supported participants to focus the reflective gaze on themselves.

Visual recordings in ethnography have been called a 'mirror with a memory' (Collier & Collier 1986, p. 7). This mirror, however, presents with limitations of perspective in relation to the subject and context of the recording, and researcher skills in recording and analysing visual data (Ratcliff 2003). Following Ratcliff (2003), video was used in this research design in conjunction with other ethnographic methods such as participant observation and interviews. By doing so, data was not confined to the subjectivities of the researcher, nor was it limited by the scope of video as method. More importantly, video was used so that participants could look at their actions, in the mirror, and reflect on the cognitive and affective processes that might shape their practice. In this way they were actively involved in co-constituting the research data (Gubrium & Holstein 2003).

Where visual research methods can be aimed at studying a society by producing images, or studying preexisting images for information about a society, this study follows Banks' (1995) third contention, where video recordings are used collaboratively with social actors to produce visual representations. In this study, visual representations underwent a further degree of collaboration whereby

participants were involved in the critique and analysis of themselves within the visual representation. Pink (2001, p. 89) suggests that this combines active discussion of 'video images with the informant while also attempting to understand how informants situate themselves as viewers of the footage'. In this way, I combined participants viewing their actions with the various discourses they drew on to discuss their actions.

Of further importance is the use of video recording to contribute to the study goal of research as praxis. Participants used video recordings as a reflexive tool, both contributing to practice and theory building. They openly reflected on their understandings of themselves and then linked this with what they observed in practice.

Use of video methods in health research and practice

Video tape technology has been used for many years in the health care arena as tool for reflective learning and research data collection. Some examples of use include communication with patients with cancer (Rosenbaum & Rosenbaum 1987) and nursing care of patients with cancer (Andersen & Adamsen 2001), patient–physician communication about HIV risk (Epstein et al. 1998), skills practice in nursing (Winters et al. 2003), evaluating paediatric resident performance (McCormick et al. 1993), nursing research into children's health and in emergency departments (de Mello, Figueiredo & Nascimento 2003; Wiman & Wikblad 2004).

Epstein et al's (1998) use of video recordings to explore patient–physician communication about HIV risk is particularly relevant to my study. Patient-physician consultations were videotaped, then the physician and patient independently reviewed the videotape, stopping the tape and making comment throughout the process. Semi-structured interviews were administered to evaluate patient and physician concerns and perceived communication barriers to the assessment of HIV risk behaviours. The researchers found that using the physicians and patients as experts was a particular strength of this study. By interpreting their own actions and feelings, the participants offered insights into the interview and uncovered unexpected barriers to communication.

Child health professionals in developed countries are also becoming increasingly familiar with the use of video technology as a strategy to assess and develop infant-parent attachment and parenting skills. This is demonstrated by the work of Martha Farrell Erickson in the United States of America through the Steps Towards

Effective, Enjoyable Parenting (STEEP) and the Seeing Is Believing program (University of Minnesota Centre for Early Education and Development 2004). In Scotland, Christine Puckering (2004) used video technology in the Mellow Parenting Program, as did Margy Whalley (2001, 2004) in the United Kingdom in the Pen Green Centre for children and families.

Many of the participants in the study attended the 2004 South Australian National Parenting Conference, where Christine Puckering and Margy Whalley presented their work. Puckering and Whalley spoke about their use of video to enhance infant maternal attachment with parents and infants with, or at risk of, developing attachment problems. Child health professionals in the CYWHS working in the family home visiting program (FHV) now use video technology as part of their everyday practice to work with parents, building and developing relations between parents and their infants. As such, most child health professionals are familiar with the use of video in the child and family practice setting.

On one occasion, I was attending a FHV with a health professional to video the intercultural communication interaction. During this visit, the FHV nurse was planning to video a brief interaction between the mother and her baby. Unfortunately, the batteries of the nurse's video-camera went flat. As I had my video camera, we tried to put my batteries into her camera. When this was unsuccessful, I offered to postpone my video recording of the intercultural communication encounter so that the nurse could use my equipment. I then loaded a spare tape into my camera and she proceeded with the consultation and recording of mother/infant interaction. I negotiated with the nurse and mother to take field notes on this occasion, and made an alternate time to return to make a video recording. During this time we joked about the commonality between child health and research equipment (field note 050819). This reflexive approach enabled the methods of data collection to be located in the everyday world of participants.

It was intended that the video recorder would be set up as free-standing where the consultation would take place. Participants suggested that it would be better if I came in to make the recording, as the nature of the consultation was that parents and professionals moved around the room and between rooms during a consultation. I was thus invited into the consultation room to make recordings.

In using visual recordings of intercultural interactions, I was mindful of the presence that both researcher and technology in the room might have on the outcome of the

clinical encounter in the room and subsequent reflections on the consultation. I considered technical matters carefully, 'because they produce the detailed subject as much as they gather information about him or her' (Gubrium & Holstein 2003, p. 29). Participant professionals were, in effect, laying their practice bare for scrutiny which I believe called for an enormous trust in my abilities to genuinely and respectfully manage research data.

Erickson (1992) argues that a video camera is no more intrusive than recording field notes when trust is developed and participants support the rationale for the research. Relationships developed during participant observation with professionals enabled participants to enter the interview setting with a sense of safety relating to how I would make sense of their personal experiences. Parent participants were given material to explain the nature of the research and were offered as much time as needed to consider their decision about consent.

Engaging participants for video recording

Participants invited to take part in video recording included child and family health professionals, parents and their infants, interpreters and cultural consultants. Recruiting parent participants was undertaken with much support from CYWHS administrative staff, staff from the ABC International Translating and Interpreting Service, and participant child and family health nurses.

When this stage of data collection commenced, participant child health professionals had for the most part already provided written or verbal consent. Those who had given verbal consent transferred this into written consent prior to video recording.

19 videos were recorded in a range of practice settings, such as child health centres and parents' homes over a period of six months. The consultations recorded had a range of purposes. In summary; eight video recordings were made of universal contact visits, one of a family home visit, one of a migrant home visit, seven of child health centre consultations and two of responsive home visits.

Parents who were culturally different to participant health professionals mostly spoke languages other than English. To maintain ethical integrity, I needed to have information for parent participants translated into the most commonly used languages. Firstly, I did a retrospective analysis of consultations over the previous six months that had required interpreters. This enabled me to decide which languages to have consent forms transcribed into. Using this data, I arranged for

consent forms, letters of introduction and information sheets for parents to be transcribed into Vietnamese, Swahili, Arabic and Dinka¹³.

Initial ideas for recruiting parent participants did not match organisational strategies for contacting and working with parents. As such, I consulted with child health professionals, managers and administrative staff to realign my recruitment strategies to have minimal impact on parents and organisational processes. A range of ideas emerged over time.

Firstly, participant child health professionals who had consented to this stage of data collection were invited to identify consultations where they knew that they were working with a parent from a culture other than their own. This approach worked only for participants who had an ongoing relationship with families, such as those involved in the family home visiting program (FHV), those involved in migrant home visiting (MHV), and those with established relationships with parents who were working through identified issues through consultations in the child health centre (CHC). For the majority of child health participants it proved difficult to plan ahead, as many did not know who they were consulting with until they saw their appointment sheet on the day of appointments.

To augment this strategy, I worked with the administrative staff with whom I had become familiar throughout participant observation. I had helped out with filing and various other office and communication tasks, including making cups of tea and coffee. As part of their role, administrative staff organised interpreter bookings for universal contact visits (UCV). They agreed to identify all parents who were noted as requiring an interpreter in one of the four identified languages. They contacted these parents with a conference call with an interpreter to arrange times for UCVs. During this call, they agreed to ask these parents, through the interpreter, if they would be happy for a researcher to come to their home with the nurse to invite them to be part of a study.

Given this undertaking, I then met with staff from the translating and interpreting agency to explain that administrative staff would be asking parents if a researcher could accompany the child health nurse to the home. I had worked with this agency to translate information for parents and had developed a rapport with some of the staff. They were understanding of the request and informed other relevant

¹³ My thanks goes to the Australian Federation of University Women, who financially supported the translations through awarding me the Brenda Nettle Bursary in 2005.

interpreters (a number of whom had also translated the written material) of the impending minor addition to their role.

Once this structure was established, administrative staff became the first point of contact for recruitment for parents involved in the UCV program. If a parent was happy for a researcher to come to the UCV, the administrative staff member would leave a note to say 'happy for researcher to attend' or 'no to researcher'. I checked records approximately three times a week. When I found an affirmative note, I would ask the allocated child health professional if they were still happy to be videoed and if the timing for video recording suited their schedule.

Where consultations were conducted at the child health centre, parent participants were generally invited by the health professional or me, to take part in the research. This invitation occurred in the waiting room prior to the consultation. At other times, I waited outside the consultation room until the child health participant had asked the parent if they were interested in taking part. If parents declined the invitation I simply stayed in the waiting area or attended to other tasks.

When a consultation was in the parent's home, such as a UCV, I travelled with the health professional to the home, and waited outside in the car. The health professional and interpreter asked the parent/s if they were happy for me to come in and invite them to take part in the study. If the parent/s were comfortable for me to come in, the child health nurse called me in from the car. On occasions, the child health nurse preferred that I accompany them to the door to explain the research, with which I complied. On most occasions the parent/s read the *information for parents* (appendix 7C) and agreed to take part in the research. After signing the consent forms, we commenced the consultation. I made it clear to parents that they could ask to turn off the video at any time they requested. This offer was taken up by many parents, requesting that the video be turned off to feed a baby, or to weigh a baby naked.

On one home visit, a mother said that she did not want to sign the consent form, but wanted to be part of the research, and she did want me to video the consultation (field note 050721). We recorded the parent's words on the consent form and proceeded with recording the consultation. This alerted me to the consideration that a signed consent is in itself a cultured strategy. On many occasions, both the mother and father were present and both parents read the information before one parent signed. On one occasion, a mother wanted to take part in the research, but wanted

her partner, who was not present, to read the information first. In this instance, another date was set for a visit when the father would be present (field note 050729). When we managed to catch up with the father at home he offered his support to the project and had signed the consent form prior to our arrival (field note 050921).

Field notes were recorded following video recording sessions. These included procedural reflections alongside initial responses to participant communication behaviours. This also provided an audit trail to strengthen the validity of the research design (Lincoln & Guba 1985).

Making records of practice

Every video recording involved a child health professional, at least one parent, an infant or child, and myself as researcher, who videoed the consultation using a hand-held camcorder. An interpreter was present for seven consultations and an intercultural consultant was present for one. Where an interpreter or intercultural consultant was present, they were asked to sign a declaration of confidentiality (appendix 9).

Recording commenced when consents had been completed and checked and there were no further questions regarding the study. I reiterated that I would stop recording at any time if requested during the consultation. When the consultation was completed I stopped recording. I did not routinely offer the parents a copy of the recording, as I did not want this to be misunderstood as coercion. Two parents requested a copy of the DVD. After gaining verbal consent from the child health professionals involved, these parents were given a copy. To my surprise, I was not asked by any parents about what might happen to the images of them and their families. I hoped that this was because I had addressed this issue explicitly in the information for parents (appendix 7c). I continued to feel some angst that parents may not have considered the scope for misuse of this data.

I used field notes to record pre- and post-video conditions. These included, for example; the place of the consultation, how we were received by the parent, and any comments that the health professional might have made about the research process or the intercultural consultation.

The 19 videos were converted to DVD. A trusted family friend of mine did this. He was paid for his time. This occurred within a week of the recording. Unfortunately, a

declaration of confidentiality was not signed, due to an oversight on my part. However, the confidential nature of the data was discussed with him. The DVDs were returned to participant child health professionals between one and three weeks after the recording and with sufficient time to allow the participant to view and reflect on the contents prior to interview.

Data collection and analysis 3: reflecting on intercultural communication

The DVDs went for periods of time ranging from half an hour to one and a half hours. I reviewed all DVDs within one week of receiving them, and then again prior to in-depth interview with participants. Most DVDs took one to two days to view and consider.

Participant talk of a partnerships approach or the parent advisor model (Davis, Day & Bidmead 2002) was prevalent in field observations. The majority of participants had undertaken training in this model before the study commenced, as it had been mandated as organisational professional development. Because of this dominance I critiqued intercultural communication on the DVDs through a lens of partnership as described in the PAM and an ethnographic curiosity of possibilities of meaning.

I used a broad conceptual framework of asking who, where, why, what and how communication occurred. Having recorded who was involved in each consultation and where it occurred, I also recorded the why or purpose of the consultation, for example, a UCV or child health centre appointment. I then asked critical questions about who directed the agenda of the consultation and why this might have been. On a micro level, I asked the same questions of particular vignettes within each DVD, such as why a health professional chose to give particular information, and who was served by this information and in what way they went about giving this information. In relation to partnership, I put myself in the place of the parent and asked if I would feel partnered and what health professional behaviours might indicate this. Of culture, I asked questions such as what specific considerations the health professional made to indicate their consideration of potentially differing cultural needs of parent participants. I noted the processes of engaging parents, attending to the core purpose of the consultation and the closing stages of the consultation.

I took notes of these reflections to inform in-depth interviews with health professionals. I kept these handwritten notes in field journals that were read and

reread prior to interviews. In this way, I moved away from traditional video methods where microanalysis is often used to describe an in-depth taxonomy of rituals (see, for example, Ratcliff 2003). It was the primary intent of this research design to use video data to prompt self-reflection of participant health professionals.

All 19 child health professional participants who consented to be videoed also consented to participate in an in-depth interview with the researcher. These participants were given a copy of their DVD for reflection, along with a note indicating topics to consider while viewing the consultation and what to expect in the in-depth interview (appendix 10). Of these 19 participants, eight had not looked at the video recording before the interview. For example, when offering Participant 4 a copy of the DVD to preview prior to interview, she said, *'I will not look at it. Even if you do leave it here... I want to see it but looking at it once will be enough; with you'* (field note 050921). It seemed P4 wanted to view the video but in a supported or structured environment.

The majority of participants who had not looked at the DVD said that they had wanted to preview it, but had run out of time before the interview. Participants occasionally postponed interviews so that they had extra time to view their DVD. The logistics of annual leave, sick days and busy family lives also meant that occasionally much time elapsed between video recording and interview. Interviews were held between a minimum of nine days and maximum of five months following video recording. Excluding the minimum and maximum times, the average time between video recording and interview was 43 days.

In-depth Interviews

In addition to the 19 participants who had visual recordings made of their practice, a further three participants from the field took part in field interviews that were transcribed for analysis. In this section I explain how the interviews were conducted

The 19 participants who consented to a video recording being made of their practice consented at the same time to an in-depth interview to reflect on the contents of the recording. Three participants were interviewed in the field without a visual recording to reflect on. This was because we were either logistically unable to organise a consultation where they might be video recorded, or because they did not wish to be recorded. These participants alternately consented to discuss their ideas around culture and communication in practice. All interview participants consented to have

the interview audio taped and transcribed for data analysis. Two transcribers were used. They both signed a declaration of confidentiality (appendix 11)

Conducting the interviews

Participants were offered a range of options regarding the place of interview. 17 participants chose to have the interview in the workplace environment. 16 of these interviews were held in the child health centre and one in an administrative centre. We used vacant rooms, such as consultation rooms, day service rooms and group rooms. Interviews held in child health centres were held during the child health professionals' lunch breaks or at the end of their working day. This meant that we met more than once for many interviews. One participant chose to have the interview in my home. This was because the participant worked part-time with a young family, and her place of work was a long distance from her home. Another participant requested that I come to her home, which I did.

Interviews often began in a hurried way, as participants were rushing to have a break. I usually prepared drinks for us before the interview, and we often ate lunch while watching and discussing the DVD. To each interview I brought with me a laptop computer on which to view the DVD and a digital dictaphone. The interviews began with general discussion on how participants found the process of being recorded and looking at themselves on DVD, if they had done so. Interviews then followed the process detailed in appendix 10.

Participant responses to visual self-reflection

During the interviews, many participants talked of their discomfort in viewing themselves on DVD, but only a few cited discomforts with my presence in the room. P3, for example, talked of feeling nervous about being videoed, but suggested that this did not affect the way she behaved in the consultation (interview 3 050920). P2 hoped that she wasn't too stilted because of the video in the room. She also concluded that she didn't think the video process resulted in her doing things differently in the consultation (field note 050831). It could be that child health participants were so accustomed to having third parties in the room through student placements that this aspect of the method caused little disruption. It seemed the video caused more concern to me as researcher than to the participants. Any concern the participants had did not seem to lead to a noticeable impact on their practice.

Most participants were not happy with the image of themselves presented on DVD. P8 said, '*I just hate watching myself on telly ... it's foul*' (interview 8 051123). I asked P13 to explain why she had felt uncomfortable looking at the DVD. Her response is typical of the concerns of most participants:

I think, just, you know, I mean I'm sort of fairly comfortable with my own image but when I looked at it on there I thought gee God I was big in there, look at those trousers, how could I wear that? And I think when I went to weigh [the baby] my bum was ... and I thought Julian can you put that video somewhere else, other than on my bum. It's fascinating, things like that, because I hadn't even really thought of; because of where you were and what you were picking up, oh my God I've been going to the gym three times a week, it's not showing up on there. I didn't get bent out of shape by it but it was just interesting. (Interview 13 051220)

Most participants initially focussed on how they looked and were critical of their bodies and clothes. We often spent time discussing these issues before progressing on to discussing communication practice. Like P13, however, most noted themselves noticing body image but were not 'bent out of shape' by it.

P18 also disliked viewing herself onscreen, but at the same time talked of enjoying having the recording to share her working life with her family. She said:

I found it really helpful for my own two kids particularly to watch ... the kids could actually see that this is what we do and they were commenting on how we were on the floor you know looking at ... what we do with the babies ... (Interview 18 060317)

Having dealt with issues of appearance, the next most common response participants had was how useful the process was for clinical reflection on practice and their beliefs about intercultural communication practice, and for recognising areas for improvements. P18, for example, recollected her role in the consultation. She said:

Like it went for a really long time, and the thing I sort of thought was the amount of stuff that you actually go through or that I went through ... I came away pretty happy ... that I hadn't sort of left anything out and that I'd sort of made a lot of plans and everything ... (Interview 18 060317)

This comment was echoed by others. Many noticed areas for improvement with their communication practice. This related to how they engaged with parents and how they worked with interpreters. P10, for example, noted

There's probably a bit right at the end where I said to her... 'is there anything else that you wanted to bring up?' She brought a bit up about the baby. It's sort of, it's hard to kind of really get the idea of what she was saying but [the baby was] sort of jittery... she said it wasn't a startle reflex and I think because of the time I kind of minimised it a little bit and if I have my chance again I perhaps would have given her a bit more of a plan with that, I wasn't really impressed with that (Interview 10 051128).

In another example, P11, watching herself on DVD, noted herself completing paperwork in the parent's presence. At this time, she commented on how the paperwork seemed to distract her from engaging with the parent. She said, 'By watching the DVD I've changed my practice in that I make absolutely sure I've got as much of the paperwork done before I go to a client's house' (interview 11 051129).

Watching her intercultural interaction on DVD, P19 noticed that the amount of time the interpreter took to interpret her communication with the mother seemed much less than the she had taken with her original dialogue. This caused P19 to question the accuracy of the interpretation. P19 suggested that she had never considered this aspect of intercultural communication before, saying, 'I've only just noticed that then' through the DVD (interview 19 060328). Following this, P19 determined to discuss her expectations regarding the process of language interpretation with the interpreter before a consultation.

All participants found the process of reflecting on practice through visual recordings beneficial to their practice. P10 summarised the general response of participants when she said:

I think it's good because I think it makes you think about your practice because you can get on a roll, can't you, and just, you do the same thing again and again, and I always like to know that I'm doing a good job and that other people think that I'm approaching them okay, so yeah, I think it's good to think about what you're doing. (Interview 10 051128)

Schott and Henley (2004) suggest that health professionals rarely get feedback about their communication behaviour or the effectiveness of this communication.

They state that health professionals ‘need safe opportunities to understand their own style of communication, to be able to adapt it to suit different people and different situations ...’ (ibid, p. 65). The use of video with reflective in-depth interviews is demonstrated here as an example of effective critical reflection.

Significantly, P7 made a point which validated the use of visual recordings to extend understandings of self in practice, saying, ‘*I think it’s always good to do something like this to actually see your work because your perception sometimes isn’t what you actually do*’ (interview 7 051107). It is this notion that perception and memory of practice do not always represent the reality of practice that prompted the use of video recordings in this study.

These examples and discussion represent the ‘catalytic validity’ of the research process (Lather 1986, p. 272). Importantly for the emancipatory goals of this study, participants shared their increased self-understanding and self-determination throughout the research process. This was enabled by attention to reflexivity and reciprocity in the research process. The historical and cultural aspects of researcher positioning were also considered throughout the process in order to engage openly and transparently with participants.

Where culture meets communication

The goal of the interview was to reflect on the place of culture and communication in child and family health practice. Having met with me in the field and viewed the *Approach and topics* information sheet (appendix 10), the majority of participants came to the interview ready to discuss issues of culture and intercultural communication, whether or not they had previewed their DVD.

After an introductory conversation, we made our way into watching the DVD together. I reiterated to participants that I was expressly looking to understand the content of communication, why specific information might have been given, where this information might have come from, what shaped their approach to communication and where this might have come from. In this way, we explored the taken-for-granted ways in which interpersonal communication is constructed. This meant that all interviews progressed in different directions, with different foci. In one interview, for example, we talked a lot about the notion of partnership, and how it was learnt, understood and enacted. In another interview we mostly talked about how culture was learned, understood and enacted.

In the 11 interviews where participants had reviewed their DVD, participants took a more active role in determining which parts of the DVD we watched and discussed. We reflected on intercultural communication within the DVD by asking questions of the actions and then discussing related affective and cognitive possibilities. This discussion was informed by field notes from participant observation and prior analysis of DVDs. In this way we formulated ideas and constructs over time and place, reflecting on previous discussions about ideas, thoughts and feelings.

Questions were generated in direct response to the DVD as we watched the everyday intercultural communication interactions of the participant health professionals. These related mostly to the behaviours observed on the DVD, or the thoughts participants were having about what was occurring on the DVD.

For example, P14 and I watched the DVD as she responded to a mother, who was asking her questions. I asked P14, *'Can you tell me what was happening then, what sort of, what did you see yourself doing in this bit?'* P14 responded by saying, *'I wasn't listening to her enough. I was jumping in with the answers and asking more questions'*. I was then able to probe further, asking, *'How come you say that?'* We were then able to discuss the pressures P14 felt about keeping within the time constraints of a consultation and the pressure she felt to give parents solutions (interview 14 060208).

In another example, P15 and I were watching her question a mother about feeding her infant. In the following interview excerpt, I asked P15 about the sense she made of her observations:

R: Can you tell me, what do you think when you look at all of that?

P15: It's just finding out what she's doing and how she's going and trying to reassure her that she's doing the right thing.

R: And in your mind is that what you're doing; you're trying to reassure her what she's doing is the right thing?

P15: Well as long as it is the right thing. So I'm just trying to ascertain exactly what it is that she's doing.

R: Because I'm interested with the questioning. I'm thinking, 'Now why are you driving those questions; why are you asking those questions about feeding?'

This opened the discussion to the possibilities of how and why one looks for a common topic to enhance the relationship, an underpinning agenda of looking for maternal strengths, and the construct of the 'right way' to feed a baby. This data built on field notes that I had recorded in stage one of data collection relating to the range of ways that health professionals support parents who breastfeed.

In another example, I used an open question that could have been interpreted from a behavioural, affective or cognitive level. While watching P12 giving information to mother about feeding her toddler, I asked, 'What do you think so far?' P12 replied:

Ah I don't know. I'm just thinking if I'm saying the right things here. I was trying to think, 'What am I supposed to be focussing on?', communication to the Vietnamese family? I think I'm focussing on talking to a family whether they're Vietnamese or not, and that's the way I really treat my families. I'm not sure if you're supposed to do it. (Interview 12 051213)

This enabled the conversation to move into a discussion on the notion of 'right' ways of practising and the construct of sameness and how we manage this in practice.

To understand how ideas and values were constructed, I asked direct questions following participant responses, such as, 'So why is it that you choose to do it that way? I mean is there a belief or a value or...?' (Interview 18 060317). This often built on field conversations. For example, I had conversed with P18 in the field about her beliefs about motherhood. This issue came up in the interview, when P18 was drawing on her personal experiences of being a mother to give an example. I was able to draw from our field conversations the following question:

Can you talk a bit more about what you mean when you say the concept of mothering is, I can't remember the words you used, either it's not valued or it's not funded or something in society?'

In this way I was able to integrate field notes, visual recordings and in-depth reflective interviews.

Participant experiences of the research process

Overwhelmingly, participants expressed their enjoyment in the reflective process of the in-depth interview. The barriers to this process were time and energy, but participants said that on reflection the process was worthwhile. This was mostly accounted for by the opportunity to reflect on practice. While participants spoke of their desire to improve practice in the area of intercultural communication, it seemed

that the opportunity to just speak about how things were going for them was experienced as a benefit.

I felt uncomfortable at times when I challenged participant thinking as part of the research process and led them into potentially uncomfortable territory. P9, for example, expressed her concerns that the consultation we videoed was a particularly difficult visit. She still agreed to take part in the in-depth interview, but had not reviewed the DVD herself before the interview. In another example, P14, who had been tentative about reflecting on her practice, ended the interview by thanking me for the opportunity to take part in the research (interview 14 060208).

A comment made by P7 summarised the expressions of other participants. She said, *'I think it's a very interesting exercise and a helpful exercise'* (interview 7 051107). Following this statement, P7 thanked me for being sensitive to staff needs. She said, *'It's always nice how you roll your sleeves up and come and help us when we need help, its very good'* (ibid). It seemed that the benefits of involving myself in the field were experienced through to the interview process.

Ordering and analysing stage two and three data

In addition to visual recordings, stage two data generated 16 'pre/post video' field notes that were loaded onto NVivo for reference. Three pre/post video field notes were integrated into broader observational field notes, taken on the same day. Transcripts of the 18 reflective, in-depth interviews and three field in-depth interviews were also loaded onto NVivo for analysis. This analysis generated a further 15 memos. All of this data was subject to the same process of inductive analysis used in stage one data analysis. As I read and reread the data, I looked for signifiers, such as participant discussions of thoughts and feelings specific to communication and culture; how and where they learned their skills; what they saw themselves doing; and how they made sense of what they did. During this stage I particularly looked at how participant actions might be shaped by their thoughts and feelings and the cognitive and affective responses they gave to account for their actions.

To prevent the categories established from analysis of participant observation data possibly predetermining the categories for analysis of transcribed interviews, this data was again analysed using the inductive approach of free nodes. A total of 1266 free nodes were attributed to analysis of the first five interviews. This constituted eight hours and 36 minutes of interview data. At this stage I repeated the process of

printing off the list of nodes, cutting them out and visually placing them into groups on large sheets of paper. While some data aligned with existing thematic groups, a further 12 thematic groups or trees were created with the remaining free nodes. I coded the remaining interviews using existing categories, creating only the occasional free node. At the end of this analysis seventeen thematic areas were:

- researcher positioning, behaviour beliefs
- analysis of methods
- organisational context
- participant beliefs underpinning practice (PO)¹⁴
- participant self reflection (PO)
- working with the cultural other (PO)
- communication practice observed (PO)
- communication; the helping process (I)¹⁵
- communication; characteristics and approaches (I)
- communication; participant beliefs (I)
- communication; participant qualities (I)
- communication; core skills (I)
- working with interpreters and ICCs (I)
- beliefs and values (I)
- working with the cultural other (I)
- cultural self, and
- linking beliefs and theories to practice.

After this process was complete, I read and reread scripts within each category to make sense of the data, and often referred back to the visual recordings and their accompanying notes. I also referred back to original field notes and transcripts for clarification. Additionally, I cross-checked information, for example, from the thematic area of 'participant self reflection (PO)', with that of 'beliefs and values (I)'. During this process, I explored the data through a postcolonial feminist lens and wrote about the areas of participant understandings of culture and communication in the context of child and family health, the external, structural, professional and personal influences on intercultural communication, the internal influences on intercultural communication, and the intersections between how intercultural communication was observed by myself and participant health professionals. During

¹⁴ PO denotes data collected during participant observation

¹⁵ I denotes data collected during interviews

this time, I noticed how participants appeared constrained and restrained by embedded binary sets.

Summary

A fundamental approach to this study, informed by postcolonial feminist literature, is to study issues of identity and representation *with* participants, not *on* the participants. The intellectual property developed through this study will, in the future, be returned to participants through the development of themes for application to professional development. This professional development will hopefully enhance the capacity of child health professionals to practise more effectively with clients from a range of cultures with a goal of reducing health care inequities. We know from the literature that communication is a stubborn and persistent barrier to improving health outcomes for migrants and new arrivals. Such stubborn persistence pushes researchers like myself to find alternative methods of inquiry and then use this to not only disseminate the findings through publications, but also to build professional development activities.

Ethnography has enabled me to bring together a range of data collection strategies. I have developed a research design that expands current use of in-depth interviews through the use of video recordings as a reflexive tool. In doing this, I have created opportunities for greater depth in understanding the possibilities of meaning (Willis 2000) presented through ethnography. Through prioritising the interwoven principles of reciprocity, dialectic theory building and validity (Lather 1986) I have co-constructed research data and theory with participants. As such, this research is presented as praxis. These principles provide a framework for the transformative agenda of postcolonial and feminist inquiry in a criticalist paradigm (Anderson 2002). I follow Lather (1986, p. 272) in claiming a ‘collaborative approach to critical inquiry ... to build emancipatory theory, and to move toward the establishment of data credibility with praxis-oriented, advocacy research’.

Throughout the research process I explored and activated my identity and social situation through dialogue with participants, through written field notes, readings and academic discussions. As such, I attempted to take responsibility for my identity as white (Harding 1991). I recognise that in choosing the methods and theoretical framework, I have challenged others to come with me to explore their constructed positioning. While this was at times uncomfortable for both the participants and

myself, it is a necessary discomfort if we are to find new ways of understanding the impact of culture in the everyday communication practices of child and family health.

CHAPTER 6

PEOPLE AND PLACE

How to form and use the written word so as to produce, in the reader's mind, the complexity and 'there-ness' of the quite differently, and in many ways antagonistically, formed original is indeed a formidable challenge. It is a multi-layered and complex task in which there can only ever be variable and partial success. Representation is always selective and transformative, putting the original in terms of something else. But this is not a road block to productive communication about ways in which human beings produce their social reality. (Willis 2000, p. 116)

Introduction

In this chapter I introduce the reader to the participants and the everyday 'complexity and "there-ness"' of the work place of child and family health (ibid, p. 116). This partial representation begins a layering of understanding that will be built up in the following analytical chapters.

To set the scene, this chapter is divided into two sections, people and place. Having set the framework for understanding the historical and sociological context for the study in previous chapters, this section ensures, as in a painting that the subject within the painting is not floating without a backdrop. Hunt and Symonds, in their ethnographic presentation of *The Social Meaning of Midwifery*, explained the necessity of the historical and sociological metaphoric 'frame' to ensure the painting is displayed at its best (1995). This section extends the metaphor by claiming the site of the study as the background in the painting which contextualises the locale of the subject within the broader historical and sociological framework.

People

Participants were recruited to this study in either their professional role or in the role of a parent culturally different to a child health professional. A total of 45 professionals and 17 parents were recruited to the study. Additional persons were present for recordings and observations, such as partners to parents, infants and children, grandparents and interpreters. The numbers of parents present in parent education sessions were not included in the data.

Child health professional participants

A total of 45 staff members took part in participant observation stage of data collection. Participants came from the following professional groups: nursing, including those at registered nurse level one, level two, and mothercraft nursing, social work, physiotherapy, medicine, cultural consultancy and administration. From this group, 19 child health professionals agreed to take part in a video recording of a consultation and subsequent in-depth interview. All but one of this group were child health nurses. To maintain confidentiality, the role of the other professional is stated as being drawn from the above health professional groups.

The question of cultural demographics

Participants involved only in participant observation were not asked any demographic details. The rationale behind this was to gather information as an outsider by initially collecting only the observational data that visiting parents or outsiders might also gather. Child health professionals who participated in video and in-depth interviews were asked for demographic information. Also, they were all asked about their understandings of culture and asked to talk about their ideas about their own cultural identity.

Only four professional participants were observed to be other than of Anglo descent. Three of the four observed to be other than white held the role of inter cultural consultant (ICC), while the fourth was a child health professional drawn from the professional group comprising the disciplines of nursing, medicine and social work. As a researcher trying to understand how culture plays itself out in the workplace, it was essential at times to take the position of an uninitiated observer, asking the question, 'How would an outsider identify this group?' I asked, 'What markers would be used to identify them culturally? If I were a parent recently emigrated from the Sudan, how might I describe the group that presents to me?' The most obvious cultural markers were skin colour, English language proficiency and gender. From this perspective, all child health professionals were English-speaking, the majority were white, and all but one female.

A missing cultural descriptor here is class. Describing class differentials is inherently tenuous, as they are constructed by one's own value base through life experience. First responses would be to describe the group as coming from the middle to working classes. This crude attempt at homogenisation demonstrates my own constructs. Australian Bureau of Statistics (ABS) data identifies categories such as income, employment status, educational qualifications, and type of accommodation

and skill level of employment as part of socioeconomic status (1991). Socioeconomic status can be viewed as one aspect of governmental categorisation of class.

An ABS interpretation of socioeconomic status was applied in this study. All child health participants who were videoed and took part in an in-depth interview were employed in professional or associate professional roles. 11 participants held undergraduate degrees. Of this group, four held one graduate diploma, one held three graduate diplomas and one held two graduate diplomas. In addition, four participants held two graduate certificates, three participants held three graduate certificates, and two participants held four graduate certificates. Of the eight participants not holding undergraduate degree qualifications, six held one diploma, one held two diplomas, one held five certificates, two held four certificates, three held three certificates and two held two certificates.

All participants held post-basic qualifications related to the expert area of child and family health practice. Four of the participants held community health qualifications and six of the participants held qualifications in health counseling. 15 had participated in the six week parent advisor training provided as organisational professional development. To summarise, all participants had expended considerable financial and personal cost to be equipped to fulfill their roles as community child health professionals. They are loosely categorised as being in a middle socioeconomic grouping.

Professional roles and experience

Within the scope of child and family health practice, all health professionals delivered a range of services to the community of babies and children and their parents. Child health professionals had discrete and sometimes multiple areas of specific service delivery. These included universal contact visiting (UCV), family home visiting (FHV), migrant home visiting (MHV), Aboriginal home visiting (AHV) and access home visiting (access HV), child health centre consultations (CHCC), and day service (DS) within the families and babies program (FAB). Depending on the area of service delivery, some participants were also involved in attending case conferences (CC) and running getting to know your baby groups (GTKYBG). Other professional consultations included developmental assessments carried out by medical officers and appointment-based profession-specific services carried out by physiotherapists and social workers. Child health nurses at RN L1 also ran

kindergarten screening programs in which all four- to five-year-olds are offered a health check.

All the areas of service delivery described above were represented by participants who were involved in video and in-depth interviewing. Eight participants were videoed during UCV, six during CHCC, one during a FHV, one during a MHV, two during access HVs and one during another professional consultation.

Health professionals spoke of a variety of related personal and professional experiences. In measurable terms, participants had worked in their profession for as little as five years and as long as 45 years, with an average of 26.2 years of experience. Participants had specifically worked in their current child health roles from a minimum of two months to a maximum of 34 years, with an average of 12.56 years experience. Participants ranged in age from 29 to 63 years of age, with an average age of 46.9 years. Eight of the 19 participants were in their fifties and five in their forties. Excluding the one participant who came from another professional group, the age demographics align with those from the 2002 National Review of Nursing Education, which cites a continued increase in the proportion of nurses in Australia aged over 45 years (2002).

Parent participants

Minimal demographic data was collected about parent participants. This decision was taken to position the researcher in the shoes of the child health professional to work from the place that they work from, thus increasing the depth of understanding of the intercultural encounter. Further, as the purpose of the study is to turn the gaze onto the child health professional and away from the migrant other, the question was asked, what explicit purpose would this data serve?

While there are examples of rigorous research undertaken by white women researchers with participants from marginalised groups engaging reflexively with participants in the research process (see for example Browne 2003), it was not the purpose of this research to focus on the problems of academic representation of the cultural other. Rather, I focussed on 'the problem of what we see and understand being framed by our own location in social relations according, for example, to gender, "race", class, and other positionings' (Dyck 1998, p. 20-21). The purpose of collecting demographic data from parent participants was to ensure that they were perceived by child health professionals as culturally different. This section describes how this was discerned in the child health environment.

It is argued that intercultural researcher/participant situations can be meaningful and productive (Shah 2004). For this project, the productive tension created by the need to engage critically resulted in parent participant data being collected only as a snapshot descriptor of the intercultural encounters, as experienced by child health professionals in their daily work. Parent participants were asked what country they had come from and the language most used. Many volunteered unprompted to the child health professional or myself an approximate stage of life when they migrated to Australia. While further information may have been interesting, it was not required to analyse child health professional understandings of their communication across cultures. Like participant child health professionals, I did not ask if a parent was a doctor, a wise woman or a peasant farmer.

A total of 17 parents participated by consenting to video recordings being made of their child health consultation with a health professional. Two of these participants were videoed twice with different child health participants. Parent participants came from a number of countries, including Sudan (N = 4), Vietnam (N = 3) and Lebanon (N = 2). One participant came from each of Korea, Russia, England, the Ukraine, China, the former Yugoslavia, India and Afghanistan. The language of preference for participants included Dinka (N = 3), Vietnamese (N = 3), Arabic (N = 2), Swahili (N = 1), Korean (N = 1), Dari (N = 1) and English (N = 6). An interpreter was engaged in eight of the videoed consultations. 16 of the parent participants immigrated to Australia in adulthood, while three immigrated in their adolescence.

Five of the parent participants were videoed meeting with a child health professional with their first-born child. Nine of the participants were videoed during consultations with their second child. For two of the parents of this group, their second baby was the first born in Australia. One of these two families was videoed twice, once with the baby born in Australia and once with a consultation for an older child born overseas. A further parent was videoed with her fourth child and two with their fifth child. Of this group of three (having four and five children), the babies were the first in the family to be born in Australia. In summary, ten of the 17 families involved were videoed with babies who were their first to be born in Australia.

An initial goal of the research was to recruit only parent participants experiencing the dual transition into both parenting and parenting in a new country. Over time, however, it became apparent that this was an unnecessary restriction in exploring communication and culture, as the focus was on the child health professionals' notions of culture and their visual reflection of this examined through communication

practice, not the experiences of parents experiencing dual transitions. This would require a different methodological approach and analysis and greater time than that available for a PhD program.

Of relevance to this study was the observation that the introduction of a parent to child health services with the birth of a child differs to that of a parent who has immigrated with children. The former would receive a universal home visit, which is a service designed to introduce the family to child and family health services in South Australia. In contrast, the latter would receive a generic service which may be initiated by referral from the Migrant Resource Centre of South Australia (MRCSA) or through child health services offered through the migrant health service (MHS). The first point of contact with child and family services might be through referral from either of these services or STARRS (Survivors of Torture and Trauma Assistance and Rehabilitation Service). The first point of contact might also be a parent's self-initiated phone call to arrange an appointment. The knowledge that parent participant experiences will differ depending on their parity did not exclude their participation from the study. The unifying factor was that the parent was born and raised in a country other than Australia and presented as culturally 'different' to the child health professional.

Place

Participant observation took place across two child and family health service delivery sites in South Australia. These were both classified as metropolitan and were on geographically opposite sides of the city of Adelaide. Both venues were located in similar socioeconomic areas and drew from similar socioeconomic and ethnically diverse communities. Theoretically, these service delivery sites would offer the same universal services to parents. The geography of each site impacted markedly on how participants felt about service delivery, their ability to work as a team and the services delivered to parents.

Site A: home and family

Site A is a 1960s brick home that has been converted into a service delivery site specifically for Child and Youth Health (CYH). It has a light, welcoming reception area with a chest-height desk, chairs around the wall, a weighing area for parents to monitor their baby's growth and boxes of toys and books. The area is modelled on a contemporary 'family room'. Off this room there is a small office used for 'open

session' consultations and consultations by appointment with child health nurses. A corridor leads off the reception area into a sitting room with a couch, comfortable chairs and a bookshelf. While the furniture is not all new, it is comfortable and in good to fair condition. This room is used as a quiet feeding area for parents and an open area for parents attending day service or waiting for the obligatory 15 minutes to pass after immunisation. It is also used as a spill-out room for parents attending parent education sessions during break times. A kitchen comes off this area. Staff would meet and talk and have lunch and tea breaks in this area, while parents use the area to prepare infant food when required or during breaks from parent education sessions. Within the building, to one side, are two large rooms, one used as a multidisciplinary consulting room and the other as a staff administration room. This room is locked, with a coded lock for client and staff security, i.e. security of personal information when staff are completing case notes and security of the staff's personal belongings. At the rear of the building there is a large group room used for parent education sessions, staff team meetings and kindergarten screening. There are also two small consultation rooms used primarily for day service clients. These rooms house cots, bassinets and other infant paraphernalia to support parents spending the day with a nurse at the service. A small consulting office adjoins these day service rooms. Client records are stored in a small room off the internal corridor opposite an administration room that houses a photocopier, printer and other administrative facilities. A few metres outside and behind the main building is another smaller multipurpose building. This building was only occasionally observed to be in use.

The building was on a popular bus route and car parking was across a busy road but generally readily available for parents and staff. Government car parking was within the grounds of the main building, so staff attending home visits only had to walk out the door to access a vehicle.

Field notes record the area appearing home-like (050727 part A 050819). The atmosphere was collegial, with staff working across all service delivery areas meeting together for lunch breaks and openly discussing daily personal and professional issues. Parents were encouraged openly in their shared use of the kitchen facilities and professional talk was generally self-monitored. It seemed, as in a home, that the kitchen became the hub. The administrative officer sat to the front of the kitchen and acted as gate-keeper when required, such as leading in a parent to use kitchen facilities or asking staff over lunch to be mindful of the level of

laughter if there were parents in the waiting area. The staff room was seen as a quiet working venue, but participants interrupted the silence of this space to informally access each other's expertise and to support each other.

Site B: exposed like a sore wound

Site B was a purpose-built venue designed as a hub to accommodate multiple child health, parenting and education services. It was situated alongside a joint car park opposite a public entry into a South Australian Government Department of Education and Children's Services (DECS) primary school.

On entry into the multi-service delivery site, one encounters the side portion of a large CYH reception desk. Understandably, not all people who present at this centre are attending to visit CYH. The CYH administrative officer is required to redirect people to other services and facilities. This is often problematic and time-consuming, as not all users of the facility informed the receptionist of their particular use of the building and no other service has a reception area open to the public.

At this venue there was also a large turnover of reception staff. During the five months of participant observation in this venue, four reception staff were employed on a casual basis. There were times with no reception support where child health staff covered the role. Often at these times as researcher I assisted in this area or assisted reception staff unfamiliar with the venue. Many staff talked of the layout of the venue, in particular the reception desk, as the reason why they had such difficulties retaining reception staff. Field notes record comments such as,

When I walk into this building I never know where I'm meant to go, who I'm meant to talk to. I can't imagine what it would be like for a parent as you walk through the sliding doors. You are faced with the big admin desk. Many times there is no one at the desk. When you go to the desk it's only for Child and Youth Health, whereas Child and Youth Health services are only part of the services that are offered at that centre'. (field note 050821)

The single-storey building was confusing on entry. On another occasion, field notes record,

I walked in and the only words to describe what I saw were "wow". There were people everywhere. I looked at the reception desk, and I didn't recognise the person

who was sitting there. She was a temp' relief person, [Participant 37]. Poor [Participant 37] seemed to be pulling her hair out. (050811)

On this occasion there was a council-run immunisation service being held in the multipurpose rooms which occupied much of the centre. Mothers, babies, children, fathers, aunties and sisters were spilling over into all available rooms. Participant 6 and Participant 41 spoke of not being able to hear telephone conversations during these busy times (field note 050811). While Child and Youth Health as a service was happy to assume the centrality of place and position amongst the other service providers by claiming the large reception area, the responsibility of this central geographical role was not supported by appropriate human resources; as field notes suggest, CYH was '*positioned to receive people but not equipped to do so*' (field note memo 050811). Despite these challenges, the room was open and airy and colourful.

In front of the reception desk was a large waiting area with couches, boxes of toys and books and a small play corner. Behind this waiting area, in the same open room, was a dining area distinguished by two to four tables with chairs around them. These were used by parents or staff for informal chatting over coffee or lunches. To one side was an open access kitchenette with a welcoming waist-height counter accessible from either end via child resistant gates. This kitchenette was used by many staff and parents. Interestingly, it seemed that staff from differing areas, were not always familiar with each other or each others' roles. People did not always introduce themselves, appearing content with their anonymity.

Behind the kitchenette was a day care centre accessible via a door to the side of the kitchenette. Parents and staff mostly used an alternate external entrance. These facilities were also used for crèche during parent groups held by services other than Child and Youth Health in the centre. To the rear of the dining area was an entrance into an external fenced child-friendly sitting area and two group rooms. These both had the facility to be divided to become smaller meeting rooms. Opposite the kitchenette, on the other side of the waiting area, was an office area for staff from another service which provided supportive services for families. These services were complementary to CYH services. Being geographically close to CYH services was beneficial for parents accessing both services. Staff from all services benefited from ease of referral and partnership activities.

Behind the reception desk were three small consulting rooms used by CYH staff and an area designed for day service facilities. The day service area comprised two consulting rooms for clients, housing cots, bassinets and infant paraphernalia, a sitting area with a couch, and a small office for staff use. Just outside the consulting rooms and near to the toilet and sliding door to the car park was an area with scales for parents to use for self-monitoring child growth. This area was also used for the 'open session'. Parents were not taken into a confidential room, mostly because there were not enough rooms and, as Participant 2 said, *'We use this open room to give them the experience that it's just for a quick chat. It's cold, and it's not confidential'* (field note 050811). She spoke of aiming to regulate attendance to open time. She suggested that if clients wanted to talk in an in-depth way about child health issues, they would be actively discouraged from using 'open time' and would be encouraged to book an appointment.

A consequence was that the needs of the mother and infant were not always met, as this example demonstrates. Participant 15, in an observed 'open session' consultation, avoided discussions of a confidential nature due to the exposed position of the consult and the pressure of seeing other clients waiting (field note 050829). There were two spare consult rooms on this occasion, but Participant 15 chose not to suggest moving location with the mother. The mother was talking about changing from breast feeding to bottle feeding. Participant 15 was not exploring the issue with the mother as she might in a confidential setting, with fewer time pressures or concerns of confidentiality. The parent was awaiting a place in the organisation's residential service to support her breast feeding and was observed to be experiencing conflict and uncertainty in her decision-making. The consult ended abruptly, with Participant 15 referring to the change to bottle feeding as accomplished, and moving the mother away from the topic of conversation. In discussing the consultation immediately after the 'open session', Participant 15 recognised the deficiencies in this approach, such as not exploring the problem raised by the mother and rushing the consultation to a superficial conclusion. Rather than initially addressing these within her practice, she spoke instead of the frustrations of feeling confined by the need to stick to time and direct the conversation to topics that were comfortable in an exposed environment.

Participants in this venue were more unsettled in their approach to work and more divided in their allegiances than those at Site A. Talk of frustration with many aspects of the venue was frequent. For example, Participant 6 and Participant 41

spoke of their concerns regarding the lack of foresight in developing a purpose-built venue (field note 050811). Participant 6 stated that *'the waiting room isn't big enough, the group rooms aren't big enough and we don't have enough counselling rooms'* (ibid). This was observed to be the case on many occasions. A further problem was the location of the CYH staff administration room, the communal lunch/tea room and the car compound.

The car park housing government cars used by home visitors is located behind a DECS primary school. Participants reported their frustration at having to allow extra time to pick up, load and return vehicles from this compound. They spoke of leaving things in the vehicles rather than unloading them at the end of each day to reduce time. During the research period, one of the vehicles was broken into and equipment stolen. Participants returned to loading and unloading vehicles. This is a common problem with use of government vehicles within many services. Participants expressed frustration in regard to the lack of recognition of their contributions in the planning stages of the venue, when issues such as this could have been alleviated or minimised.

The CYH staff administration room was located within the DECS primary school on the opposite side of the car park. This meant that nurses had to walk across the car park to access this joint office; this in itself, however, while being a source of annoyance, was manageable. What seemed to follow was a division between home visiting nurses and clinic nurses. Clinic nurses would often content themselves to stay in the purpose-built venue for the day, taking their breaks communally or catching up on administrative and clinical work in their allocated consulting rooms. Home visiting nurses would come and go through the DECS building and have little contact with the others. This lack of crossover during transit and informal communication times often led to communication difficulties and lack of opportunity for informal sharing of expertise and support for level 1 registered nurses. Level 1 registered nurses mostly undertook child health centre consultations (CHCCs). For example, Participant 15 said,

It splits us up. There were already personality differences but now there are fewer chances to work through them and build up a team environment, people can easily avoid each other'. (field note 050905)

This problem was compounded by the CYH-allocated tea room being a shared facility located behind the staff administration room. This facility was shared by

DECS staff from a number of school and support services. While this provided an opportunity for inter-service networking, its facility as a space for restorative breaks was compromised by the openness of the venue. This prevented and discouraged conversation of a more intimate nature. Use of the room as a spill-over facility for professional groups was also problematic. At times, there was physically no room to stand to have a break amongst the crowd of participants from the presenting unknown group.

A potentially more concerning problem was that access for all staff and some parents and children to this tea room was via the CYH staff administration room. DECS and other staff and parents walked freely from the car park through the CYH staff administrative office into the tea room or from the school through the tea room and staff offices to the car park. In the staff room were active client records, government car keys, telephones and computing equipment common to any administrative office, yet this area was used as a thoroughfare. Participant 15, for example, spoke of an incident where she needed to make a mandatory notification¹⁶. Participant 15 looked for a private office from which to do so, but found that none were available. She would have had to wait until the following morning to access a private room. Participant 15 was compelled to make this call in the potentially public domain of the staff administration office (field note 050905). Participants claimed they highlighted these potential concerns in the planning stages of the building, but that these were disregarded. They reported frustrations from their attempts to lock the door, which resulted in problems of managing accessibility. Attempts to simply close the door were not respected by others, and professional privacy consequently remained non-existent in this area (field notes 050829 & 050905). These frustrations were also felt as a researcher using the venue.

Summary

This initial representation of the visible geographical aspects of the service also suggest my underlying assumptions as a middle-class, white, woman researcher and mother about what mothers, infants and families might need in an environment to feel comfortable. I found safety and security in the health service that visibly represented a Western 1960s house, with a receptionist as mother who tracks the progress of the day and busy-bee health professionals who care for clients and share the load. I found Site B chaotic.

¹⁶This is a telephone call to report an incident of child abuse and requires giving out private client details and professional knowledge of the incident over the phone.

Site B professional participants contended with greater challenges of organisational geography despite the venue being purpose-built. Where Site A was valued by professional participants as home-like and welcoming, Site B was characterised by uncertainty and confusion. Problems of confidentiality arose in direct service delivery and in attending to administrative tasks. There was a sense of exposure and risk rather than the safety of a professional work environment. The notion of communal service delivery sites is sound in its provision of multipurpose access for parents and opportunities for partnership and networking for professionals, but in this venue its use by such a divergent range of groups, the limitations on space and the apparent lack of opportunity to negotiate space compromised its use for parents and professionals.

Site A, on the other hand, mirrored a place of early parenting, that is, a 'home' for clients and service providers which resulted in a sense of comfort and team spirit. Participant 12, for example, stated, '*I like everybody to feel comfortable and cosy and at home*' (field note 050819). It also represented a safe haven for parents, particularly mothers and their babies. Site B had been operational for approximately two years, so many teething problems of integration still existed.

The benefits of a shared approach to caring for parents and children under five years through multipurpose venues are well documented (see, for example, Cox et al. 1991; Dagg 1997). This is an approach being adopted by the South Australian Government through uniting child health, education and family support services (Department of Health 2004). Perhaps more attention to essential facilities is needed to ensure uncompromised practise, and to provide opportunities for individual and inter-service team development and maintenance. The sense of not being listened to and not having professional opinions valued by managers and organisers was corrosive.

In trying to understand the world-views that these child health professionals held and used in their workplaces, I found that there existed a number of collisions or colliding realities. As observed in a kaleidoscope, not all of these collisions were unhelpful or intended as harmful, but they did pose conflicts for child health professionals working with people from cultures other than their own. In the following chapters, I draw from the data to build a picture of the interrelated domains of professional practice and the broader cultured understandings of child health professionals. Within these fields, participants seem to limit their understandings by aligning with the colliding axes of binaries, rather than seeing the binary points as

ever-present within a broader kaleidoscope of possibilities. After setting the scene, I introduce participant constructs of developing relationships within an intercultural context. This is followed by critique of participant approaches to communication and their use of information in the production and reproduction of knowledge within child and family health.

CHAPTER 7

COLLIDING PHILOSOPHIES OF CARE

Introduction

This chapter specifically attends to issues raised by child and family health nurse participants. Nurses held strong views regarding their belief in the principles of social justice and their varied roles in delivering preventative health care within a primary health care agenda. This belief was mostly talked about by participants as colliding with, rather than working alongside, changes in organisational directions for service delivery.

A collision seemed to exist around ownership and control of the scope and direction of professional practice. Participants seemed to align themselves along a binary of 'us' and 'them', where child health nurse participants ('us') were in opposition to the organisation ('them') in their beliefs and goals regarding practice. This binary seemed to operate on two levels. The first was a structural level where participants' sense of 'us' related to professional goals of child health practice that were understood to conflict with the changes made to the structure and delivery of child health services. Changes towards a focus on universal service delivery were understood by participants as serving political and fiscal agendas rather than the identified individual needs of parents. The discomfort with this binary seemed to be heightened by participants experiencing practice in very different ways to how it was portrayed through popular media.

Secondly, the 'us' and 'them' binary was visible on an individual level when participants enacted changes to practice. Participants suggested that the increased level of practice directives limited their scope to engage with parents in meaningful ways, such as building relationships and following through with clinical management. The organisation required participants to perform in more routine and prescribed ways, with a greater focus on bureaucratic tasks. This agenda conflicted with participants' sense of themselves as agents of community care rather than providing prescribed care in the community.

Further, the division of us and them at times divided the multidisciplinary team, with many nurses placing social workers and psychologists in the camp of 'them', seeing them as complicit in changes in service delivery and thus scope of practice. This

division seemed to reduce the scope for cooperative practice development between participants and the structure of the organisation. Importantly, it also reduced participants' belief in their ability to advocate for marginalised clients, such as those who are culturally different to themselves. The following discussions present an examination of the interplay between professional ideologies and how these philosophies are variously represented through discourses of equity, empowerment and care.

Investigating what 'they' are doing: what used to happen

During data collection, CYH was in the process of implementing changes in the content and scope of services to families. While care remained guided by NHMRC recommendations, services changed from a community approach, where child health nurses worked within teams to meet individual and locally identified community needs, to a program-based approach prioritising universal individual interventions. In this process, individual needs were assessed to identify those families at risk and who would benefit most from intervention. In the facilities where I observed practice, community engagement became the domain of managers, social workers and inter-cultural consultants.

While organisational discourses of practice changed from 'primary health care' to 'population health outcomes', understandings of underpinning ideologies seemed unattended. At this time of structural change, the organisation also implemented the widespread use of the parent advisor model. From this, participants understood that senior management were committed to implementing partnership principles within organisational communication. This belief in a shared ideology of partnership was shattered when participants observed senior management not subject to the compulsion to attend the PAM training or to enact partnership in changing practice directives. Implemented in a top-down manner over existing professional beliefs and practices, the unattended ideological differences between primary health care and population-based outcomes fuelled conflict.

Prior to 2004, child health nurses in the field were allocated a number of births within a given local government area. They generally contacted the parents of the baby by telephone and, depending on the parents' needs, variously organised a home visit, booked an appointment at a child health centre or left the parent to consider their options. Following initial enrolment, child health nurses generally offered parents ongoing support through a child health centre. Continued care with a constant known child health professional was mostly possible.

Child health nurses determined who in their community required home visiting and determined the length of time for visiting. Child health nurses referred to allied health professionals both within and outside of the organisation. Aboriginal health workers worked alongside child health nurses to engage and work with Aboriginal families. Migrant home visiting services were organised by child health nurses in the field, who liaised with country-specific migrant workers, such as Vietnamese health workers.

This system was not without problems. Many parents did not engage in the service, especially those most at risk. The *CYH Annual Report (2005b)*, for example, suggests a 61 percent increase in the number of enrolments due to changes in service delivery between the 2001-2002 financial year and the same period in 2004-2005. In some areas, parents were considered 'over serviced' because they enjoyed and benefited from the regular contact with child health professionals and other mothers. These parents were generally assumed to be those in higher socioeconomic areas, referred to unofficially as the 'worried well'. In other areas, nurses felt the burden of needing to attend to a greater number of home visits to engage families without extra funding for this resource-rich activity. This was generally claimed to be in the lower socioeconomic areas. Many nurses knew and experienced problems of the uneven distribution of resources.

Within a new public health framework, the organisation asserted a strong epidemiological evidence base for changes in practice to support population-based health outcomes. However, participants' experience of these changes seemed to conflict with their professional beliefs around community child health practice and primary health care. Both claimed equity and equality as discourses of care, but there was little shared meaning between these discourses and their ideological underpinning. The next section briefly explores, through the literature, how the organisation constructed its understanding of equity in health care provision, followed by a presentation of the conflicting positions on community health and primary health care experienced by child and family health nurses.

Universality, health inequalities, inequities and disparities

Terms such as 'inequalities', 'disparities' and 'inequities' are ascribed different meanings, but are often used interchangeably in academic and policy literature (Braveman 2006; Pittman 2006). Paula Braveman clarifies that 'health disparities' is a term mostly used in the USA. It refers to the notion of difference typically focussed

on 'racial/ethnic differences in health or health care [where] standard measurement approaches have involved comparing other racial/ethnic groups to Whites or non-Hispanic/Latino Whites, that is, persons of primarily European origin' (Braveman 2006, p. 179).

'Health inequalities', a term used predominantly in Western Europe and Australia, also refers to difference, but predominantly difference in socioeconomic status, rather than race and ethnicity. In addition, but to a lesser extent, health inequality pertains to gender and then ethnicity or national origin (ibid). The added dimension of fairness separates equity from disparities and inequalities. Braveman cites Margaret Whitehead in clarifying that 'equity' in health implies fair opportunity for reaching health potential without disadvantage, if it can be avoided. Braveman systematically reviewed definitions and applications internationally, arguing the need for a definition that explicitly specifies the relevance of social position and the types of comparisons that should be made when using the terms health disparities/inequalities/equity. Braveman states:

A health disparity/inequality is a particular type of difference in health or in the most important influences on health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have experienced social disadvantage or discrimination) systematically experience worse health or greater health risks than more advantaged groups. (Braveman 2006, p. 180)

A health inequalities agenda therefore draws on human rights concepts in aiming to systematically reduce potentially avoidable differences in health between groups of people who have different relative positions within social hierarchies (Braveman 2006).

Health inequalities in Australian child health

In an Australian child health context, Garth Alperstein and Victor Nossar reviewed the NSW *Family First Initiative* and its ability to reduce health inequalities (2002). Like *Every Chance for Every Child* (Department of Human Services 2003a) in South Australia, a combined universal and sustained program was undertaken. Based on family home visiting and community capacity building, the program claims to 'have the potential to break the cycle of poverty, vulnerability, and disadvantage for this cohort of children and their families: and to begin to reduce health inequalities'

(Alperstein & Nossar 2002, p. 40). This agenda clearly addresses disadvantage between groups within a specific population cohort.

Based on Rose (2001) and Marmot's (2001) work, Alperstein and Nossar caution against focussing on a preventative services to high-risk families without a parallel population-based strategy (2002). Victora et al (2003) confirm globally that while a combination of these two approaches offer promise in reducing child health inequalities, targeted approaches have come nowhere near eliminating inequity.

Vimpani (2000, p. 538) states that 'the best home visiting programs are universal in scope'. This addresses the social justice principle of equity in access to health care. With a broader and global child health agenda, Victora et al concur that universal coverage approaches are clearly superior where high-risk groups are difficult to identify (2003). From this discussion, a number of questions arose regarding the nature of child health risk that was used to identify need in the child health context. Participants reported that risks that might prompt enrollment in the family home visiting program included Aboriginality or the mother of the newborn being classified as 'young'. This is confirmed in the *CYWHS Home Visiting Manual*, which denotes priority criteria for enrollment into this program as mothers under 20, Aboriginality, social isolation and negative maternal attribute (Children Youth and Women's Health Service 2006b). While this is now clearly stated, at the time of data collection these priorities were still being determined. Participants remained uncertain about how universal first home visiting might benefit the population as a whole.

Rose (2001, p. 995) identified that population strategies attempt to 'remove the underlying causes that make disease common'. How disease is identified within the CYH approach to universal services is not explicit. It seems that 'disease' is identified as a sociological construct of risk where families are identified within social welfare parameters that intersect with child health, such as potential inability to care for children due to socioeconomic and environmental conditions. Thus, the purpose of this universal intervention is not to remove underlying causes of 'disease' across a whole of population approach; rather, it is used as a universal strategy to identify those families at risk of problems. This rests on a new public health approach whereby the medical view of health is challenged to incorporate the importance of environmental factors (Baum 1998a). This link did not seem clear to the majority of participants, who did not appreciate the paradigm links between population and primary health care. This confusion centred on understandings of 'universality'. It seemed that they equated a notion of universal contact with universal care.

Universal contact as universal care

The majority of participants had the opportunity to listen to presentations on the benefits of population health approaches to child health in the early stages of changing practice. However, many remained frustrated as they attempted to understand a purported whole-of-population approach to care that, in practice, is experienced as a segmenting of continuous family intervention in order to identify families at risk. To explore this issue, I refer to an observed discussion between participants. In this discussion participants explored their understandings of current approaches to care and the notion of universality.

During an afternoon discussion in the nurses' administration office, P1 expressed her frustrations in attempting a third universal contact visit (UCV) with clients who *'are never home'* or are *'not home when they say they will be'* (field note 050622). She exclaimed that CYH has never engaged *'the two percent'* and asked why so much money is being spent to *'get them in'* when CYH does not even prioritise their attendance to services. P4 explained to P1 that *'the two percent'* is from a population health presentation that staff attended detailing the argument underpinning sustained family home visiting. She explained that the two percent are the group of families with multiple conflicting problems whose needs are primarily attended to by child and family welfare services; in South Australia, Families SA. She explained to P1 that UCVs are not aimed at identifying or supporting this group.

How this two percent is determined or identified was not clearly ascertained during the period of this research. Child health professionals also seemed unclear of this notion. It was understood by some that a primary purpose of UCVs is to identify the 12 to 15 percent of new births whose prospects are believed to be considerably improved by intensive child health services delivered through the family home visiting (FHV) program. This is explained in the *Sustained Home Visiting Program Model* (Department of Human Services 2003c). Confusion and frustration existed around not only the imposition of a constraining uniform practice model to identify those who will benefit most from targeted FHV services, but also the usefulness of a single segmented visit or UCV to families who did not qualify for FHV.

In a further lunchtime discussion, P7 said:

... they say they have a client focus, but they don't. If they did we would be able to do a lot more. What does one visit, to the clients who are at last being shown some interest, do? (Field note 050701)

In this extract, P7 suggested that if the organisation is to claim its purported client focus within a universal approach, all families are deserving of ongoing care. P7 perceived care from an individualised approach not necessarily compatible with a universal one. According to Marmot (2001, p. 988), this approach is primarily based on 'the detection and modification of individual risks'.

P7's concerns were a clear example of what Rose describes as the 'prevention paradox', where 'a preventative measure that brings large benefits to the community offers little to each participating individual' (1992, p. 12). In describing this paradox, Rose uses the example of the changes required by individuals to transform a population's health as being small. For example, using butter instead of margarine is only a small change in relation for each individual relative to the large change it would make to obesity or heart disease on a population-wide basis (Rose 1992, p. 13).

The change referred to by P7 is her perception that the majority of individual clients are now receiving only a small amount of care and time in a single visit. In this way she does not see this visit as the beginning of a potentially longer term individually focussed intervention based on principles of primary health care. Through Rose's 'prevention paradox', P7 questions what the larger benefit brought to the whole of community might be through universal contact delivered as a single assessment-based home visit. While these benefits might include the notion that all families have contact with a child health nurse to assess their baby and introduce them to child health services, the question remains: does this universal contact through home visiting make any impact on child health outcomes for the majority of the population, or is it only useful in identifying risk?

Conflict around the purpose of the UCV highlighted a binary division between participant nurses and the organisation. The organisation possibly saw the UCV as a universal measure to bring about a small change in the health care outcomes for the whole population, but did not explicitly state the nature of this change. Many participants perceived that they were not able to enact care effectively in the limited scope of the UCV. They experienced UCV as a service separated from the FHV program, which offers continuous care. They saw little scope for individualised care within this model.

If this experience of UCV as a separate service unrelated to others is also shared by parents, how would we examine its efficacy as a service? In order to make sense of

participants' experiences of UCV as separate, the following section explores how universal home visiting services are presented in the current child and family health literature.

Care as a single universal contact home visit

The two main arguments in the literature advocating for a universal approach to health services are that it is non-stigmatising (Barker 1990; Deave 2003; Department of Human Services 2003c; Victora et al. 2003) and that it is appropriate when high-risk groups are difficult to identify (Victora et al. 2003).

The goals of universal home visiting detailed in the proposal for the implementation of the sustained home visiting model are to:

- Connect with the parents and promote parent-infant bonding and attachment
- Provide an opportunity to respond to issues/concerns the parents may have regarding the baby's health and development
- Conduct a comprehensive infant health check
- Establish with family any specific support needs and how these needs can be addressed
- Connect the family to local services/programs available
- Link parents with appropriate early health support services e.g. child health clinics, parenting groups, family and baby programs. (Department of Human Services 2003c, pp. 9-10)

This description of UHV appeals to the primary health care goals of child health practice. It includes a health promotion aspect, an opportunity for responsive needs-based care and a point of access into specific local and health-related services. What is implicit, but unstated in this description, is the goal to prevent stigmatised identification of those who are at risk and difficult to reach.

Of concern to nurses is that parents may not identify concerns through one home visit, and may need more time to develop a trusting relationship, particularly with clients who differ culturally to themselves. Research literature confirms that in the environment of population-based approaches, high need individuals who are screened for risk factors can be missed (Browne 1989). A safety net such as the opportunity to develop a relationship with an individual nurse needs to be developed (Barker 1990).

Using issues of depression and child abuse, Elkan et al (2001) applied Rose's population health thesis to the targeted versus universal home visiting debate in the United Kingdom. They found, for example, that a one-off depression screening is unreliable as it yields a score for a moment in time that may change the following day. They interpret Rose's (1992) epidemiological work as suggesting that 'health visiting interventions targeted only on mothers with high depression scores are likely to leave untouched a vast, submerged burden of disability arising from depression' (Elkan et al. 2001, p. 116). They suggest instead that child abuse and depression exist along continuums within society, not only at the deviant margins. For example, the needs of those inflicting abuse on their children within the vast majority will not be addressed. Therefore, there can be no downward shift in the distribution of the incidence of severe abuse (Elkan et al. 2001). Elkan et al maintain that 'a one-off screening exercise designed to pick up "severe cases" or those at "high risk", will be out of date almost as soon as it is completed', and that these parents may never return to the service of their own volition (2001, p. 117).

Universal contact as non-stigmatising

One of the arguments to support a universal approach is that it is 'non stigmatising and more likely to reach all families who can benefit' (Department of Human Services 2003c, p. 7). The argument to prevent stigmatising families can be traced to reflections on the purposes and effectiveness of home visiting in the United Kingdom, where the focus of universal home visiting moved from one of monitoring to screening (Cowley, Mitcheson & Houston 2004) within a child protection framework.

The universal nature of the first parent health visitor scheme (FPHVS) in the United Kingdom, for example, was 'felt to prevent stigmatisation' (Deave 2003). The FPHVS, based on Barker's (1984) child protection framework, offered all parents of first-born children a sustained home visiting program for approximately 12 months. Deave indicated that approximately ten percent continued with the scheme until the infant was two years old (2003). This differs to the notion of universal service employed by CYWHS, where sustained home visiting is only offered to a select group of families who are predominantly young or socially isolated mothers or families of Aboriginal or Torres Strait Islander descent.

Two points of interest arise from analysis of approaches to reduce stigmatisation. The first point is the child protection agenda driving the universality of contact, and the second is the nature of universal contact. In South Australia, all child health

professionals are mandated notifiers¹⁷, obliged under law to notify child protection concerns. The primary focus of community child health work remains overtly child health and parenting. Child protection services (Families SA) take on the greater welfare role. While child protection and child health services in South Australia work alongside each other, there were few formal links observed within practice. Those that were observed were often vague and uncomfortable (case conference field notes 050705, 050809 & 050825). A child protection agenda may be driving changes to community child health service delivery in Australia (Layton 2003; Vimpani 1998), but popular community discourses suggest that child *health* services are seen as socially acceptable to the community, whereas services such as Families SA are seen as more stigmatising. UCV is presented to both child health professionals and families as informed by a health rather than a welfare or child protection agenda.

Information gathered in the UK informed the design of universal care within the Australian context. Australia's history of colonisation differs to that in the United Kingdom. The relationship between health and welfare was assumed to be similar. However, the catastrophic treatment of Australia's indigenous populations led to a very different popular consideration of health and welfare agendas. The ramifications of the forced removal of Aboriginal children are felt to the present day (Bird 1998). This also holds for poor mothers and those from minority cultural groups, in the wider Australia population, whose children could be taken away with little concern for the mother or family relations. This has really only changed since the advent of single parent benefits, more emphasis on the needs of families, and recognition that children do better with their family, even when it is poor and has problems. In light of the 'care' of forcibly removed indigenous children in government-sanctioned institutions, nurses are particularly keen to differentiate their child health agenda from an overt child welfare agenda.

From this we can see that the argument of universal contact as non-stigmatising presents yet another binary for participants to contend with. In trying to remain located at the health end of the health or welfare binary, it remains challenging for child health participants to recognise the value of the potential benefits of a universal service, as it is used to serve a welfare agenda. This is particularly difficult when a

¹⁷ In South Australia, under the *Child Protection Act 1993*, 'certain groups of people are required by law to report to Families SA if they suspect on reasonable grounds that a child is being abused or neglected and this suspicion is formed in the course of their work' (Department for Families and Communities 2007)

perceived welfare agenda is understood by participants as theoretically flawed and resulting in reduced capacity to offer alternate essential services.

Professional identity

Child health nurses' beliefs about practice and how practice should be enacted are imbued with personal and professional politics of identity. Participants represented themselves as nurses with a central belief that nursing is something that one is, rather than what one becomes. P2, for example, said that she makes a 'good nurse' because she's committed and has '*an intrinsic, ... you know there must be a bit of my brain that lights up ... when I do this ... that's always been there*' (interview 2 050916). When asked about approaches to care, P10 said, '*I guess it's just, I don't know ... the kind of person that I am I guess, I think being a nurse you want to be empathetic and you want to be helpful I guess*' (interview 10 051128). Professional critiques of practice were thus always jointly interpreted through a lens of personal identity. Nursing was mostly expressed through discourses of vocation and devotion, where nurses are born, not made.

This belief in the intrinsic nature of self as nurse was even stronger when participants spoke about working in community settings. Reflecting on the type of person that goes into community nursing, P11 said, '*Nobody's going to become a community health nurse unless they had some sort of belief in why they're doing it*' (interview 11 051129). Part of this belief was that working in the community was different to working in hospitals. Participants tended to distance their community practice from the practice of nursing in institutions. P5, for example, said:

I try to distance myself from the institutional care that my grounding is in, because they seem to identify and label people which I'm very against, and because it's a sickness focus. (Interview 5 051025)

The community was believed to be intrinsic to the health of the individual and the family (P7 interview 051107). P2 stated, '*Hospitals! You know there's just this is blip in someone's life (laughter) this is not where people live, people live in community and are mainly well*' (interview 2 050916).

This belief was supported through professional discourses of primary health care and the new public health. For example, P2 talked of '*building strong families which build strong societies which build ... strong communities*'. As she watched herself on DVD, P7 in another example, explained how she links parents to community and

society to mitigate isolation and therefore build society. P18 and P6 spoke passionately of their role in community capacity building through the provision of groups where parents can spend time together building relationships based on the commonality of their parenting experiences, thus building their own social networks. Interestingly, the groups run by P18 and P6 were not part of formal program delivery. As such, they felt continuous pressure to change the focus of these groups to information-giving only and leave networking to organisations outside CYH. Participants believed that siloed approaches to care of families and prescriptive tasks of universal services undermined the essential components of their primary health care agenda.

How 'we' experience it

Participants experienced UHV as a program delivered in its own right attempting to meet primary health care goals through a single universal home visit. This perception was fuelled by their experiences of delivering UCVs in discrete program areas. They saw this as preventing their ongoing engagement with families. In addition they were uncomfortable with the UCV goals being seen as primary health care objectives.

Most nurses were employed in a specific program, such as UHV, FHV or CHCC. Of the 18 child and family health nurse participants who took part in videoing and in-depth interviews, 11 were involved at some time in UCVs. Nine had no opportunity for follow up with UCV clients in the child health centre setting. Seven attended exclusively to UCVs and Getting to Know Your Baby groups, while the other two had dual roles of Aboriginal home visiting and UCVs. If any of this group of nine worked with a client on a parenting or child health issues, their only point of follow up was a phone call or to revisit the client. There was limited time allocated for these purposes, as P3 explained:

... by the time you do three visits a day and you're meant to be back and the fourth time is meant to be a follow up visit, by the time you get back to the office, finish the paperwork of the last three you've done, make one phone call, it's after five o'clock. You don't have time. (Interview 3 050920)

A further two participants involved in UCV had a dual role of CHCC immunisation. This enabled some 'unofficial' follow up time at the child health centre.

'Bloody home visits, I'm packing my bag and going home' (P12 field note 050728)

... people were very unhappy and angry talking about being understaffed. P34 was talking about 'bloody universal home visits', and not having enough time and being told that universal home visits take priority over all other activities. She said, 'If those people up there want universal home visits to take priority they can come and tell everybody else that we are not going to give them the service'. (Field note 050728; emphasis in original)

Frustration over the primacy of UCV was ever-present at both sites. The above note was made just after I had arrived in the field one morning. P34 spoke heatedly, after having to telephone a client to say she could not attend the intensive day service she had booked into to explore a breast feeding problem. P34 had been instructed to cancel her DS to attend to other nurses' UCVs due to sickness. While P34 thought the DS more important, she was told that the organisational focus was on UCVs. This example epitomises participant frustrations about the organisation's restructuring of service delivery.

In this example, P34 was angry that she was 'told' how to direct her practice, and was thus regulated. Additionally, she was angry that the time taken to offer every family of a first born a home visit meant that other services were reduced or cancelled. These services included day service and child health centre appointments, which are client-initiated needs-based services. At the time of this field note, parents were waiting up to two weeks to work with a nurse on issues such as breastfeeding, sleep or behavioural issues. This is a particular concern for breastfeeding, for example, when the WHO recommends that mothers exclusively breastfeed their children for the first six months of life. With a two-week waiting period, many mothers will wean their babies. Participant 34, like others, took an individual needs-based approach to care, built on the premise that parents will develop their parenting skills agentially through contact with supporting child health professionals and will be empowered to care for their children and seek support when the need arises.

Many participants believed that their capacity to provide individualised care was eroded by the epidemiological or population-based approach taken by the organisation, where needs are identified through population risk factors. It was in direct conflict with the child health nurses' beliefs that their role was to work

alongside parents in supporting parenting and managing child health. The problem is explained by Participant 19 in the following way:

... a UCV is not designed as a needs based process, it's not designed as that, it's designed to get them in, it's designed by the government and it's this beautiful wonderful thing and every baby gets a UCV but it's really not focussing on the client's needs. It's focussing on our needs to get them in, get them registered, get everything in our book, everything in their blue book and then get them into clinics but it's actually not focussing on what the clients need there and then when you're going in. (Interview 19 060328)

Participant 19 was frustrated that, rather than care for a mother and baby as she is professional equipped to do, she was servicing a political and administrative agenda. Participants seemed to experience a binary pull between organisational foci of a universal model negatively perceived as political tactics for funding, and clinical practice foci of individualised care premised on discourses of empowerment. Similarly, P20 asserted that the purpose of UCVs was to make South Australia's statistics look 'great' and to say that every family is offered a home visit (field note 050801).

This pressure was heightened through popular media reportage of UCVs. A press release from the Premier of South Australia, dated May 3, 2006, stated, 'Another part of the \$17.8 million *Every Chance for Every Child* initiative is the *Universal Contact Visit*, which offers every South Australian family with a newborn baby a visit by a child health nurse in the first few weeks of their baby's life' (2006). A similar statement was repeated on the front page of *Healthy Focus: the Official Newsletter of the Children, Youth and Women's Health Service* (2006). This public advertisement of the financial investment invoked a sense of valuing the program that perpetuated the child health professionals' frustrations when the lived experience of delivering the program was markedly different to the media rhetoric.

On another occasion, Participants 1 and 34 discussed a television report from the previous night (field note 050609). It seemed that a senior member of CYH staff had been on a commercial television channel proclaiming the benefits of one of the tertiary level services offered through CYH. In this example, they were exasperated that this particular tertiary service was being promoted while they were being pressured to reduce their delivery of these services in favour of universal contact services. This television report was raised by P34 because parents who had seen the report, had, that morning, asked her to provide them with more services.

Participants felt that while the organisation was saying one thing to them about prioritising UCV, it was saying something else to the public.

‘Stupid questions’ (interview 3 050920)

Frustrations about being directed, by the organisation, to practice in areas that participants felt left them with little room to act agentically with parents were felt at the individual level with parents through the use of the Pathways to Parenting questionnaire, or P2P (see appendix 12). P10 explained the problems of asking the questions in the UCV, saying that they are missing the point of meeting clients’ needs:

... going in and asking them a whole lot of questions about stuff that I don’t feel like we have much right to know unless they want to tell us, unless they feel comfortable to tell us then yeah I think that’s missing the point, and not developing, because I don’t think you get a chance to develop a relationship anymore, I think you have a certain amount of questions you’ve got to ask and get through a certain amount of stuff and it’s almost like you bust through the door and bombard them with all this stuff and then you go and that’s it. And then you say, ‘Oh come and see us some time’, and it’s like I don’t think so. I mean it’s not always like that and I think there are circumstances where it is a valuable tool to have, and it can work really well and it can be people that are happy to give you that information and perhaps will but I think also it can be a bit tricky too. (Interview 10 051128)

The P2P is asked of all parents who are visited for a UCV. Child health nurses are instructed to read the following to clients:

I would like to know more about you and your family. I have a questionnaire called “Pathways to Parenting” to go through with you. In the Pathways to Parenting we are asking everyone the same questions. Some of these questions are personal and you do not have to answer questions if you do not want to. I will read the questions as they are written and that way everyone is asked the same things in the same way. (Appendix 12)

Of most concern to participants was the time taken to implement the P2P and the intimate nature of many questions, such as use of illicit drugs and experiences of abuse either as a child or as an adult. The questionnaire is asked of the primary care giver, which is most often the mother of the infant. If the father was present, participants would trouble over whether to ask these questions in front of the partner, orchestrate a quiet moment with the mother or leave them unasked, which may defeat the purpose of identifying families in need. Many participants left the

P2P until the end of the visit to ensure that as much time as possible had been spent on developing a relationship trusting enough to ask the P2P. A problem of time for the child health nurse arose if parents revealed situations of abuse or high needs. They felt clinically under-equipped to deal with these issues and felt that, due to time pressures, they would open a Pandora's Box, leave it open, and disappear from the clients' life. Participant 1, for example, said, *'All this thing does is open up lots of things and then leaves you hanging. We can't even use it to offer other help, we don't get extra time if they bring up issues'* (field note 050609). Concerns primarily related to control of child health professional practice and concerns for leaving parents' issues unattended.

In not being able to support parents as they believed they were equipped to do, participants felt that they had failed in their role. This deeply personal concern, shaped by beliefs in the value of mothers and families, was expressed by P8 when she said, *'You care about people. You care about their answers ... You're not just ticking off a form'* (interview 8 051123).

Use of a structured health needs assessment tool

A structured health needs assessment tool is similarly used in the United Kingdom to identify families at risk. Mitcheson and Cowley investigated its use and found clients expressing serious concerns to the health visitor during the questionnaire-style assessment tool that were left unattended (2003). They claim that 'the insensitivity of the questioning style and the controlling nature of the interactions seem potentially quite harmful to vulnerable clients' (Mitcheson & Cowley 2003, p. 421).

Conversational analysis of the P2P was not undertaken in this study. However, findings from thematic analysis are comparable with Mitcheson and Cowley's findings. Similar to Mitcheson and Cowley's study, features of the needs assessment stage of the health visitor-client interaction were that it was overtly controlling, there was an asymmetry of participation, and the health visitor dominated the agenda. These findings could be explained by the very nature of giving a structured questionnaire in any setting. It is the nature of the relationship, formed in the context of the entire encounter, that is most important. Interestingly, Mitcheson and Cowley's study found that client questions were only invited when business was concluded (2003). In this study, participants were observed mostly to save the P2P questionnaire until the end of the home visit so that they had an opportunity to build a relationship with clients during the visit by focussing on

immediate parental concerns and a child health assessment during the time of the consultation. The questionnaire often acted as a summary of already known issues. Having worked on establishing a relationship, the questionnaire was less of an intrusion.

Problems of time management and duty of care remained. Fitting the questionnaire into the consultation after having attended to parental needs continued as problematic, as did the potential to leave unattended sensitive parental needs raised at the end of the consultation with little or no opportunity to follow up effectively.

From their one year study conducted in North London exploring the health visitor assessment processes including use of a structured health needs assessment tool (HNAT), Houston and Cowley claim that structured health visitor needs assessments addressed 'superficial issues not of immediate significance to the client' and that 'deep seated emotional and psychological problems were left untouched using the HNAT with its questionnaire, checklist approach' (2003). This reflects the concerns of universal home visiting nurses in South Australia. Health needs assessment is considered by nurses as an ongoing process (Cowley et al. 2000) and is confirmed by health care researchers as being a complex continual event requiring highly skilled health visitors (Bryans & McIntosh 2000; Cowley 1995; Cowley et al. 2000; Mitcheson & Cowley 2003). Cowley et al claim that:

structured assessment tools impede the relationship building process and provision and suggest disapproval of such non-specific support; instead, they are used to identify an organisationally-approved diagnostic label, without which health visiting services are disallowed. (Cowley, Mitcheson & Houston 2004, p. 521)

Can the same restrictive medicalised outcome of using a structured assessment tool be claimed of the South Australian participant group? While there were a number of similarities, there were certainly some clear differences in the use of structured assessment tools. To begin with differences, the South Australian participants were observed mostly to work to establish a relationship with clients and ask the P2P towards the end of the consultation. This unfortunately meant that little time was available to address the presenting issues, as described in the initial vignette by P10. This approach might mean that, having built an environment of trust, parents may answer the questions in a more genuine way. The UK participants mostly asked the questionnaire at the beginning of the consultation (Cowley, Mitcheson &

Houston 2004, p. 510), which may have established an inquisitorial or judgmental environment for the remainder of the consultation.

Prior to the introduction of SHNAT, the role of the health visitor in the UK was general social surveillance, support and prevention (Cowley, Mitcheson & Houston 2004, p. 523). In South Australia, practice could be claimed to have previously had a minimal social surveillance role favouring medicalised health surveillance based on National Health and Medical Research Council recommendations. In the UK study, health visitors did not always explicitly ask the parents' permission to gather such data, nor were they explicit about the underpinning child protection agenda (ibid). In the South Australian context, participants always explicitly asked parental permission, as seen in appendix 7. Participants did not, however, explain the child protection agenda underpinning the questionnaire. Interestingly, from observational data, it would seem that participant health professionals themselves did not recognise the underpinning of a child protection agenda. It seems, rather than UK health visitors were aware of this agenda but actively deceived clients about the purpose of their agenda (ibid, p. 521). Cowley et al claim that where the objectives of the encounter are 'unclear, opaque or even suspicious to one or both of the participants, then confusion and conflict are more likely to occur' (ibid, p. 512).

Risk factors underpinning the SHNAT in the UK include epidemiologically defined family dysfunction and abuse serviced through a medically defined population approach to public health (Cowley, Mitcheson & Houston 2004). Participants from this South Australian study used the P2P, which clearly asked questions relating to experiences of abuse and family dysfunction but also socioeconomic considerations with a focus on infant parent attachment, to begin the identification of risk. If parents did not clearly fit these categories, they may have been excluded from appropriate services.

The criteria of 'nurse concern' also existed, where the nurse can argue her clinical concerns relating to, for example, revisiting a client or advocating for a parents' entry into the FHV program. This independent professional judgment, however, is mitigated by the requirement that all nurses present cases of concern to a case conference chaired by a social worker. Observations across both sites suggest that the social worker often challenged 'nurse concern', appearing to claim a gate-keeping role over further home visiting services based on an assumption that many nurses over-serviced, either out of habit instead of professional judgment or

because they were meeting their own needs to revisit clients. The following field note from a case conference setting demonstrated this issue:

P6 talked about going back in to check with the mother and her [breast feeding] supply. P22 asked, 'Why would we go back in?' P6 said, because I'm in the middle of an intervention helping her with her supply. P22 asked, 'Can she visit a clinic?' P6 said, 'It's more to do with continuation of care. I can't see her in the clinic. Sure she can go and see someone else, but it's helpful for new mothers to have some continuity of care'. (Field note 050825)

In advocating for her client, P6 prioritised an approach that involved developing a meaningful relationship with the client. Instead, it was argued that the client was best served to develop a relationship with the organisation. For P6, this conversation devalued her professional beliefs. She maintained the need for ongoing support for the private and intimate nature of supporting breast feeding. P6 also argued that the very nature of child health was the support of growth and development over a period of time rather than unrelated independent contacts between an individual and an institution. The outcome of this discussion was that P6 did not revisit the client; instead, she followed up with a phone call, and the parent was referred to a different nurse in the child health centre.

Continuity of care: the importance of developing relationships

The importance of developing a relationship between a visiting health professional and the family is highlighted in studies from the UK (Bidmead & Cowley 2005b; Deave 2003), Canada (Heaman et al. 2006), and Sweden (Jansson, Pertersson & Uden 2001). The UK and Canadian studies relate to the care of families in programs for targeted high needs families, similar to family home visiting. Integral to this approach is sustained visiting by the same child health nurse over a period of two to three years.

There is less research about programs offering universal accessibility to a service through universal home visiting based on population health approaches to care. The Swedish study, for example, describes a national child health promotion program that supports the families of children from birth to seven years as being accepted by 100 percent of parents of new-born babies. This service, however, offers a choice of contact options, either a home visit or a consultation in a clinic setting (ibid). Research on UK universal health visiting suggests that, rather than developing a positive relationship with health visitors, many parents felt judged by appearances or

socioeconomic markers and regarded the contact as ‘unnecessarily bureaucratic ... consisting of a high degree of “box ticking”’ (Roche et al. 2005, p. 510).

So discouraged was P25 that she spoke of her decision to resign her position to get out of ‘*seeing people for just one hour and then never seeing them again*’. She declared, ‘*I can’t keep working like that*’ (050829 field note), talking of the inability to form a relationship with the client to support them during the ongoing growth and development of their baby.

Participants see forming a relationship with clients as integral to their practice. In reviewing mothers’ views on the first parent home visiting scheme in the UK, for example, Deave suggests that despite the small numbers in the study, the findings may indicate that mothers place importance on health visitor continuity (2003). In evaluating parent counselling in community child mental health, Davis and Spurr confirm the need for continuity of care provision (1998). While this opportunity was provided and valued for child health nurses and clients involved in the FHV program, it was denied to the majority working in UCV and thus to the majority of parents. In child health, comprehensive care equates to the opportunity to provide continued care.

In a comparative analysis of contemporary Australian nurses’ discontents, Forsyth and McKenzie cite the lack of opportunity to provide comprehensive care as one of two most important issues for experienced nurses (2005). Comprehensive care means having time to spend with clients exploring social concerns and problems, developing rapport, and subsequently developing a deeper understanding of client needs (Forsyth & McKenzie 2005). A major block to being able to provide this care is cited as ‘lack of time available for anything other than minimum care’ (ibid, p. 212).

Reflecting these findings, Participant 3, for example, stated:

I find also the time restraint on forming a relationship with somebody in that one and a half, two hours that you’ve got, you’ve got to really put limits on what you can do. (Interview 3 050920)

Participants mostly seemed conflicted in determining whether these limits were set by clinical judgment of parental needs or by organisational need for the completion of paperwork. As P19 said:

... we should be going with how, what the client wants us to do rather than what we have to do as a process, and I think the more things they make us do on the UCV the more structured the UCV becomes, so we're not actually allowing that client to participate, we're almost taking over and actually not allowing that communication, and that client to actually go 'well actually I don't care about any of the information you're giving me I just want you to help me settle my baby'. (Interview 19 060328)

Participant 19 recognised the conflict between approaches to needs assessment and their potential impact on clients. Similarly, in a conversation analysis of health visitor consultations in two counties in the United Kingdom, Mitcheson and Cowley identify that health visitors often offer unsolicited information that is not in response to issues raised by clients (2003). They claim that this information reinforces the role of health visitor as expert and minimises client contribution and, in doing so, clients are disempowered (ibid). This is of great concern given that enabling and empowering as part of health promotion is a core role of the child and family health nurse discussed in chapter 2.

Care and caring

To make sense of the ontological conflict between approaches, I draw on the concept of 'care' raised by many participants defending their need for time and scope of practice. As a third body, this concept, raised by both parties, allows us to consider that there is always more than one issue being contested at any given time and that each issue informs and shapes the others.

Care was used by P8 as a lens through which she made sense of the P2P. She said, '*You care about people. You care about their answers ... You're not just ticking off a form*' (interview 8 051123). For P8, care was paramount, as it was for P6 in arguing her need to revisit a parent to offer ongoing breast feeding support. Suzanne Gordon (2005, p. 74) argues that:

The caring, nurturing side of nursing with its ability to deliver efficient care and make order out of chaos-so connected to femininity-seems to be the only uncontested space for nurses, yet it is simultaneously devalued.

Participants believed that the care they offered to clients was not valued by the organisation, saying they are not listened to and that their scope of practice had become so limited and repetitive that they were becoming deskilled. Following is a brief discussion on possibilities of interpretation of nurses' perceptions of being deskilled. After this, declarations of not being listened to will be examined.

The politics of repetition: ‘they don’t really care’

Participants talked frequently of becoming deskilled due to increased repetition in organisational work through UCV and the P2P. They feared for the future of the professional of child and family health nursing and their own ability to continue practising due to fatigue and lack of stimulation. Underpinning all of these concerns was a belief that ‘the organisation’ no longer cared about child and family health nurses or families who were not eligible for the privileged FHV program. I present an extract from interview with P7 with which to discuss these issues:

P7: Well I just think in the last twelve months our organisation has gone pure numbers, they’re not worrying about the clients, they still hide behind that client friendly [approach] but they don’t really care at all and the last thing that have shown that they don’t really care about clients whatsoever, [is that] we’ve got eight or ten pages of stats for one client, roughly.

R: So is that pathways to parenting?

P7: That’s part of it, that’s different again.

R: There used to be one page of stats?

P7: Let’s take a new enrolment ... you take your wad of pathways to parenting, plus there’s a separate pad for your genogram, and just to add insult to injury the genogram, they’ve made it a half a page, it’s an A5 size, and when universal home visiting first came out the nurses said this is not big enough, so it went to an A4 sheet size, very good, because I believe that parents really shouldn’t have more than one partner because it’s just too hard to do the genogram (laughing), but that’s beside the point, but you really needed A4 to get all these partners and all the children on these genograms. Now we’ve got A5 again and you’ve got a pad for that so you’ve got to rip that off the pad. It doesn’t seem much but it’s all time-consuming, there’s no holes in that genogram that’s another issue, so [you have to] punch holes in it, they are rectifying that but it should’ve never happened. Then you take out a child registration pad and an adult registration pad, you take the one to four week health check pad out and under child registration and adult registration, the poor father’s not mentioned unless he actively plays a part in the interview, he doesn’t get enrolled so there’s nowhere to put the father’s name on, it’s just crazy and so much repetition. (Participant 7 Interview 051107)

P7 argued that bureaucratic concerns have overridden concerns for parental needs. This resulted in a reduction in time to meet concerns identified by parents. Scope to direct practice was also compromised, as it was controlled by a standardised

approach to 'care'. Interestingly, P7 explained how fathers miss out on care because there is no space to name them on the paperwork. Although expressed in a joking way, P7 said she was not inclined to be interested in the extended families of mothers with multiple partners due to the size of the paper and extra time required to record a family genogram. This raised questions about unexamined normative standards of the style and size of families that exist in Australia that does not include those who require a lot of room for documenting.

Other participants talked of repetition, resulting in them feeling more fatigued (P9 field note 050728) and reducing their skills to the level of feeling like a '*trained monkey*' (P18 field note 051031). The effects of Weber's bureaucratic systems, Taylorism and Fordism seem to be felt by participants.

Organisational systems

Through a system of formal rationality, bureaucracies operate in a highly predictable manner, seeking to quantify as many things as possible to manage predictability and emphasise control as dominance over people (Ritzer 1993). Not only does the bureaucracy control the worker in this way, it also controls clients such that they may only receive selected services rather than a range of services (ibid). These aspects of bureaucracy are demonstrated through the introduction of UCV, where all clients receive a single introductory visit but are unable to access extended home visiting for identified problems with the same nurse. While they may be offered a service with another nurse at a child health centre, this is perceived as a fragmentation of services. Nurses also reported being reprimanded if they '*see*' a particular client for '*too many return visits*' in a child health centre (field note 050825). In this way nurses experience power as domination.

Ritzer (1993, p. 22) adds that 'instead of remaining efficient, bureaucracies can degenerate into inefficiency as a result of "red tape" ... and ... the emphasis on quantification can lead to large amounts of poor-quality work'. P7 demonstrated this when she explained with a sigh how the nature of bureaucracy had contributed to professional apathy:

... well they have made one feel apathetic, you just do the best you can and that's it and you won't worry about it, you'll just do it ... they're asking us to do it, there's no hiding it, you'll do the bare essentials and that's all and if you've forgotten something you won't bother checking on it or getting that piece of paper back and re-ticking it or writing it up, nuh, stuff them, so they've created apathy. (P7 interview 051107)

Frederick Winslow Taylor's system of 'scientific management' forged the way for work to be broken down into small, measurable and thus fragmented tasks which were determined as the most efficient way to complete a task (Taylor 1947). In this way, the worker lost control of the work, as the conception of the task was separated from its beginning (Williams, Cooke & May 1998). This resulted in jobs becoming routine and workers becoming deskilled (Braverman 1974).

Fordism closely followed Taylorism, adding to Taylor's scientific management the moving assembly line. Key to Fordism was the homogenisation of the workforce so that individual workers with fewer but more specialised skills became interchangeable. This is seen in the CYH environment as nurses doing either UCV or FHV but not a combination of both. The product, for example a UCV, was also homogenised into a controlled, predictable artefact.

During a lunch time conversation, P1, for example, spoke of her concerns about new recruits into the organisation becoming deskilled and their potential loss of connection between their role and the WHO principles of primary health care in the community:

It seems we don't have the option to get out into the community anymore and to do any community development ... Us oldies remember doing all of that ... I really worry about these young'ns coming through; you know they think what we're doing is great, but their skills, I'm not sure about their skills. They're not getting exposed to enough different things. (P7 field note 050701)

In this example, P1 reflected the concerns of the majority of nurse participants who had experienced many years of organisational change leading to current changes in practice directions. Not only was P1 concerned for her own practice, she was also concerned about the professional development and ongoing skill set of child and family health nurses of the future. The broad sense of health promotion and inherent empowerment at community level was disconnected from the distinctive tasks of UCV child health centre work or running groups.

To further understand this disconnect, I searched all interview texts for the word 'community'. I found 87 passages in 17 documents relating to this term. The overwhelming majority of these were related to child health professionals talking about community health qualifications and the importance of communities, representative of cultural others, for example, the Vietnamese community. A smaller

group were related to examples such as that of P2 talking of a passion for working in the 'community' (interview 2 050916).

This raised questions about how a profession with clinical competencies purportedly underpinned by primary health care was developing as a profession. These findings, however, synchronised with observations and videotape recordings of practice, which was universally experienced as individualised care often conducted in the home setting. No community development was observed as core to a nursing role. This loss of skills might be partially attributed to Taylorist or neo-Fordist structures of care.

During a brief conversation in the filing room, P18 said, '*... You just get sick of fighting it. It's like a big a bulldozer coming in and wiping over everything*' (field note 051031). P18 claimed that the organisational structure prevented her from building capacity in communities by working with clients in a responsive way. P18 then said:

We're supposed to be providing a service for parents but there is no service to offer any more ... any trained monkey can put the baby on the scales stretch it out and tick the boxes. (Field note 051031)

Williams, Cooke and May (1998) question the vision for the future of nursing. Based on Braverman's (1974) work, they ask if nurses will become progressively deskilled as managerial controls increase, or whether a post-Fordist sensibility will prevail. In the latter scenario, a post-industrial knowledge-based society will ensure rewarding jobs for a core of highly skilled professionals. This division was evident in the new structure of child and family health work in the CYWHS. One group of nurses involved in UCV had their work highly regulated and prescribed, while others involved in FHV had greater scope to work in community with an enhanced sense of 'personal rationality' (Foucher & Howard 1981).

Williams, Cooke and May draw on George Ritzer, who argues that rather than moving towards a post-Fordist era of professionalisation, we have entered a neo-Fordist era of McDonaldisation. McDonaldisation is characterised by 'homogenised products, rigid technologies, standardised work routines, deskilling, homogenisation of labour (and customer), the mass worker, and homogenisation of consumption' (Ritzer 1993, p. 155). Where Williams, Cooke and May argue that managerialism has brought McDonaldisation into the health care workforce, I argue that a rationalised system to meet population health outcomes has contributed to McDonaldisation of services in child and family health.

While we do not see rigid technologies, we have seen the homogenised product of the UCV: homogenised consumption through the universalisation of home visiting as standardised initial contact and homogenised labour through participants being perceived as generic enough to work anywhere. Standardised work routines were evident where nurses completed four home visits each day, every day. As P3 says, *'... You know that the next day it's going to start again and you'll do exactly the same thing'* (interview 3 050920). Participants also talked of their experiences and fears of deskilling.

Of importance for this study were the assumptions that underlay a homogenisation of the customer. Where some parents were identified for specialised FHV programs, the majority were allocated or referred to universal services. Homogenisation for this group assumed that they were all the same and had the same needs, able to be met through the same service. Discussed further in chapter 8, this is a tenuous position to take. In doing so, the cultured, raced, gendered and class consideration of a population was not considered. As such, it supported beliefs of Australia as a monoculture and child health and parenting expectations in Australia as unilateral.

This approach ignored the social construction of race, where power relations favour those in positions of privilege who are white. In this situation, those who understood Australia's child health system and speak English were privileged over those who did not. However, they were assumed to be the same and assumed to require the same services. Within mainstream child health services, this homogenised approach presented a discourse of denial of difference premised on a belief in these services being egalitarian.

In this way, child health professionals became trapped in a structure that sought homogenisation of care. The influences of these structural systems of organisation shaped the way child health nurses experienced their everyday work and how they enacted care in this environment. They were left feeling fatigued, frustrated and with a belief that these systems were evidence of the organisation no longer caring for clients. Additionally, nurses felt that their practice base was being eroded and their expert skills were not valued by the organisation. Nurses felt disempowered in their ability to provide services that they believed were essential to support parents, especially those who did not qualify for the intensive FHV program.

The politics of empowerment: they don't care

The second challenge to enacting professional care for clients built onto the structural impositions of neo-Fordist rationality within a bureaucracy. Nurses felt disempowered within their practice when they experienced the organisation not listening to them and thus devaluing their professional knowledge.

'Not being listened to' related to issues across a broad spectrum of organisational governance. P34, for example, exclaimed, *'Oh the nurses are not listened to! We can say all we want and it won't change anything'* (field note 050609). This was in response to recommendations nurses had made to improve the P2P. While some of the changes were implemented, many changes were revoked for administrative purposes, such as the size of the genogram discussed by P7 (interview 7 051107).

Participant nurses also felt they were not listened to when requesting to work in particular areas. After being asked to offer a work site preference and then being arbitrarily placed in a different work site, P32 said she was *'sick to death of it! No one seems to listen even when they ask for [your opinion]'* (field note 050609). At another time, P8 expressed similar frustrations when she had applied for a position and expressed a preference to accommodate the needs of her family. She was offered a position, but one that put her family under considerable strain due to its location. P8 explained how the manager used a discourse of luck to explain her success in gaining the position. P8 suggested that even though the exact words were not used, she felt she was told to 'like it or lump it', leaving her with a sense that anyone could do the job and she was just lucky at the time (field note 060109). This was also an example of the effects of a Fordist understanding of nursing skills being interchangeable for the delivery of a homogenised service.

Loss of professional agency was also felt by participants, resulting from a belief that they were not listened to when advocating for services for clients from cultures other than their own. P25, for example, was so frustrated at not being listened to in her advocacy for clients who were migrants and new arrivals that she decided to leave her position. P25 thought it an insult that the migrant home visiting program had been cut from full time to six hours per week. She had explained this to her manager and nothing had changed, nor was she given any indication that things might change (field notes 050829 & 050830).

Milisa Manojlovich (2007) argues that nurses need to feel empowered in order to empower clients, further contending that powerless nurses are ineffective nurses.

While Manojlovich at times adopts a modernist understanding of power as possessed rather than exercised, we can still conclude from her research that unless nurses take up the authority within their role through exercising power as productive, they will be less able to work with parents to empower their decisions and actions.

Theories of empowerment are based on a premise that a parent, for example, is only likely to change unhelpful behaviours if they are empowered to do so. People are empowered when they feel they have agentically contributed to change. Empowerment discourses in health suggest that the first step to empowerment is self-initiated help-seeking behaviours. Participants were concerned not only for their own sense of disempowerment over the content and context of nursing practice but also for their successive loss of scope to empower clients who may not take up initial imposed universal contact opportunity.

Exercising power through care

While nurses continued to care for clients, they felt the organisation's way of caring was privileged over their professional modes of caring. Consequently, their intrinsic beliefs about the nature of care were discounted.

Patricia Benner (2001) argues that nurses who embrace caring, empathy and compassion as components of power are more likely to adopt and accept authority within their practice. If we consider caring as integral to both parties' goals for health outcomes, it becomes possible to imagine that when nurses embrace caring they make spaces for resistance that are constructive rather than little acts of rebellion. In this way, the three bodies collide and intersect, rather than one being a discourse through which we view a binary.

P8 resisted within the confines of the P2P by halting her questioning to respond to client needs (DVD 8). P32 resisted the structural imposition of a single contact by arguing her clinical decision to return to a client's home for ongoing care.

In privileging discourses of caring, nurses were able to exercise power that was then productively used to empower parents. At times, however, participants exercised this power in ways that were not organisationally sanctioned. P5 and P7, for example, talked of their frustrations in trying to provide additional services for parents who are migrants or new arrivals to South Australia. These parents did not qualify for FHV. P5 and P7 believed they were not well-served in mainstream

services. They had argued their case with management and felt that they were not listened to. This resulted in their taking actions based on professional judgement that did not fit with organisational directives. P5 said, *'No bastard will listen to us'*, and then continued to work in a way that suited a professional ethic of care (field note 050629).

These experienced expert practitioners (Benner 2001) did not trouble over the consequences of their actions. Other participants felt more conflicted in taking such courses of action and were left feeling as though they could not serve two masters.

Between a rock and a hard place

Participants talked of their work as always in a state of compromise. They were constantly juggling to meet the needs of the organisation, maintain their professional standards and meet the needs of parents and their babies. While some engaged agentially in supporting families within the structural framework of services and the structured approach to care, others felt that if they had not completed set work they had not done their job properly. P8, for example, said:

... as part of my job there are things I have to do, or should do; that's what's expected for these visits and so if you didn't get those things done you feel a bit 'oh I'm not doing the job properly'. (Interview 8 051123)

While P8 spoke respectfully with mothers and listened to their concerns, she limited her engagement with mothers' needs. P8, who had been in the role for less than one year, said she would need an obvious example of parental need to change her direction, saying:

... there is stuff that you actually ... you feel like well I actually have to get this done ... and that at least gives you a plan. It's certainly not, 'What would you like us to do today?' ... cause if you ask that then you're never going to get anything done ... if there's other stuff obviously, if she burst into tears or had major breast feeding issues ... then you would say in your own mind, 'Right well I'll put the questions away, I won't do that today'. (Interview 8 051123)

P8 was videoed having completed only a small number of UCVs. However, during the consultation she attended to parental issues raised before and during the P2P about family relationships. She was observed to suspend the questionnaire to support the mother and asked the mother for directions about how she would like to

proceed. Having completed the questionnaire following the mother's instruction, P8 reiterated her offer of support.

P8 used a belief in the importance of motherhood and family life to empower her to resist organisational constraints despite her conflicting sense of organisational pressure. P10 similarly attributed her ability to privilege parental needs within organisational pressures to a belief in the importance of motherhood and experience:

...[I] think that [comes] with experience. I think probably a few years ago I ... would've felt probably more like I had to get what I was there to do done, but I think more and more now, maybe after being a mother maybe that shaped my thoughts as well but I think now if issues come up that they want to talk about that are more important than checking of the PTP then I'll do that. (Interview 10 051128)

In these examples, both P8 and P10 exercised power between organisational structures and goals of professional and personal practice. Foucault suggests that, within humanism, power has often served more as an ideology of domination rather than liberation. In exercising power in this way, participants resist humanist assumptions of power as dominance. They use power as productive in taking up their agency within the system and enact it from the bottom up. They are empowered by a belief in the importance of motherhood and experience that enables them to care despite structural impositions.

When care is not exercised as power

Enacting care was more difficult when participants used the homogenised framework of the UCV and P2P with clients who come from cultures other than their own. Assumptions regarding the agentic position of parents to seek help are left unattended. We know that many parents who are in need do not seek help (Attride-Stirling et al. 2000; Davis et al. 2000). For vulnerable clients who were referred to mainstream services, this posed an enormous gap in identifying those moderately affected by issues such as depression. The following section uses an example to illustrate the problems of overlaying homogenous assumptions of care onto an encounter with a mother who is marked as culturally different.

I went along with P9 to video a UCV with a mother who was Sudanese and spoke Dinka (field note 050922). We were met by an interpreter at the door who made introductions. The only information I gathered about this mother was what P9 asked and what was necessarily recorded for organisational documentation. I wanted to

understand how participant health professionals engaged with the content and history of cultural aspects of family care.

P9 followed the procedure for a universal contact visit, asking the mother about how the baby was going and how she as mother was faring. She conducted a health assessment and filled out the necessary paperwork in the child's personal health record and for her own records. In this way she had done her job.

Throughout the consultation, the mother talked about feeling depressed because she had not heard from her husband or other family members in Sudan for many years. She worried that he might be dead. She talked about how she had also spent many years in a refugee camp without her husband and was now living with her uncle. She explained that she was caring for her five children in addition to her uncle's children. She said she was also very tired. P9 sat on the bed listening to the mother but did not offer any further support (DVD 9).

Returning to the office in the car following the UCV, P9 commented that she felt frustrated because she had nothing to offer the mother as support. By this P9 meant that there was no written material to offer the mother. Further, she commented that the structure of the UCV meant she could not revisit the mother.

Organisationally, P9 is supported to offer a return visit if she identified concerns. In this instance, the mother's feelings of depression could have constituted a reason to return. P9 was an experienced nurse who had worked in the organisation for over ten years. She did not offer to collaborate with the ICC, saying that she was too difficult to get in touch with. She did not ask if the mother was connected to the Survivors of Torture and Trauma Assistance and Rehabilitation Service (STARRS).

P9 also talked of resisting the directive to use the P2P with mothers from CALD backgrounds, as she thought it inappropriate. At another time, P9 had said when visiting a mother who was Cambodian:

I won't be doing the questionnaire. It's too hard with an interpreter. It's hard enough to get across ordinary messages let alone all the misunderstandings that can happen with that questionnaire. (Field note 050728)

At this time, P9 did not suggest how she would alternately assess the client needs, nor did she consider how *she* might understand the parent. P9 considered only how the parent might understand her. Houston and Cowley confirm that using a

structured health needs assessment tool with clients who have different ethnicity and language to the health visitor results in the client not being able to set the agenda or to 'have control over the process' (2003, p. 92). Even though the Sudanese mother raised issues of depression, P9 did not take them up. P9 offered no alternate therapeutic assessment, claiming it was too difficult with a mother '*like this one*' as her problems were too vast: '*Where would you start?*' (field note 050922). One wonders if the P2P might have been useful in compelling P9 to follow up the mother's issues. While the P2P was considered culturally inappropriate, it may have served its purpose in this situation.

This example illustrated the problems of applying a generic approach to a consultation, when a parent does not fit a standard mainstream model. Problems of language and understanding were observed through using an English, Western-style health needs assessment tool with a mother with complex cultural needs and who spoke a language different to that of the health professional. Many health visitor participants in Houston and Cowley's research similarly gave up using the structured health needs assessment tool because of difficulties interpreting the complexity of issues within it (2003). In this situation, there was a double barrier to care when the P2P was seen as culturally inappropriate while the culture of the mother was too different to consider.

Structured home visiting assessment tools clearly do not cross the 'cultural divide' (Cowley et al. 2000). With specific reference to ethnic communities, far from helping a client, a structured health needs assessment used insensitively 'can at best do no good at all and at worst have a detrimental effect' (Houston & Cowley 2003, pp. 92-93). Unless alternate approaches to structured health needs assessment are articulated, such as continuous and unstructured conversational assessments, some of South Australia's most vulnerable children and their families may be excluded from the opportunity to receive appropriate targeted support. As stated previously, the majority of CALD clients were observed as streamed into universal services.

Following the guidelines of the UCV, P9 also talked about the importance of having the baby immunised and where the mother might go to have this done. The mother did not have any transport, nor did she live on a bus route to council services or Child and Youth Health services. The mother indicated that she knew of a GP or family doctor not too far away near a shopping centre:

P9 was looking around the room, looking at me, looking at the mother and said something like, 'Well I suppose you will just have to go to the family doctor. I don't think there's any other choice'. (Field note 050922)

P9 then proceeded to tell the mother that she needed to make an appointment with the doctor. When the mother looked worried and blank, P9 engaged a teenage family member who was also in the room to organise the phone call. P9 assumed that the teenager would have greater English proficiency than the mother. P9 also suggested that the mother write on a piece of paper the dates for the baby's immunisation and put it on the fringe.

P9 did not enact cultural care for this mother. P9 had a colleague in the same team who did home visits for immunisation when parents, particularly those from CALD backgrounds, had difficulty accessing services (interview 1 050721). P9 could also have contacted the ICC, who organised transport for mothers who were from CALD backgrounds to attend a council immunisation service that coincided with a meeting group for CALD mothers (field note 050927). My limited understanding is that Dinka is not a written language. P9 assumed the mother's literacy in asking her to write the immunisation times of the fridge and when she became concerned over not having written resources to offer the mother.

When filling out the baby's personal health record (PHR), P9 told the mother that she could come to a child health clinic any time, and indicated on the page the record number the mother would need to read to the receptionist if she rang to book an appointment. It seemed that, again, P9 did not consider that the mother would have difficulty ringing to make an appointment and that she had no transport. P9 assumed that the mother would homogenise into the service as it was provided to the majority of mainstream clients without exercising her agency to care. P9 felt that she had done her job but that she no longer valued her job because she could only do one visit and was not supported with multicultural resources. She blamed the system without recognising her own contribution to rendering the service superficial (field note 050922).

Other participants recognised the culturedness of the system when we explored it during interview even though they were not sure how to translate this observation into practice. P8, for example, talked of the challenges of inviting parents from CALD backgrounds to the child health clinic. She said, '*You might say to other people, "Come along if you need us, you know where we are, come to us"*' (interview 8

051123). P8 went on to question how someone who spoke a language other than English might be able to use the service comfortably. P8 also recognised the assumptions in her general approach to inviting parents to attend.

Summary

From this chapter, it is evident that child and family health nurses experience the tensions in the binary between 'us and them', that is, the organisation and themselves within the practice of child health nursing. Both parties claimed similar goals of equity and care for infants and their families. However, both equity and care were understood and talked about in different and contradicting ways by staff and the organisation. Participants saw their goal of care enacted through a way of knowing that constituted individualised care with the opportunity for degrees of nurse-determined continuing community care. The organisational process of child and family health care seemed to involve controlling decisions regarding who receives various levels of care based on epidemiological principles of population health. Notions of health promotion through community development appeared absent for those involved in UCV.

Where the organisation saw health care outcomes on a continuum, best served by identifying those who might best respond to continued care through a system of universal contact (Department of Human Services 2003a), participants saw this system of universal contact as divisive within practice, repetitive and reductionist in scope, despite the high level of skill required for universal health assessments and even with a 'bloody' questionnaire. This added to the divide between nurses who were offered scope for highly trained professionalism and those delegated to repetitive generic tasks. Identification of this binary was important, because it prevented many nurses from finding the professional space to provide individualised care to those families who did not fit the assumptions embedded in mainstream services. A 'family' was assumed to be monocultural, or 'like us', having the capacity to speak English and being sufficiently agentic to navigate the complexity of the Australian health care system. As such, the system did not accommodate the social construction of culture and social inequality, nor did it provide room to address issues of privileged and structural racism within practice.

In reflecting on how a binary plays out, Derrida suggests that the supplement marks what the centre lacks (1976). In this binary, if we view the organisational structure as the centre and the supplement as nursing practice, we can imagine that what the

centre lacked was a view to pluralism that enabled the individualised care that child health nursing practice claimed to offer. The centre needed what the supplement had to fully define and confirm its identity. The structure thus relied on the skills of child health professionals in meeting the individual needs of clients within the scope of the structure in order to be complete.

If we then consider that there always exists more than the binary, the primary third body introduced for analysis was the notion of care. When participants privileged notions of care, empathy and compassion, they harnessed relations of power. In doing this, they were no longer colluding in their own subjugation; rather, they stepped more fully into the authority of their role.

The problem for practice seems to be how we might support nurses to claim care, empathy and compassion in a practice world that seeks to relegate care to the margins. In stepping into their authority, nurses thus empowered can facilitate parents, particularly those allocated to universal services when their needs are clearly not universal in presentation. Nursing's claim to legitimacy through a focus on intellectual content has often been performed by marginalising its unique efficiencies of care (Rosenberg 1987). These more ubiquitous notions of care, devalued by the profession itself, are not offered the same scholarly inquiry as the more 'rational' subject of intellectual property.

The construct of care is explored more fully in chapter 10, where it becomes evident that the ability to care is not something taught in the professional domain. It is developed and experienced in the privacy of personal lives and shaped through subjectivities of society and the political environment. Until we value caring and find a professionally sanctioned discourse through which to examine and ratify its scholarly contribution, we may be forever fighting within the binaries of us and them.

CHAPTER 8

COLLIDING IDENTITIES: SAMENESS OR DIFFERENCE

Introduction

The colliding realities presented in this chapter relate to the conflicting world view that, in one sense, we are all the same, while in another we are all different and therefore need to be treated as individuals. Participants used this binary to make sense of their world. The language they used to talk about this binary demonstrated that they had deeply personal understandings of culture. These understandings did not seem to easily transfer to the complex environment of professional health work, particularly when that work was with people from cultures that were different to their own.

In this chapter, I explain how participants presented as knowing and thinking about culture, and how they represented themselves in the professional context of working with clients who were culturally different to themselves. While participants readily identified the range and nature of influences that shaped their beliefs, such as families of origin and personal life experiences, they mostly did not understand this self as being in any way cultured or part of a culture. In other words, culture was what migrants or indigenous people had.

Following this line of reasoning, participants implicitly used liberal discourses of fairness and equity to suggest that they liked to treat everyone the same, even though they seemed not to readily identify the nature of this sameness.

Difference, on the other hand, appeared to be something that participants tried not to identify, as they believed that identifying difference might alienate and disengage parents and that that would be unfair. This approach was reinforced by the parent advisor model, which suggests that health professionals show respect regardless of difference and encourages them to suspend judgemental thinking (Davis, Day & Bidmead 2002). Paradoxically, participants indicated that they were comfortable with difference, but this was stated only in as much as the difference served the needs of self. The findings presented in this chapter illustrate how these tensions played themselves out during intercultural communication encounters.

Treating people the same

Participants watched the DVD of themselves talking with people from cultures other than their own. Most often they described themselves as treating everyone the same. They did this through universalising discourses of motherhood and humanity. They did not want to treat people differently as they thought that this might make parents' feel uncomfortable.

For example, P2 said, '*I understand she's got a big history there, but as a mum I think she just wants to be treated the same*' (interview 2 050916, emphasis in original). On the surface, this is indeed respectful. However, this response raised questions about what or who P2 thought mothers would like to be treated the same as. Perhaps P2 assumed the mother from Lebanon, with whom she was consulting, wanted to be treated the same as mothers in South Australia; it was initially unclear. Motherhood was assumed to be a universal experience around the world. The valued characteristics of caring, nurturing and protection, common to the experience of mothering, work against understanding motherhood as a deeply cultural experience. As discussed in chapter 7, there are potential problems in uncritically homogenising services and mothers in this way. The following sections explore how sameness seemed to be understood in relation to motherhood.

During the interview with P2, we were discussing possibilities of meanings of culture. P2 said that she believed '*we do ... have a very egalitarian streak that runs through Australian culture*' (interview 2 050916). P2 then used the following example to demonstrate how she understood equity to work in a consultation:

... the way I deal with a woman from a different culture, or indeed a woman, even you know a woman, from any culture be that mine or Aboriginal or Somali ... or Lebanese I think that they are the same ... I think that I am on the same level ... as them despite the fact that I am the person that they come to see ... I am the professional person in the room ... that doesn't make me a better person, and that I think would be the way that I would speak. (Interview 2 050916)

Like those of other participants, this idea of sameness and fairness was underpinned by a strong belief in Australia being egalitarian and, in a sense, inviting participants to take part in Australian values. By using a unifying discourse of womanhood, P2 believed that she was being egalitarian in her approach, and that parents would receive this message and see the situation as she does because of her modelling. Moreover, in naming her professional personhood and responsibility

in this way, she did not want to imply a status difference on a personal level from the woman. P2 did not seem to recognise that this belief might blinker her from realising the very real imbalance of power relations within the room because she was and remained the professional within the balance of power. On the other hand, her talk may well have indicated her attempt to explain how she mediated difference in the clinical environment.

In another example, P12 explained:

you're treating them all the same because you're not saying well I will provide this service to you because you're white but I won't provide that service to you because you're black. (Interview 12 051213)

Here, P12 relied on a rather blunt measure of equity to explain herself. She claimed to ignore the politics of race and other cultural differences through a somewhat naive reference to the discourse of equity in service provision. Her response, however, reflected a conscious act against perpetuating racism as described in the *Racial Hatred Act*, a 1995 amendment to the 1975 *Racial Discrimination Act* (New South Wales Department of Education and Training 2005). This act 'aims to strike a balance between two valued rights – the right to communicate freely and the right to live free from vilification' (ibid). The Act says that it is unlawful to 'offend, insult, humiliate or intimidate that person or group' where an act is perpetrated because of 'the race, colour, or national or ethnic origin of a person or group' (New South Wales Department of Education and Training 2005). In this example, P12 was making an overt attempt to be non-racist in her approach through equity of service provision. Confusingly, at the same time, this response denied all that is embodied in the 'other' represented by their difference. This included more than a delineation of black or white; it also included issues of migration and identity as they are understood within relations of power in a *postcolonial* Australia.

Throughout these discussions I continued to trouble over what participants believed parents wanted to be treated the same as. Did they think, like P2, that parents want to be treated as an imaginary universal parent or mother? What then might this universal parent or mother look like? Behave like? Relate like? Perhaps, like P12, treating people the same was underpinned by a non-racist agenda of ensuring equity in service provision. If this was the case, what benchmark of sameness was being used?

It became clear that P2, like many other participants, wanted to treat people in ways that made them the same as themselves. P8 explained this, saying, '*You want everyone to be the same as you because then life's normal*' (interview 8 051123). Many questions arose from this statement: Normal for whom? What might normal look like? As a white middle-class professional woman, P8 suggested an unrecognised agenda of assimilation by wanting people to be the same as herself. Normality was defined by P8 as all that is like or the same as her own life. Even in professional practice, participants used language like that of P8 in an attempt to maintain the status quo of their own social collective; that is, the loosely formed social grouping that they understood themselves to belong to. In this way they validated and maintained the worth of their own position of normality through an ongoing process of representation (Hall 1997b). This surreptitiously reinforced and privileged the lifestyle and culture of the child health professional over that of the parent.

One way of understanding participant responses is to examine the individual/collective dualism embedded in humanist discourse that is hegemonic in Western culture (Davies 1991). Bronwyn Davies (1991), writing about how children come to know and experience themselves as gendered, explains that within this dualism the individual is socialised. In the first instance, they are socialised by the collective. Then, once these norms have been internalised, they become part of the individual. The individual can then seek to stand apart and assert him- or herself, becoming a successful individual within the collective. Applying this construct to the analysis of participants' talk about sameness, we can see why they might have assumed that all people are universally socialised through a homogenising individual/collective dualism. Participants such as P2 suggested that they believe migrant parents want to be socialised into the normative society, and others, like P8, who was very candid and adamant in her statement about sameness and what constitutes 'normal', seemed to be suggesting that it was much more difficult to think about difference. Perhaps this was because it might have required something *different* from her, and in not knowing what this might be, she asserted sameness as the preferred way of working. Further, when statements like this were made, the possibility of a conversation about it was closed off.

To better understand these assumptions about how the self is constituted or shaped within discourses of sameness, I asked participants how they might explain their ways-of-being in the world and how these ways might have come about. Through

these discussions, we also explored notions of culture and how these understandings aligned with understandings of self.

Understanding the construction of selfhood

Not surprisingly, given the context of the research, participants mostly spoke of themselves in their role as child health professionals. Nurse participants, for example, strongly identified themselves as community health nurses with a focus on education and building strong communities.

Participants claimed for themselves characteristics of nurses, such as empathy, genuineness, and being helpful. While these characteristics were named in the context of their work role, when asked how these might have come about, participants without exception spoke of these as being an intrinsic part of their nature. These characteristics were identified as being formed and developed within their family of origin, or to a lesser extent shaped by ongoing personal life experiences. It was noteworthy that neither formal learning nor professional development featured in the shaping of these characteristics.

This point was illustrated by a section of an interview with P10. We were watching her on DVD working to form a relationship with a parent. We talked about where P10's approach might have come from. She suggested that perhaps it was a combination of her own parenting experiences and *'who you are and I don't know how that comes about'* (interview 10 051128). She then clarified that it was *'definitely how you were raised, like how you were brought up, what sort of family values your family had and how your parents sort of taught you to treat other people'* (ibid). P10 spoke of a strong memory of the family value to *'respect other people; they were never judgemental'* (ibid).

Families of origin were named by many participants as having shaped their beliefs and values and their understandings of who they were. Families of origin were, for example, named as having promulgated characteristics of non-violence and being non-confrontational (P7, interview 7 051107), having a strong sense of social justice (P2, interview 2 050916) and being tolerant (P3, interview 3 050920).

Many participants also explained how larger social structures, such as religious groups, shaped their characteristics of self. Through the church, P8, for example, learned to *'just accept people for who they are ... I guess that's in me'* (interview 8 051123). Frequently, beliefs in the essential goodness of humankind were attributed

to religious experiences of early childhood. Many participants played down this Christian influence, suggesting that they were no longer influenced by religious beliefs. P3, for example, spoke of discarding her religion in adult life after being raised in a *'very religious'* family. However, she still attributed her belief in accepting all people *'for what they are'* to these early life experiences. On the issue of accepting difference in others, P3 said, *'I think anybody would do that ... don't you think everybody accepts everybody for what they are?'* (interview 3 050920). Despite the passage of time, P3 continued to believe uncritically that people in the world are universally accepting.

While participants were able to articulate the construction of their identity through individual development within families and the structures of a collective, they did not at any time attempt to name or describe the collective. The nature of the collective was assumed as universal. To explore participant ideas and place within collectives, I asked about their everyday understandings of culture and how they learned about it.

'Culture is a big term isn't it?' (P4, 050921)

Like P4, most participants found the idea of culture to be vast and complex. While understood as an intrinsic aspect of self, ideas about culture were most often understood in practice as defining difference through cultural markers such as skin colour, language and religion. The constructed nature of the child health professional's self was considered primarily in the personal sphere of family of origin or lived experiences of self as daughter, mother, or partner. This understanding of culture did not, however, extend to an understanding of the situated nature of self within historical contexts of a raced, classed and gendered society.

When asked about culture, P2 spoke of culture as a fluid and intrinsic process, suggesting that *'it becomes imbued in who you are'* (interview 2 050916). This was understood as being represented through overt marks of culture within particular ethnic groups such as religious practice. P2, for example, said:

for me looking at say an Aboriginal culture there are rules, quite strong rules and boundaries ... and in a Muslim culture or Hindu culture there are rules and boundaries in there ... (Interview 2 050916)

P2, like the majority of participants, understood culture from an anthropological sense where groups or 'cultures' are distinguished by common customs and ways of

being in the world informed by a national or common 'spirit' (Jordan & Weedon 1995). This anthropological approach to understanding culture in nursing was taken up and promulgated by Leininger in her transcultural approach to nursing care (Leininger & McFarland 2006, see discussion in Chapter 4). While the participants in this study did not articulate their knowledge of transcultural theories of care, they nevertheless measured their perceived cultural proficiency through knowledge of the cultural other. As P13 said:

culture just sends me into a spin and I think, "My God". I don't know enough about it, like when I was coming to [this work site] I thought, "I don't know enough about other cultures that are out here", and it makes me anxious that I'm going to say the wrong thing or be inappropriate, so I guess I'm coming more from a religion side of things with culture, especially with Muslims that I'm going to upset somebody. (Interview 13 051220)

Participants almost without exception began their talk about culture as something that others have. In this sense, culture was about how others lived, where they came from, what they believed and did. When I asked about what the idea of culture might mean for her, P14, for example, said that it is:

just respecting peoples' upbringing, their beliefs, where they've come from and that they've got life skills as well and you know respecting that because we all bring life skills especially to everything, and just respecting where they've come from. (Interview 14 060208)

Similarly, P15 said:

it is very broad, culture, it isn't just they belong to another race or anything, they are still people and there's a lot of similarities but there are a lot of differences. (Interview 15 060221)

P15 suggested that, even though culture is broad, people are all essentially human. It seemed that she may have been looking for a starting place for meeting the cultural other by using the commonality of humanity, whereby one might recognise similarities while valuing differences. P15's call on an essential nature of humanism seemed implied when she said, '*They are still people*'. This appears logical, but I nonetheless asked why, in the light of recognised difference, must an argument be made to support a claim that one who is different remains human.

As a political critique of colonialism, Roland Barthes (1972) charges that the category of human was invoked to classify other races as subhuman. While essential humanism claims a position of sameness of the human spirit, it paradoxically evokes a binary as an oppositional referent; the non-human (Young 1992). It is through this oppositional referent that those in the dominant group can gain identity and strength (Said 1978). Franz Fanon (1967, p. 131) proposes that proclamations of an:

essential quality between men manages to appear logical in its own eyes by inviting the sub-men to become human, and to take as their prototype Western humanity as incarnated in the Western bourgeoisie.

From this perspective, P15 could be seen to perpetuate a cultural divide by positioning those who are culturally different to herself as subhuman, by not allowing 'them' entrance into the essential spirit of the humanness of 'us', which is incarnated as white and Western child and family health practice.

In seeking to respect where 'they' came from, participants like P14 and P15 assumed culture as difference, experienced by a cultural 'other'. This represented a discourse of binary polarisation where the ideologies of the majority always oppose those of minority populations (Henry & Tator 2006).

It seems that by always trying to understand the cultural 'other', the complicity of the 'self' in a history of colonisation, was ignored. This was evident in discussions with participants and in traditional cultural awareness programs. This approach left unattended historic and situated issues of gender, race, and socioeconomic inequalities. These cultural attributes were played down to construct and problematise difference according to 'cultural' and ethnic affiliations (Culley 1996; McConaghy 2000; Mulholland 1995).

McConaghy states that when we engage in 'othering' we are 'categorising human existence, characterising people on the basis of certain criteria such as world view or similar anthropological construct, and homogenising their experiences' (1997, p. 85). In doing this, 'othering' as a form of racism, remains central in a neo-colonial environment. In this way, participant polarisation of us/them, alongside a belief in essential humanity is expressed as a form of democratic racism.

Frances Henry and Carol Tator (2006, p. 22) introduce democratic racism as a form of ideology that accounts for 'two conflicting sets of values that are made congruent

to each other'; democracy and racism. Drawing on research undertaken in a Canada, Henry and Tator argue that most Canadians 'hold some degree of racist attitudes' (ibid, p. 19). Where people live a society that values democracy they recognise that these attitudes are socially unacceptable and therefore develop justificatory arguments and mechanisms to enable racism to exist alongside democratic ideals. They argue that these arguments, such as binary polarisation and liberal humanism enable individuals and society to demonstrate the democratic values of an egalitarian society while 'at the same time undermining and sabotaging those ideals' (ibid, p. 19).

This deconstruction of practice through theory left me unsettled, as P15's belief in and generous application of humanity clearly demonstrated faith in egalitarian values. I asked myself, of what use it might be to recognise these aligning forces. I returned to watch P15 enacting her humanity on DVD and observed how surreptitiously democratic racism crept into practice. P15 was video recorded consulting with a parent and child from a Middle Eastern country. Having left detention, the parent, a father, had found work and had taken time off work to attend the consultation. P15 spoke loudly to the parent and child in the room, commenced the consultation before the booked interpreter had arrived and determined within a few minutes of communicating in English with the family that the child was not developmentally ready for the booked health assessment because he had not been in the country long enough (DVD 15).

While P15 used a homogenising discourse of humanity to state that '*they are still people*', she did not treat these people in the same way that she treated English-speaking families. Even though an interpreter was booked, P15 exercised her authority within relations of power to 'other' the family by communicating inappropriately with the family and deferring the consultation. In these ways, she engaged in democratic racism. On this occasion, as with many others, well-meaning use of humanist discourses expressed in interview, were not always demonstrated in practice.

Dyer (1997, p. 2) suggests that 'there is no more powerful a position than that of being "just" human. The claim to power is the claim to speak for the commonality of humanity'. Following Dyer, identifying the use of humanising discourses alongside binary constructions of us/them begins a process of dislodging misdirected authority within intercultural relations of power. While notions of essential humanity such as those expressed by P15 are appealing to our sense of social justice and equal

opportunity, this view 'ignores the social construction of race, in which power and privilege belongs to those who are White' (Henry & Tator 2006, p. 25).

Applying culture to self

Given that participants referred to themselves using an essentialised and normative 'us', I wondered how they made sense of themselves in this group. The majority of participants denied that they had any right to claim themselves as cultured at all. I gave all child health professional participants a printed sheet with their DVD that indicating the approach and topics for interview (appendix 10). In this way, participants could think about their understandings of culture as they privately watched themselves on DVD before discussing their ideas with me at interview. P13 referred to this sheet during a discussion about how we might understand ourselves as cultured. She said:

I don't think of me as having a culture at all really. But then we all do when you really analyse it, you know I didn't read that and think, "Well my culture is", you know that wasn't something that came to mind at all. (Interview 13 051220)

Where P13 recognised the absence of an overt consideration of herself as cultured, in another example P9 identified herself as Australian, yet denied that this can be claimed as culture. P9 said that she was '*fifth generation Aussie ... we haven't really got any cultural mix within our family*' (interview 9 051125). This second example reflected the response of the majority of participants, where culture primarily related to an ethnicity different to their own. The self was, then, understood as cultureless.

While many participants named themselves as Australian, not surprisingly, they also struggled to communicate what being Australian meant and how they might claim Australianness as part of being cultured. It is something our nation has struggled with for many years (Hodge & O'Carroll 2006; Kellehear 1996). Continuing the conversation, P9, for example, spoke of being an Aussie because:

I'm just going back to when the ancestors came out from England and counted on since then ... I suppose I feel Australian ... because it's the country I've been born in and grew up in. (Interview 9 051125)

P9 said she was historically located as Australian because of ancestry, being born and socialised as Australian. Similarly, P10 spoke of not recognising herself as having any culture. When asked, '*Do you ever think about the fact that you've got your own culture?*', P10 replied, laughing, '*No*', then reflected, '*Sometimes I do and*

then sometimes I think we're not very cultured, we're so easy going I think Australians, not even Australians, I don't know; like me (interview 10 051128). Perceiving culture as something that can be acquired, P10 then explained how Australians lack traditions and religious structures, even '*Australians ... like me*' (ibid).

Exploring the possibilities of what P10 meant by '*Australians ... like me*', we might imagine she is talking about being a caring child health professional/mother positioned to help others, equipped with her personal life experiences in a professional capacity. We might also imagine that in referring to herself as Australian, P10 is also implicitly referring to her heritage, which could be described as Anglo, educated, middle-class and employed.

Hodge and O'Carroll (2006, p. 73) suggest that our sense of belonging to a national community is 'a powerful fiction with many real consequences'. They suggest that institutions within Australia construct and teach identities, which then maintain the fiction. This fictional identity is taught in crisp terms 'as though it were a single, homogenous entity' (ibid). Participants spoke in this way about an institutional homogenous identity. This identity was linked to an understanding of the imagined national community. National identity as Australian, however, was formulated on identification with those who are officially like 'us'.

In very ordinary taken for granted ways, without malice or unkind intent, participants spoke about 'us' or 'we' and 'them'. In doing so they continued constructing and strengthening *their* national Australian identity set against the difference of the 'other'. This classification relies on the 'other' to identify the self. While the other remains at the periphery, the identity of self is reinforced and sustained. This use of language sustains dominant yet unmarked discourses of what sameness or imagined national identity might mean. The following discussion with P13 depicts a common, generally unstated assumption about what it is to be Australian.

We were talking about early life experiences when P13 told a story that she remembered from her school playground. She recalled that in the playground there had been some Greeks, some Italians, some English and some Australians. We talked about how she might have determined who the Australians were, and P13 suggested that they might be the ones with Australian citizenship. I then posed a problem for P13, detailed in the following excerpt:

R: ... if we put you in a room and, say, this lady who was Chinese, if people were looking at you both and not listening to you ... what do you think their assumptions might be?

P13: That I'm Australian.

R: Yeah, but would they assume she was Australian?

P13: No, not at all, and yet she could've been born in Australia, you don't know do you.

R: I often wonder about why is it, why is that so, I mean why do you think that you would be the one that's assumed to be?

P13: Because I look more Australian. (Interview 13 051220)

We talked about why P13 looked more Australian and arrived at an understanding that, because P13 had white skin, she would be identified against others with different coloured skin as Australian.

Naming whiteness

Aileen Moreton-Robinson (2000) introduces whiteness as a socially unacknowledged and institutionally embedded norm that defines the human condition. Moreton-Robinson (2004, p. 75-76) explains that as an epistemological '*a priori*', whiteness 'provides for a way of knowing and being that is predicated on superiority, which becomes normalised and forms part of one's taken-for-granted knowledge'. P13, like P10 and P9, assumed whiteness as the normal condition of Australians. For them it was a taken-for-granted assumption of the human condition, such as when P10 said '*Australians ... like me*', meaning white, and P13 said, '*Because I look more Australian*', meaning she looked white. These examples showed how whiteness was normalised.

David Owen proposes that one of the properties of whiteness is that it 'becomes defined as natural, normal and mainstream' (2007, p. 206). P19 illustrated this when asked if she ever thought about difference such as skin colour in her practice. P19 seemed somewhat taken-a-back by the question and unsure of how to answer:

Probably personally no because I don't even, I don't know, I don't even think of them being of a different skin colour, it's not something that I even, it's nothing that I even have ... (Interview 19 060328)

P19 explained that her personal life experiences of living and learning with people from a range of cultural backgrounds has led her to not notice difference in skin colour. P19 seemed not to realise that part of the privilege of being white was that she was able to not notice skin colour, ethnicity or Aboriginality, whereas those within these categories of other are constantly confronted by the fact that they are not white. By doing this, P19 treated people the same. They were the same as her, and thus normalised as white. P19 became colour blind. While this may not have been problematic on an individual level for P19, it acted to deny any cultural heritage others may have wished to claim by offering them an imaginary whiteness. This discourse of denial also reinforces democratic racism in practice (Henry & Tator 2006).

When those from the dominant epistemological position in the West ascribe race as a categorical object only assigned to others, their identity as white becomes invisible or unassigned. We need to be able to identify and name whiteness so that we can pay attention to 'the racialised nature of power and privilege' (Haggis 2004, p. 50). By naming whiteness we remove the 'moral haven ... for those who "inhabit" white locations' (ibid). Discourses of humanism and colour blindness seemed to provide a moral safe-haven of non-complicity that masked whiteness and its incumbent power relations.

In explaining how this epistemology is understood, Moreton-Robinson draws on Foucault, who explained that knowledge leads to ordering through the establishing of difference, which is then defined by those differences in establishing order (2004, p. 77). This difference is made visible through skin colour as a signifier of race. To make sense of professional knowledge, child health professionals used skin colour to identify difference, ordering, and racialising the other. In this way they demonstrate that 'race is reserved for the other ...' (Moreton-Robinson 2004, p. 77). Situating the other as racialised denies the embodied identity of the other in favour of the assumed *a priori* identity of whiteness. In doing this, child health professionals placed themselves in a double bind of denying their own subjected identity alongside a denial of that of the raced other.

This concern is expressed by Owen, who states that 'whiteness situates persons racialised as white in a social location that provides a particular and limited perspective on the world' (2007, p. 206). Whiteness in the practice of the child health professional is limiting in two ways: first, by denying a place for contextualised identity developed from multiple available subject positions of the

child health professional and, second, through a limited perspective of the world, whiteness denies the identity of other.

Whiteness at work in multicultural

The cultural self of child health professionals was identified as predominantly culture blind or colour blind in response to the normalising function of discourses of whiteness. Discourses of nationalism were taken up to explain the self, but again this national identity was assumed to be white. How then did participants understand Australia as a multicultural? The white Australia policy has not been officially observed in Australia since 1973, yet it lives on implicitly in the fabric of the ways we as a nation think about and respond to race and racism. It is essential to understand participants' notions of multicultural, as these personal beliefs and values, like those, for example, of mothering and communication, are also brought unexamined into the professional place of work.

During the time I was in the field interviewing for this study, which focussed, among other things, on exploring with participants their understandings of themselves as cultured, a significant event (the Cronulla riots) occurred that turned the political, media and academic spotlight onto Australians' understandings of nationhood. This event created a space to link general topical discussions about racism, nationalism and Australian identity with research objectives. The next section briefly describes and contextualises these events.

Experiencing white Australian nationhood

December 11 2005 saw the beginning of a series of racially motivated riots in and around Cronulla, a tightly held Anglo-Australian beachfront suburb of Sydney. At this time I was about half-way through collecting the data for this study. The interview with P13 was held nine days after the beginning of these riots.

The front page of *The Age* reported that riots began with an:

unprecedented outbreak of violence at Cronulla Beach, where drunken mobs among a crowd of about 5000 chanted racist slogans and attacked people of Middle Eastern appearance in apparent retaliation for the bashing of two lifeguards a week earlier. (Nicholson, Skelton & Silkstone 2005, p. 1)

Photos of the riot show men, women and youths of Anglo-Australian origin with racist slogans painted on their chests and t-shirts such as 'we grew here, you flew

here', 'wog free zone', 'Mohammed was a camel raping faggot' and 'Aussies fighting back! Patriotic Youth League' (O'Brien & Kearney 2005, p. 11).

Following this action, people of 'Middle Eastern appearance' retaliated, focussing their attacks on Cronulla and surrounding suburbs. There was a police lockdown of east coast beach suburbs that extended north to Newcastle and south to Wollongong, a distance of approximately 400 kilometres. Media debate surrounding these events was swift and represented many views. Political, community and religious leaders were unified in condemning the violence but differed in their opinions about root causes. New South Wales Premier Morris Iemma stated that the riots revealed 'the ugly face of racism in this country' (Nicholson, Skelton & Silkstone 2005, p. 1). Prime Minister John Howard responded, stating, 'I do not accept that there is underlying racism in this country. I have always taken a more optimistic view of the character of the Australian people' (ibid). One wonders who Mr Howard was talking about when referring to a unitary Australian character.

Talking with P13, I explored my confusion about how people might identify who is Australian. We had been talking about the Cronulla riots and I explained a concern that occurred to me while reading the newspaper. I explained that I was intrigued that, three days after the riots, the papers had turned their interest to why the Australians of Middle Eastern appearance were angry and were retaliating. I talked of a television report that showed images of youths of Middle Eastern appearance in a car being pulled over by police and other similar looking youths sitting on a roadside curb being detained by police. I wondered how it was that even if they may not be amongst the violent aggressors, their skin colour marked them as potential agitators; they were detained because of their Middle Eastern appearance. They were viewed as 'foreigners within', even though they might be Australian citizens by birth or application, but were forever marked by their skin colour (Nicolacopoulos & Vassilocopoulos 2004, p. 32). Even though they could claim to be Australian, they were held as foreigners within at this stage of the riots, as youths (not *Australians*) of Middle Eastern appearance were in the throes of retaliating against their white Australian aggressors. Where one group held a label of not white and not wanted as Australian if they presented as violent, the other group held a label of assumed Australian because they were white and in part had their violence sanctioned as patriotic in their defence of location.

Considering the possibility that any of the white youths might not be Australian citizens (for example, they may have been born in England) and yet would still be

assumed Australian because of their skin colour, P13 laughed. She had not previously considered this irony. She continued the conversation, explaining that on a recent trip to England she noticed that:

the majority of people there are black skinned but they're born in England, and you'll see when you watch the Olympics, like, that lot of the English runners are black ... but they call themselves English because they're born in England. (Interview 13 051220)

Interestingly, P13 did not refer to the 'black skinned' people as English, but rather as those who 'call themselves English'. In doing this, she demonstrated how difficult it can be to challenge assumptions about dominance of skin colour in Western nations such as England and Australia. P13 could have said they 'are' English because they were born in England. Instead, P13 demonstrated how the cultural other can claim citizenship but is often not recognised by the dominant group as belonging because of their difference.

Following the Cronulla riots, Catharine Lumby, an academic from the University of Sydney, commented:

There is a sense that when the media talks about "we Australians", there is an assumed Anglo-centric perspective. The media often talk about men of Middle Eastern appearance as if that group were not Australians, yet many were born in Australia. From their perspective this can only perpetuate alienation. (cited in Stewart & Hodge 2005, p. 11)

By talking of English runners as black skinned, P13 similarly alienated those who were not like the dominant group in society as not belonging.

Where Lumby implicates media in their role of othering those who are not observed to be Anglo-Australian or white, Scott Poynting (2004), author of *Bin Laden in the Suburbs*, writes of deep-seated longer-term political issues. Poynting argues that there has been a concerted effort within Australian politics to portray those of Middle Eastern appearance as Arab or Muslim others. This was made visible through the policies of the One Nation party, and John Howard's engagement in race-based populism in the 2001 election (O'Brien & Kearney 2005, p. 11).

The race-based populism of the 2001 election pivoted around the decisions John Howard made during the 2001 election campaign. On August 26 2001, Arne Rinnan, the captain of Norwegian cargo ship the *Tampa*, responded to a distress signal from

Australian authorities who had been monitoring a sinking ship in Australian waters. The passengers, mostly from Iraq and Afghanistan, were attempting to seek refuge in Australia. Captain Rinnan rescued the passengers then, as prescribed by international law, asked the permission of the Australian government to land the passengers at the nearest landfall. This landfall, Christmas Island, was in Australian waters. The federal government refused to allow Rinnan to land, redirecting him to Indonesia. Passengers on the ship were angry at the redirection and demanded that Rinnan change course for Christmas Island. Rinnan changed course, but was refused entry. Australia sent troops to provide food and medical care to passengers on the ship and to protect the borders of Christmas Island. This stalemate continued for three days, until Captain Rinnan declared a state of emergency and entered Australian waters without permission. Australian troops boarded the ship in an attempt to prevent it from landing at Christmas Island. The federal government immediately attempted to pass a Bill called the *Border Protection Bill 2001*, which would legally protect the federal governments' position. This Bill was rejected by the Senate. Many of the refugees were eventually landed on the small pacific island of Nauru and held in detention camps, while others were accepted by New Zealand.

Prime Minister Howard campaigned on this event, stating that 'we decide who comes to this country and the circumstances in which they come' (cited in Gordon, M 2005, p. 6). The victory of John Howard's Liberal Government in the 2001 election was argued as a de facto referendum on multiculturalism resulting in a 'no' vote (Hodge & O'Carroll 2006). Michael Gordon (2005), national editor of *The Age*, took up this point, reflecting that the Anglo-Australian youths involved in the first act of the Cronulla riots adopted this mantra, demonstrating how they would decide who comes onto their patch. Made visible through media and politics, this act of othering premised on a perceived Anglo-Australian perspective is emphasised when placed in a global context. For example, white Anglo-Australian unease with Muslims and people of Middle Eastern appearance has increased since the bombings of the Twin Towers in 2001, Bali in 2002, Madrid in 2004, and London in 2005 (Gordon, M 2005; O'Brien & Kearney 2005; Stewart & Hodge 2005). Following the Cronulla riots, Michael Humphrey from University of Sydney stated that:

September 11, the Bali and London bombings particularly, and the way our government focussed on the politics of fear around security heightened the fear we were hosting dangerous people within. (cited in O'Brien & Kearney 2005, p. 11)

This fear is exacerbated by the inflammatory use of language by people in positions of authority in the Western world, such as US President George W Bush's use of the phrase 'war on terror'. Terror has an invisible yet imagined face of anyone other than white and Western. The 'war on terror' was taken up by the Australian Government, as demonstrated in the national 'Be alert but not alarmed' advertising campaign (Cornall 2003, p. 8). This highly visual campaign directed Australians to protect their borders, supposedly from unwelcome foreigners. This ostensibly predisposes 'us' to consider the risk of terror from those who appear as foreign yet live within. These 'others' are argued as circulating among us. This language positions 'us' as white and Western and vilifies all 'others', especially those of Middle Eastern appearance and newly arrived, as having potential for terror through a politics of fear. An example that builds on this politics of fear, generating a belief that as a nation we are hosting dangerous people, was seen during the *Tampa* crisis. Hodge and O'Carroll (2006) explain that during this time a claim was made that mothers seeking asylum in Australia were accused of throwing their babies overboard. These mothers, in the eyes of the media-watching population, by 'throwing their children overboard', lost all rights to be regarded as human beings. They were othered as dangerous people. On October 9 2001, Prime Minister Howard was quoted as saying:

A refugee flees persecution or flees a country more than anything else in the name of the future of his or her children and anybody who would endanger the lives of their children in that kind of way, I find it hard to accept. I certainly don't want people of that type in Australia, I really don't. (Fairfax Digital 2002)

These claims were later found to be false. It was also claimed that Prime Minister Howard knew these claims were false when they were reported to the media, and yet were used anyway to shore up his political position in the run-up to a federal election (Australian Broadcasting Corporation 2004). This approach to national leadership incites citizens to be watchful of the foreigner within, as they may inhumanely harm their children, may try to trick 'us' into giving them illegal entry into 'our' country, and may be plotting to blow 'us' up. When the leader of the nation says, 'I certainly don't want people of that type in Australia, I really don't', anyone who identifies as other than Anglo-Australian and is identifiable by having skin other than white are put on guard.

Hodge and O'Carroll (2006) draw on the work of media sociologist Stanley Cohen (1980) to explain how this event created folk devils out of distressed asylum

seekers. They explain that when there is insecurity in society alongside a system of mass media that can project that insecurity to a single issue, a moral panic can occur. It is called a moral panic because 'the public response to the feared threat is completely out of proportion to its reality' (Hodge & O'Carroll 2006, p. 23). They argue that folk devils take on the role of scapegoats in situations of moral panic. While apparently presenting as the 'same', they are symbolically marked as 'different'. These folk devils carry all society's evils, so that by marginalising the scapegoat or folk devil the rest of society can feel good. In this instance, asylum-seeking mothers who were misrepresented as throwing their children overboard were allocated the role of folk devil. This label has transferred through global events to apply to all people of Middle Eastern appearance or represented as Muslim.

Participants, like all people living in the nation of Australia, took up these political issues represented in various visual, auditory and literary ways in the media and made sense of them. The language used to represent these events in images, such as those of youths with racist slogans on their bodies, and commentary from the Prime Minister on the country, influenced the sense that people make of these events. Similarly, images of babies thrown overboard acted to dehumanise the cultural other. They worked by displacing universal humanistic characteristics of the nurturing mother, replacing it with one of a folk devil.

Making sense of multiculturalism in an environment of fear

Participant understandings, interpretations and experiences of multiculturalism were, again, all drawn from their personal experiences of the world. Despite significant national and international events influencing ideas of nationalism and multiculturalism, the majority of participants said that they did not consider ideas of multiculturalism in their everyday work. They suggested that they believed policies relating to multiculturalism in Australia had nothing to do with them or the way they worked. While maintaining this position, some participants, when pressed, conceded that the only times that they did consider multiculturalism was when their personal safety and their family or personal enjoyment might have been threatened in some way. Multiculturalism was only considered when it intersected with personal life spheres. Multiculturalism was not interpreted as being part of work life, but difference was. What persisted in participant constructs of multiculturalism was a binary of sameness and difference fuelling a quiet taken-for-granted democratic racism made visible through understandings of schismogenesis. In the following section I explain

schismogenesis, and how difference was mostly conceived as a problem. The only exception to this was when difference was seen to serve the self.

Of fear and emus and enjoyment

Three recurrent responses from participants to issues arising from living in a multicultural were active political disengagement, fear, and personal enjoyment. These themes are presented in the following section using case examples with participants. Interview data from P7 and field notes from conversations with P34 are used to discuss the workings of fear. Interview data and field notes from conversations with P12 are then used to explain how participants disengage politically. Interview data from P7 and P10 is then used to explain how participants enjoy multicultural.

Fear, difference, racism and schismogenesis

The notion of fear was expressed in different ways by a range of participants throughout data collection. While some were guarded in their comments, the media exposure relating to the war on terror and the Cronulla riots enabled these conversations about race and culture to be topical and controversial rather than specifically research-related. The following excerpt from interview with P7 offers an example of how fear is inscribed within multicultural:

P7 ... I think it's really good for Australia to be so diverse in people, but I do worry about getting a very criminal element in Australia but I don't know how you're going to police that.

R: When you say criminal element, what do you mean?

P7: Well see we most probably got that back in the fifties with the Italians with the Mafia and that, and when the Vietnam war was on and then we got the boat people, apparently, and I don't know if it's true or if it was just hearsay that a lot of the Vietnamese boat people were actually criminal element, and this is just what I hear, in Adelaide or South Australia I've heard that really they don't do much with the Westerners in the crime area but they do a lot of stealing from each other and stabbings ... but that will eventually, in ten, twenty years that will change and that criminal element if it continues then it's attacking everybody in society. And I don't know if I had rose coloured glasses or what have you, most probably do ... but well, we have been safe, touching wood ... (touching the wall) ... we've been very isolated from the rest of the world geographically so I think we've been a very lucky country and it's been good to live here and I don't want that to be gone. (Interview 7 051107)

P7 was afraid that within the groups of people entering Australia through immigration, there would be criminals and that may eventually come to make her world or neighbourhood unsafe. She talked of Italians and Vietnamese, and now perhaps in light of media campaigns such as 'be alert but not alarmed' she has another group of cultural others to fear. P7 talked of this fear being attributed to her knowledge of how people change in times of war and how when there is increased diversity there is increased risk of violence between people. She said:

you can do really cruel things in war time and I'm fearful, I don't believe in hurting another person and I'm scared of a criminal element and people harming other people ... and that comes from my own beliefs and value system I suppose ... my parents bringing me up so I'm bringing that aboard. (Interview 7 051107)

After this conversation, I asked P7 if she was aware of Australia's Anglo heritage. I was considering that Australia as we know it today began as an English penal colony, and the belief of Terra Nullius enabled white settlement by displacement and violence, which resulted in the genocide of many communities of indigenous Australians. P7 explained that South Australia, unlike other states and territories, was not settled by convicts, but rather by free settlers comprising many people from prestigious English backgrounds. P7 did not consider or imagine historical Anglo violence had anything to do with her and where she lived and how she worked. By excluding this from her consciousness, P7 was able to focus her fears about cruelty and violence onto those who are not marked by an Anglo-Australian heritage. In this conversation, she was not able to reflect on the historic violence of her own cultural heritage.

P7 identified the problem as difference. She said that she would not call herself racist, but clearly brings 'aboard' her long-held fears of criminality perceived to exist in cultures that are different to her own. P7 believed that those who were culturally different to herself brought with them to Australia a tendency to violence and were perceived as a threat to P7's isolated and protected Australia. To understand the workings of this everyday fear, I draw on Hodge and O'Carroll's (2006) use of the term 'schismogenesis'.

Coined by Gregory Bateson (1973), 'schismogenesis' describes antagonistic or oppositional relationships between groups. 'Racism' is a term that is often viewed as the opposite of multiculturalism. It is a term that 'distorts and limits debate and understanding' (Hodge & O'Carroll 2006, p. 6). Schismogenesis can be used to

understand how racism comes into being and does not minimise, in any way, the dreadful impact of events carried out in the name of racism. Where racism is assumed as perpetuated because of difference, schismogenesis recognises that while it is natural for societies to split and rebuild, these splits are not always based on difference nor are they always destructive. Racism built on difference is termed 'complementary schismogenesis' and racism that emerges from sameness is called 'symmetrical schismogenesis'.

Applying this understanding to P7's comments we could imagine that a clear complementary schismogenesis exists; that is, racism based on difference. P7 saw the other as different to herself and the cause of her fear. If P7 were to consider her historical cultural position also as immigrant, and the complicity of tremendous racial violence in the taking over of Australian territories and the legacy of the white Australia policy, she might consider that the problem could be one of sameness rather than difference. Perhaps, then, symmetrical schismogenesis was taking place, where racism occurs because the other is too much the same as the self (Hodge and O'Carroll 2006). The difference matters, because if we take the face value of racism through complementary schismogenesis we are always looking to name the other and their difference as the problem. If we move towards understanding the workings of symmetrical schismogenesis, the focus is moved to the self and an understanding of how the self is culturally situated historically and politically.

In another example, P34 spoke a number of times about her apprehension in home visiting some families whose culture was different to her own. This related to fear of reprisal from fathers when undertaking an assessment using the pathways to parenting (P2P) questionnaire. Over the course of an afternoon field observation, P34 spoke of her frustrations with the P2P, saying that she often did not ask the questions because she was afraid:

...[in] some of these Asian homes there are holes in the walls and broken furniture, you know what has happened, so I ain't asking the questions. (Field note 050609)

Later in the day P34 added '...those Albanians will cut your head off as soon as look at you!' followed by:

You know for some of these families it's culturally inappropriate, with the Lebanese or Iraqis, I don't even go there with the questions. In their houses they are the boss. I

had one where the mother died from being bashed you know, DV, they had to wash the blood off the walls! I'm not going there. (Field note 050609)

While P34 did mention violence relating to men in general, this violence was noticeably always related to men who were also culturally different to P34, such as Asians, Albanians, Lebanese and Iraqis. P34 indicated her belief that domestic violence is a cultural norm for many of for these men, saying:

... domestic violence is entrenched in these cultures; the husband doesn't love you if he doesn't give you a good hiding every now and then, that's a European thing culturally. (Field note 050609)

P34 initiated these conversations, and for her the focus of her frustration was the invasive aspects of the P2P. P34 did not stop to consider that perhaps her unexamined fear of non-Anglo men may be more problematic than the invasiveness of the P2P. Because P34 talked of her fear of men from other cultures, racism in this sense was built by both issues of gender and the complimentary schismogenesis of cultural difference. She used the same discourse to normalise domestic violence as culturally appropriate. In all of this, difference for P34 was experienced as a problem, even though the problem that was named was the formal assessment tool of the P2P.

Emus and political disengagement

In another example, P12 took up a political issue different to those surrounding multiculturalism in response to her fears for her children in their adult life. The issue she took up as politically relevant mattered only in how she saw its effects on herself or her children. Issues relating to culture and multiculturalism did not seem to affect her directly, so she avoided any related media exposure. P12 said she actively tried to remain uninformed and thus apolitical on issues of culture and multiculturalism.

In this example, P12 explained how, in a consultation, she managed to focus on individual client needs together with treating people 'the same'. We moved into a conversation about where the ideas for treating people the same may have come from and explored a range of social and political influences. P12 said, *'I hadn't really thought about it, I'm not really into politics or government, I don't take much notice of what they say'* (interview 12 051213). Given that this interview was held two days after the Cronulla riots, I asked what thoughts P12 had on these events. The following excerpt from the interview tracks the conversation:

P12: Yeah once again I'm an emu, I put my head in the sand, I get along, I do my own things.

R: So you don't think about that kind of stuff?

P12: No, it's a terrible thing but I don't think about it.

R: Like all these riots in Cronulla at the moment that are happening, haven't thought about that?

P12: Nuh. On the radio they had about these riots and I'm going "what riots would that be?" and they were having this big chat or something on the radio and I was thinking "what's happened", I never watch the news, I never read a paper ... Yes see I don't think too much about that sort of stuff, I feel as though I'll be in this job until I retire or whatever, I think nothing much is going to change for me, I feel more for my children and I think that Howard's new industrial relation thing needs blowing up and I went and protested.

R: So there are some things you think about politically?

P12: Yes, if things tweak, that was more I was thinking for my children, I was thinking can you imagine them trying to negotiate?

P12, like others, determined that she was not affected by broader national politics; they can 'do their own thing'. P12 believed she was justified in ignoring politics. She mixed her metaphors, taking on an Australianised version of an ostrich and burying her head in the sand. By doing this, P12 filtered out any challenge to her personal beliefs and values. P12 did, however, respond to issues that affected her direct sphere of family. In considering possible effects of the new industrial relations laws, P12 was activated to become political and attend a protest. It seems that the notion of multiculturalism and its attendant issues of racism, identity and nationhood were not affecting P12's personal life in such a way that she needed to take notice. Participants only took up political issues if they related directly to their lives.

Multiculturalism as good and self-serving

Participant ideas about multiculturalism were often viewed through a self-serving lens. Participants spoke of valuing multiculturalism because it offered external cultural signifiers that enhanced their world and their self-identity. When asked if she thought much about multiculturalism P7, for example, said:

I suppose a certain amount because again work, and plus when you walk down the street and Australia's multicultural and it's lovely. It's all this wonderful food ... I think it's really good for Australia to be so diverse in people ... (Interview 7 051107)

In this situation, P7 experienced multiculturalism as a white person in the privileged position of being able to choose how difference impacts on her and her life. While P7 is sincere in her approach to multiculturalism, Ghassan Hage would classify P7 as a 'good white nationalist' (2000, p. 78). P7 embraced her white view of multiculturalism where it is 'lovely' when you walk down the street, have 'wonderful food' and it is 'good for Australia to be diverse'. To be good is to be 'morally excellent; righteous; pious' (*Macquarie Dictionary* 2008). Perhaps P7 referred to multiculturalism being 'good' for us because it would help our moral national character, not necessarily because this was the way she might have liked it to be.

In a similar vein, Hage (2000) argues that good white nationalists have embraced the fantasy of white supremacy in Australia through overt displays of tolerance. This White nation fantasy is described by Hage as a 'White belief in one's mastery over the nation, whether in the form of White multiculturalism or in the form of White racism' (ibid, p. 18). Hage goes on to explain that through discourses of tolerance, practices perceived as morally 'good', such as P7's reflection, are structured in the same way as overtly racist practices of exclusion. P7, for example, while intending 'good' will, shared and inhabited the same position of power as those overtly racist within a nation imagined as 'theirs' (ibid, p. 79). If this analysis is accurate, P7, like other participants, was in the position of enacting practice that is morally pious and paternalistic, perpetuating an assimilationist agenda in parenting.

Similarly, P10 spoke of her enjoyment in working with people from cultures that were different to her own when she said:

I think I enjoy it and I like learning about other cultures and I like being around other people that do think differently and live differently and I think that probably comes back from travelling, like I do really like going to the market and I really enjoy that so it's probably an enjoyment factor. (Interview 10 051128)

While this vignette could be similarly analysed using Hage's understanding of white nationhood, it could also be interpreted as genuine interest and open-mindedness. Learning and growth occur when individuals are genuine in their interest and engagement with a subject. This raised the question of how we can then determine when a self-serving agenda is helpful to genuine engagement with clients and when

is it alternately perpetuating a racist agenda through supremacy and paternalism. It also raised the issue that to undertake education in this area requires people to get uncomfortable, as they examine the ways 'white' plays itself out in life and practice (see for example Simpson 2007). I asked how we can differentiate between genuine interests in the cultural other for the purposes of developing a professional relationship and interest in the cultural as serving the self through access to things exotic. Does it really matter whose interests are being served?

These issues go to the very core of postcolonial thinking. In identifying their personal interests in other as self serving, P10 and P7 were using the other to represent the self. Hall says that 'only when there is an "Other" can you know who you are' (1991, p. 16). In doing this, P7 and P10 used the other as an oppositional referent to self. Their identification of other reinforced who they saw themselves as. They valued the other only in as much as it offered external cultural signifiers to enhance their world and their self-identity.

Hall clarifies that identity is a process. Rather than being outside, the other is also inside the self, alternately competing and aligning in the formation of self-identity (ibid, p. 16). While participants may have recognised the external cultural signifiers of the other that they accrued in creating their identity, what was less clear was how they used the subject positions available to them through this accumulation of difference, which may not have been in their conscious awareness.

Participants were in a position of authority in which they had the capacity to take up a subject position that not only used the other as oppositional referent to self but also or instead used their connections with the cultural other to demonstrate respect, empathy and genuine interest, thus enhancing the professional relationship for the benefit of the other.

Davis et al. (2002, p. 60) state that 'people who are genuine are not acting a part or pretending, deliberately or otherwise'. Trying to understand this statement within the context of multiculturalism is difficult. While participants are genuine and open in expressing their enjoyment of the cultural other, at the same time the other is used to reinforce self-identity. Further, the relations of power enacted through tolerance often remain invisible.

Government policy and practice

To understand the complexity of participants' ideas about multiculturalism and practice, conversations were held around the links they made between their beliefs, professional practice and policies around multiculturalism. The majority of participants suggested that government policy had no influence on their practice or their way of being in the world.

When asked if things like Australia's multicultural policy might have influenced her personally or in the way she works with people, P10, for example, said, '*Yeah probably, I don't think it's really influenced me directly I don't think*' (interview 10 051128). P10 seemed to have a formless sense that multicultural policy has some impact on her but did not name or discuss how this impact might look or be interpreted. P10 could not see any impact on self because the cultural self is unaware of its position of white privilege and does not feel uncomfortably subjected by the policy.

Similarly, when asked if she ever thinks about things like Australia's multicultural policy and the influences it might have on her work, P14 said:

... hadn't really thought of that, no ... do the best you can for the people you come in contact with day by day and help them be the best they can be with support. It's an interesting one isn't it? I think you can get, if you dwell too much on who gets in and why you probably become a bit angry and disappointed at some of the choices that are made so you've just got to do the best to help the ones that are here. (Interview 14 060208)

P14 said that she didn't think of these issues. However, when she had a moment to reflect, she identified some genuine concerns for migrants. P14 expressed concerns at the way decisions are made about who gains entry into Australia. She interpreted this thinking as unhelpful 'dwelling' that leads to sad and angry feelings. These feelings were directed towards those making decisions, presumably the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA), although P14 did not name this department or those making decisions. This seemed to be a 'get on with it' approach of contenting oneself with a belief that some things cannot be tackled, so deal with those that can. P14 returned to a discourse of helping those who do make it through to make sense of the frustrations of existent policies.

P4 stated that government policies have no effect on how she works with families. Like P14, she attended to the local and immediate needs of presenting parents. When asked about links between national policies and practice, P4 said:

I haven't thought about that. I don't think I've ever thought about the, up there where they make all the rules and all of that, how it would impact on our work with families, just doesn't enter into it. (Interview 4 050921)

When asked if the content of such policies might ever matter to practice, P4 replied, 'No, I don't think with the policy and that I don't think it will ever change the way I would work with these families' (ibid).

P4, like the previous examples, did not recognise that policy and national sentiment influence every aspect of who she gets to work with, how they got here and the securities or insecurities about how long they get to stay here, which impact on their physical and mental health. P4 did not recognise that the very way she identified 'these' families as a category was dependent on how government policy enables or delimits the experiences of 'these families' within the nation of Australia. Take, for example, the pictures and language used in the media about the Cronulla riots which identified all people, especially male youths of Middle Eastern appearance, as folk devils in the context of the war against terror.

Some participants talked of direct personal experiences of Australia's policies on multiculturalism from a point of view other than white. In the sphere of these participants' personal lives they had experienced the challenges of migration, of difference, of uncertainty and of not being white. It is only from these very personal experiences that some participants saw more than a white multiculturalist viewpoint.

P4 and P12, like others positioned as white multiculturalists, used a discourse of humanity to blinker their positions of relative comfort from the potential impacts that multiculturalism might have on the cultural other. Annette Browne (2001) argues that liberal ideological premises, including political neutrality, have diverted nurses' attention away from social determinants of health. As such, nurses' capacity to influence the political, social and economic determinants of health continue to be limited by a reluctance to question the taken-for-granted assumptions of liberal humanism in intercultural health communication, education and practice.

Stepping out of the binary

It is difficult to make sense of how the binary of sameness and difference can facilitate intercultural communication. Treating everyone the same as the self creates a mask of whiteness that does not recognise relations of power and assumes an assimilatory agenda. When difference is recognised only in as much as it serves the self or is experienced only as problematic, it is interpreted as democratic racism. As Hage (2000) suggests, cultural interpretation also presents an unhelpful binary of either white multiculturalist, which equates to being racist, or non-white multiculturalist, who is forever subjected to the actions of the white multiculturalist.

Perhaps the binary can be unsettled by drawing on a third body ever-present but masked throughout this discussion of sameness and difference, that of the cultural self of the child health professional. While participants identified the constructed nature of this self, they were unable to name it or recognise its influence. For the majority, this unidentified self was the collective of white Australians who most often do not claim their identity as it has become synonymous with a taken-for-granted normative collective position of the Western nation of Australia. By not naming this white cultural history, participants excused themselves from contending with the social and political history that accompanied the culture of whiteness.

Once an understanding of the situated and constructed nature of the cultural self is undertaken, we might consider how ideas such as symmetrical schismogenesis play out. This might open a window to see that understanding Australia's history of penal settlement and colonisation is reflected in migration stories of contemporary new arrivals or refugees. There is much similarity between these historical stories. There are also many similar stories between white woman's motherhood experiences and those of the migrant women they are now serving.

Even though parents who have migrated to Australia are culturally different to child health professionals, they are in many ways much the same. The racism observed in this study was not overt as in the way of complementary schismogenesis, but perhaps a result of parents being too alike, thus their difference is negated by the dominant white majority. This might go some way to exposing the covert nature of democratic racism within communication practice. Perhaps understanding possibilities of how this covert racism works may lead us away from the binary of racist/non-racist to a third body of integrating the many personal and private subject

positions of self into practice. In this way they can be examined and explored and taken into the consultation mindfully and not left outside by the front door.

A position of either sameness or difference is not helpful on its own. Turning to a three body analysis, we might consider how introducing understandings of the self as cultured might disrupt these binaries and offer opportunities for practice. We see that the cultural self is always present in working with sameness and difference, even though participants were generally unable to identify or name what this self was or recognise the inherent influence of this position on relations of power in intercultural communications. Like a kaleidoscope, these bodies are always interacting and giving us new and tempting possibilities.

CHAPTER 9

DEVELOPING RELATIONSHIPS IN AN INTERCULTURAL CONTEXT

Introduction

How individuals develop relationships within intercultural communication interactions is as important as the content of information given to parents at that time. Like the content of information given, participant approaches to communication interactions were shaped and informed by a complex intersection of individual, family and social constructs. As such, the ideologies that inform communication practices for the majority of participants are formed within the Australian context of whiteness. When asked about approaches to communication, participants mostly spoke about the importance of personal constructs such as building relationships, being respectful, building trust and being genuine. In addition, participant approaches to communication were strongly informed by discourses of partnership. While partnership as a concept has long been held, akin to empowerment in areas of primary health care (McMurray 2007), it was explicitly introduced to the participants' workplace through the organisationally endorsed Parent Advisor Model (Davis, Day & Bidmead 2002). A partnership approach was valued by the majority of participants as it was believed to encompass a personal and professional fit.

Key to partnership is the recognition of complimentary knowledge and skills of health professionals and parents (Davis, Day & Bidmead 2002). Alongside this understanding, Davis et al. suggest that partnership requires the health practitioner to have specific qualities or attitudes such as respect, genuineness, humility, empathy, personal integrity and quiet enthusiasm (*ibid*). While the authors explain the importance of possessing these qualities, they do not describe how to evaluate the presence of these qualities or how to develop them if they are absent. Like other communication models (see, for example, Bolton 1986; Lewis & Slade 2000), Davis et al. turn to behavioural markers such as attending and facial expression to indicate the presence of these characteristics.

Contemporary pedagogies of communication commonly used in health service delivery do not explicitly recognise that personal ideologies shape and inform these qualities in the health care communicator. There seems to be very little if any attempt to explicate how these ideologies might be deconstructed for examination

and understanding of communication practice. When asked about partnership, the participants in this study seemed to rely on dominant ideas about the self and individualism to inform how they worked with people from culturally and linguistically diverse backgrounds. In their talk they did not refer to race, gender or class as influencing factors that might shape how they learned to communicate, or how parents seek help or behave in the context of relationships with child health professionals.

In this chapter I use examples to demonstrate how participants explicitly state the personal constructed nature of their communication practice. I then describe participant understandings of partnership and the attendant core qualities of helpers particularly, respect and genuineness. Throughout this, examples of practice are given where participants saw themselves through behavioural analysis, meeting requirements of partnership. However, a deconstruction of the ideologies informing these behaviours suggests that the accompanying construct of genuineness in practice might not always be possible. In this chapter I explore how participants manage conflicting ideological positions in practice. It seemed at times that learned communication skill sets were enacted so that practitioners could disguise conflicting ideological positions. Further, I question the efficacy of a pedagogic focus on developing skill sets without accompanying deconstruction of underlying ideologies. It seems that without ideological exploration, issues of race, gender and class are left to creep out unnoticed and unquestioned into the communication practices of child health professionals.

Learning about communication and relationships

Participants understandably explained their learning of communication as a complex mix formed primarily in childhood and developed through personal life experiences. Professional learning was often not volunteered by participants as playing a part in shaping their professional practice. Professional perspectives were generally only described following direct questioning.

Communication practice was often described by participants as an intrinsic part of human nature. P2, for example, explained, *'I think people will do it ... in a way that comes naturally to them'* (interview 2 050912). P12 similarly suggested that her approach to communication was based on personality and temperament, suggesting it was something people are born with. She said, for example, *'Some are a bit more*

high strung and some a bit more relaxed you know that sort of thing' (interview 12 051213).

Not only were approaches to communication spoken of as intrinsic, they were also attributed to a psychology of early socialisation. P7, for example, said, *'Let's face it I'm a people person ... I do like people'*. When asked where this might come from, P7 said, *'I'd say it's ... personality and upbringing too, again that culture of upbringing environmental, mum and dad parenting, yeah, many, many factors'* (interview 7 051107).

Deconstructing participant discussions around their social learning of communication, it became apparent that values underpinning the importance of interpersonal relationships were being named rather than skills. For instance, in explaining what is important to her when communicating with parents, P13 said:

one of my values is probably as I've grown up that it's important for me to have that trusting relationship with people ... so from my background I guess, but you know if I don't feel comfortable in a situation then I'm not really going to open up and talk to someone about things. (Interview 13 051220)

From this personal value, learnt through her family of origin, P13 concluded that she believed parents would not open up to her if they did not feel comfortable. Therefore, she focussed her attention on developing trust in relationships with parents.

P2 raised another aspect of the intrinsic nature of communication skills when she said, *'If you're the sort of person who does this sort of work then ... you're naturally attuned to people'* (interview 2 050721). Communication then for P2 is a 'natural' part of being a child health professional. On the other hand, P8 questioned the assumptions within this belief when she said, *'Being a nurse, people have that assumption "well you must be that sort of person" and I think lots of us are, but there are lots of people out there who have done all the same study who are not "that sort of people"'* (interview 8 051123, emphasis in original). P8 acknowledged that this is sometimes the case, but questioned its universal applicability. Reflecting on the capacity of formal education and professional development to make any difference to the communication approaches of health professionals, P8 continued, *'I know I've been taught all that but often I just think you've either got or you haven't'* (interview 8 051123). This statement seemed to summarise the ongoing debate within participant discussions as to whether communication can be taught at all. P8

wrestled with understanding which aspects of communication are natural and which are not, saying, *'There's a lot of theory there that you are taught and it's hard to know which bits of that you actually use and which bits are just in you'* (interview 8 051123). It seemed that skills can be learned in a professional context, but values have already been learned, and there are few places in professional pedagogy or practice to critically examine the nature of these values.

Experiencing the parent advisor model (PAM)

When asked to reflect on their professional learning of communication, participants mostly spoke of picking up information from a range of professional sources. P17, for example, said of her professional knowledge of communication, *'I guess it's really an amalgam'* (interview 17 060323). P10 was less certain of her grounding but said, *'I wouldn't remember any I don't think, no definitely not, but I'm sure it is in there ... you could hypnotise me and I'm sure I could recall it (joint laughter)'* (interview 10 051128).

When participants did not voluntarily raise the PAM I asked specific questions about their views on the communication practices advocated in the model. Rather than accept the PAM directly into practice, the majority of participants spoke of how they wove the PAM into their web of personal and professional experiences as connected knowers. Responses to the implementation of the model as the preferred approach were diverse, ranging from elation to incredulous indignation. Most reflected a non-committed, resigned, and at times sceptical acceptance of yet another organisationally authorised approach to care.

Some participants spoke of the enforcement of a particular pedagogical model as *'ridiculous and insulting'* to their professionalism. P7, for example, said that the PAM is a complete repetition of what she learned in the graduate diploma of health counselling. She also spoke of the six week professional development program not recognising the experience of child health professionals. She scoffed at how she was instructed at a basic level in how to make contact with a parent, saying, for example, *'You know "knocking on the door", get out of here'* (interview 7 051107). She did, however, suggest that it might be *'good for the young ones who've never worked in the community'* (ibid).

In contrast, P12 spoke of the PAM as helpfully reinforcing that she was *'doing OK'*. She identified the model as repetitive, but suggested that since undertaking the

training she noticed how the micro-dynamics of her communication could be improved and she had changed some of her behaviours, like turning around from her writing and engaging with the client during a consultation (interview 12 051213).

In these discussions the idea of working in partnership was highlighted, as it reflected a personal professional fit with the participants' way of being in the world. P12, for example, said, '*Partnership training confirms that's the way you should go, but I've always been like that*' (interview 12 051213). P3 also said:

I think it's the way we've always worked in [the residential unit]; not having the answers, to work in partnership with them and find out what they can do about ... what they want to solve or what they want to change. (Interview 3 050920)

While participants did not all enjoy the process of being mandated to attend professional development nor the adoption of a specific model of communication, they resoundingly saw the idea of organisationally sanctioned *partnership* as a helpful development in building relationships with families that centred on the needs of the family.

Developing relationships

Davis et al. (2002) argue that relationship building is a fundamental and vital task of the helping process. They suggest that through a process of attunement health professionals and parents form essential impressions of each other. Parents then making 'tentative decisions about whether they can relate to and work with the helper, in terms of whether she/he is or will be caring, understanding, trustworthy, helpful or useful' (Davis, Day & Bidmead 2002. p. 35). Participants placed high priority on developing relationships in the communication interaction. While this aligns professionally with the PAM, most participants said they did this because of it was a 'natural' thing to do. This is consistent with participant explanations of their general approaches to communication and their understanding of partnership. P10, for example, said that she prioritised developing relationships because:

I think it's just human nature isn't it, I mean I think whatever kind of relationship even it's buying fruit from a fruit and veg. (Participant 10 Interview 10 051128)

While participants generalised their desire to develop relationships as intrinsic human nature, their purpose for establishing relationships with clients was quite specific. Participants explained that the purpose of establishing a relationship was to enable the 'helping relationship' and to establish a 'right of return to the service for

parents' and also at times for themselves to 'return with follow up care' for the family. I explain these ideas in the next section. This is followed by an exploration of who participants saw as the prime focus of their relationship work. This focus understandably varied within the context of family, but it was predominantly observed to be the mother, in order to facilitate the best interests of the infant or children in the family. I then illustrate participants' explanations of the process they used to form relationships with parents.

Enabling the helping relationship and establishing a right of return

In observing the ways participants established relationships with parents, I noticed that many took time to establish an environment that enabled a helping relationship, and endorsed a right of return to the service for the mother and infant. They used this as the motivation to work towards establishing an open and trusting relationship with mothers and fathers. Participants believed that if parents felt welcomed and listened to, they would feel comfortable to return when they identified specific needs. In the following example, P10 explained what she saw herself doing on the DVD, then explained what motivated her to act in this way. P10 said she and the mother were:

just getting to know each other. It's kind of a warming up I guess, try and make her feel comfortable, trying to let her talk, like if she wanted to talk, let her say what she wanted to say, just listening and try and let her know that I was listening to what she was saying. (Interview 10 051128)

P10 placed high importance on taking the time for this mutual getting-to-know-you. She acknowledged the reciprocity in the relationship, implying that it is as important for the mother to get to know her as it is for her to get to know the mother. Interestingly, P10 seemed to play down the function of this time suggesting that they were "just" getting to know each other and "just" listening. However, she did explain that the aim of this was to assist the mother to feel comfortable and enable her to 'say what she wanted to say'. According to P10, this might enable the mother to express her concerns so that P10 might help her. In addition, she recognised the therapeutic nature of listening when she said:

when she feels comfortable that she can say something, then she can, and potentially I can help her or you know maybe just listen to her and that would be enough help for her. (Interview 10 051128)

P10 then suggested that by taking the time to do this, she establishes a right of return for the mother. She said, *'and then even, just making her feel comfortable to be there and to come back again'* (interview 10 051128). P3 also spoke about her efforts to develop a relationship that enabled parents to return for ongoing care. In the following statement she gave an example of how this works in practice:

some people tell you what they want you to ... what they think you want to hear ... and I've had a couple of mums who've come back to see me later on and said 'I didn't tell you the truth then but I feel it's OK to talk about it now'. (Interview 3 050920)

P3 recognised that mothers at times respond to the authority of the child health professional and give information that does not reflect their situation accurately. Further, P3 suggested that developing a trusting and friendly relationship invites parents to not only return in the future, but to be more open.

Through further observations and discussions it emerged that participants had more to their agenda than enabling parent-led discussions and establishing a right of return. P1 demonstrated this when watching herself on the DVD. She explained the importance of developing a relationship so that the mother would feel comfortable to continue to use the child health service. She spoke of *'not being too forceful in trying to push our views on to them ... too early'* (interview 1 050721). P1 then said if she was to do this:

you're not going to get in the door again for a start ... what will they think? You know, it's too invasive ... and they'd be very reserved in asking us back there again. I think. (Interview 1 050721)

The focus for P1 seems to be two-fold. She did not want to seem too forceful or invasive as she considered, on the one hand, that this may damage the relationship, and on the other, that it may deny the child health professional entry on future occasions. In this instance, it was the child health professional wanting a right to return and engaging the mother to ensure this right.

P1 also mentioned not wanting to *'push'* her ideas onto the mother, and then added *'not too early'*. In saying this it was not quite clear what she meant by the word *'push'*. I wondered if she wanted to persuade the mother, to promote her ideas on child health, or provide information to the mother, or something else? What is interesting here is that she did not use professional language to talk about what she

does in practice. This lack of specificity in practice may mean she opens the way to being criticised when her practice is compared to the standards of the profession or the organisation.

It is the explicit goal of child health intervention to promote health through fostering, encouraging or 'pushing' ideas such as immunisation, child safety, health and well being. P1 recognised that by taking it slowly and engaging the mother, she would increase the opportunity to develop a relationship with the mother. Once a relationship of trust was established she recognised that she would be able to use that position of trust to engage the mother with ideas that could be helpful to her and her baby.

Interestingly, while participants espoused that relationship building was within discourses of partnership, approaches like P1's continue to follow a transplant model of communication practice. In this model the professional role is to establish a relationship with the parent so that once the parent trusts the professional, the professional can transplant their information to the parent and the parent will trust and use this information (Cunningham and Davis 1985). This model of communication is problematic. It does not address the imbalance of relations of power between professional and parent, as it assumes the health professional decides which knowledge, strategies and goals are necessary for child health in any given encounter with a parent.

Participants discussed the process of establishing a relationship, in the context of partnership, as important to enable parents to communicate freely and feel comfortable to return to the service. However, partnership seemed to be understood in terms establishing a relationship to enable the health professional to use this relationship to take control of the health care encounter. While this professional desire to impart information is supported in the context of health promotion, health promotion discourses explicitly call for partnership with attention to relations of power in enacting the promotion of health (World Health Organisation 1997, 2005).

Relations of power in relationship building

Perhaps participants continued to understand partnership in terms of transplant approaches because they struggled with how to enact health promotion particularly in intercultural contexts. Despite claiming to practice within a framework of primary health care, it seemed that for many participants health promotion was still practised

as information giving from a behavioural change perspective. The broader comprehensive model that advocates partnering individuals and groups, supporting and following their lead, was not evident in the talk or observations of practice of the majority of participants.

In the following example, P1 and I were watching her DVD and discussing developing relationships across cultures. P1 said she hoped the mother did not raise the issue of genital mutilation as she would be uncertain how to proceed. She was afraid her response might negatively affect the relationship and close doors for ongoing care. P1 tried to manage the tensions between recognising the cultural significance of female circumcision, her legal obligation to report it, and her awareness that a consequence of inappropriately raising it may result in being *'misinterpreted and then a backyard job being done'* (interview 1 050721). P1 considered that the relationship needed to be managed steadily so that difficult issues could be discussed and that decisions were made for the best interests of the baby and mother. In this high risk situation P1 prioritised the importance of developing and managing a relationship to serve the baby and mother.

P1 recognised that even by raising the issue of female genital mutilation in the early stages of the relationship, her actions could result in a negative outcome for the baby where the mother may disengage from the service. In doing this, she recognised and considered relations of power inherent in the relationship and the authority inherent in her role. She used this authority to maintain relationships for ongoing care. On the other hand, by not raising the issue as a topic of conversation, P1 might not have advocated in the best interests of the child. P1 felt frustrated that she was not able to follow up with this family as they were categorised into mainstream services. In mainstream services they were offered attendance at the child health centre where P1 had no allocated time to provide service.

Part of P1's frustration seemed to be that her work to develop a relationship with the client may not result in the client transferring that sense of relationship to another health professional in the organisation. The mother may not return to the service. If the mother did return to a child health centre, the same situation may arise, where the mother will be engaged by another child health nurse who also does not raise the issues of FGM in order to preserve the relationship.

In a different scenario, P18 spoke about the importance of developing a relationship with the mother, saying, *'The first five minutes you have to work your arse off to*

build the relationship' (interview 18 060317). P18 did this because she believed that the mother is the cornerstone to the wellbeing of the baby. She said:

number one is maternal confidence and the general health because as I said you can have a happy healthy baby but if mum is falling down in a heap then everything will eventually fall in a heap, so right in on first contact I want to build a trusting relationship with the woman. (Interview 18 060317)

What was interesting about P18's approach was that she was overt in her use of power relations. For example, she said:

I always introduce myself as a lactation consultant because I think if you say "consultant" people think "oh you're a consultant" they'll actually open up and ask you questions. (Interview 18 060317)

When asked if she uses this as a kind of *'power trick'*, P18 said, *'Yeah it's a trick but then I would never, like I would absolutely work with what they want sort of thing'* (ibid). I questioned why P18 chose to enhance her authority in an intercultural context when her authority is already confirmed by being a white health professional. P18 argued that in the interests of developing a relationship with the mother and gaining trust in her clinical authority, she was prepared to privilege the voice of authority by naming herself as consultant. P18 did not seem to recognise that in the intercultural context this authority is already stamped on her very appearance, her professional title and her association with the organisation.

The power to name is central to colonialism (Jordan and Weedon 1995) and neocolonialism. P18 gave the impression that she was happy to use this power, asserting it in the best interests of the mother. Use of the word *'consultant'* is riddled with authority and influence, and looks to elevate the professional over the other. The need to identify self as elevated infers a need to prove the self in the face of the other. Through a postcolonial lens, one can only see self when that self is positioned against the colonised other. The other is used to identify and name the self, thus giving the self identity. From this view, P18 at the very least can be seen to unintentionally collude with perpetuating a colonist agenda of maintaining the creation of other as inferior to herself and thus maintain the superiority of whiteness. In this way it is possible to imagine that P18 paradoxically addresses her needs while claiming to attend to the mother's.

Further, P18 identified herself as superior to other child health professionals by naming her consultancy and reinforcing her subject position of greater status power. P18 argued this decision by suggesting that once authoritative trust was established she would use this to follow the mother's lead regarding what the mother would like to do, thus confirming her intent to do 'good' within the relation of power. Here, partnership, as a discourse, seems to be used to veil the impact inherent in these relations of power. The approach to communication used by P18 in this example follows a transplant model where authority is used in the power relationship to validate her position so that the information she gives will be valued and enacted by the mother. On the other hand, by overtly stating her position as consultant, P18 could be interpreted as stepping into and claiming the full authority of her role. How she used this authority, particularly in intercultural encounters, is also important.

Where P18 was observed to enter the consultation with a whole-hearted belief in the centrality of the mother, the critique of practice becomes more difficult. Her intentions were sound. I continue to ask myself, why pull the wings of a butterfly just to see how it works? How a professional might explore the ways they explicitly or implicitly enact their particular use of authority in practice is not clear in the child health literature. While Davis et al. (2002), in the PAM, outline the professional's role in the practice of partnership, their literature does not provide strategies to help practitioners reflect on how their past practices, beliefs and values shape the way they adopt new practices.

Mothers who are migrants to South Australia may recognise the authority of child health professionals and interpret this as reinforcing their position of subordination. P18 did not consider that by emphasising the authority of her position she might make it difficult for the mother to assume a subject position other than subordinate. If the mother assumes a subordinate position P18 may, contrary to her intent, reduce the opportunity for the mother to engage in partnership and voice her concerns. P18 assumed her own belief that a professional with a name of consultant would necessarily facilitate a mother to ask questions of that consultant. This assumption lacks validity in Western contexts of community health practice, let alone across intercultural encounters.

The work of developing relationships

Participants worked towards developing relationships with parents using a range of strategies based on everyday life experiences. These primarily included using

strengths based approaches, friendship and attendant small talk. This next section uses examples to demonstrate how participants named and applied these personal constructs while watching themselves in everyday professional work environments.

Strengths based approaches

Although participants did not generally name their approach to therapeutic communication as 'strengths based', I observed this to be a common strategy. A strengths based approach comes from social work literature and focuses on empowering clients for change (see, for example, Nash, Munford & O'Donoghue 2005; Poulin 2000; Saleebey 2005). As an approach to therapeutic communication it has been used in the care and management of older adults (Fast & Chapin 2000), children, adolescents and families (Sharry 2004) and in supporting parenting in early childhood (Erickson & Kurz-Reimer 1999).

To illustrate participant use of a strengths based approach, I use the following example. Watching the DVD together, I asked P11 what she saw herself doing. P11 replied:

Oh well just trying to develop a relationship I think. Just trying to sort of talk to her about how is it going with her with her child ... and being positive ... so sort of giving her as many positives as I can sort of building that up a little bit about saying well she knows everything anyway, she didn't need the baby weighed and all that sort of thing. (Interview 11 051129)

P11 did not identify this as a strengths model of communication; to her it reflected her natural way of being in the world (interview 11 051129). This could explain why, like P10 discussed earlier, she devalued her approach by saying "just" trying to develop a relationship and "just" trying to talk with the mother. Approaches understood as coming from the personal domain seemed to be minimised as unimportant.

Other participants also used a strengths approach to working with families but did not articulate it as such. P2, for example, said:

I don't want her to feel that she's a bad mother ... by concentrating on this terrible bottom ... I want her to have some positive ... experience like to tell me some positive things about her parenting. (Interview 2 050916)

At the time, P2 was watching herself asking questions of the mother in the consultation that she already knew would elicit a positive response so she could

'build the mother up'. While the benefits of this approach are well documented (see references above), one wonders about the pitfalls of building someone up when one has not first invested the time to understand the context of this positive reinforcement to thus ensure genuineness in the interaction. As participants did not recognise the framework of this approach, it follows that they also may not have been aware of the consideration that empty praise may be misinterpreted as paternalism.

Another way that participants applied strengths based approaches was through purposely displaying positive responses to the baby as a strategy to enhance their regard with the mother. When asked what she saw herself doing on the DVD, P7 said:

I suppose it's getting to know the baby, because babies have personalities too, and babies are precious little items ... and it's important for parents to know that you care for their baby as well; communicating with the baby, talking. (Interview 7 051107)

P7 continued, saying that this approach increases the relationship with the mother 'because you're interested in the baby and that's their number one' (ibid). Similarly, P13 said, 'I think we need to interact with the child more at that age [four to five years] then the parent warms to you more as well' (interview 13 051220). She identified a need to engage with young children to support the relationship with the mother, saying, 'You're valuing their child and making them important' (interview 13 051220). This built on the belief that most parents want others to think that their child is special and important.

P2 believed that talking with the baby helps to engage the mother because the baby provides a non-contentious middle ground through which both the mother and the child health professional can meet and have a starting point to discuss more sensitive and challenging issues. She said during interview:

You know it's not confrontational ... we both have the baby's best interest at heart. She knows that I do have ... the baby's best interest at heart so that puts me in a good light ... to start with ... and then that gives her time to work out whether I'm somebody that she wants to speak to. You can't walk up to somebody and say "how's your domestic life?" (joint laughter) ... but you can meet in the middle over something that's very easy to engage with like a young baby ... and then develop, use that baby as the basis for developing a relationship. (Interview 2 050916)

P12 similarly talked about connecting with the baby, which translates into forming trust with the mother. She said it was important that:

they think that I do connect or show some sort of knowledge or understanding or something with the children then maybe what I'm saying might be worth a go, maybe I have got something worth listening to or trying or something ... they're looking at trusting you. (Interview 12 051213)

Developing trust means that the information given is validated. It seemed that, like the transplant model, trust was important so that professional information is well received. The relationship with the baby was used to build a platform on which to give information, not necessarily explicitly, to create space for listening to parents and following their lead. Perhaps it is that child health professionals like P10 do listen, but do not value this as part of their professional role, relegating it to the personal and universal sphere as 'just human nature'.

Participants seemed to base their desire to build a relationship with the baby on a range of reasonable assumptions, such as the mother's belief that the health professional's singular focus is on the baby, and the baby acts as middle ground for the consultation. I questioned the transferability of these assumptions to cultures other than white middle class. I wondered how useful it might be where parents are refugees and may be living in fear of not being accepted for residency in this country, of being deported, and are likely to have been involved with social welfare or criminal law agencies. Introduced in chapter 1, in a study of East Timorese women living in Australia on temporary protection visas, Susan Rees (2004, p. 263) argued that 'fear associated with forced removal from Australia was the predominant issue' among this group of women. Professional participants in this study described the psychological consequences of fear and anxiety as 'absolutely overwhelmingly enormous' (ibid, p. 263). Fear and anxiety pervaded participant women's concerns for the future of their children (ibid, p. 264).

P2 did not appear to consider the mother's social and cultural context during the consultation, and seemed to assume that she was a mother like any other mother. In this particular situation the mother, a new arrival, living in a situation of domestic violence, isolated and struggling financially, may have different beliefs about P2's role. These may have had more to do with imagining P2 in the role of assessing the appropriateness of their residency in Australia. She may have thought that P2's interest was indeed in the baby, but that P2 had the authority to report that her care

of her baby is inadequate, and that her baby may be taken away from her or she may be forced to leave the country.

While P2 works for a child health organisation, the goals of this service were not, during my observations, made clear to the mother. In this situation, P2 may well not have seen herself as a representative of the Government of South Australia or have thought about how the mother may see her.

A further assumption made by P2 was the notion of middle ground. It makes sense, as P12 suggested, that talking with the baby enables the mother to take time to assess if she can trust the health professional enough to talk more with her. What was not clear was the notion of middle ground. Middle ground implies that two parties come together with a united core interest over which they can negotiate. Firstly, this assumes trust that both parties share a common goal of the welfare of the baby. The next assumption is a sense of equity or neutrality at the centre; that both parties are of equal positioning within relations of power and are able to contribute on an equal footing. These assumptions do not consider the imbalance of relations of power inherent in the communication encounter, especially with a parent who is located at the margins of society. It is perhaps a disservice to believe that both parties can engage in a consultation about child health from a safe position of a neutral centre, which assumes that both parties have equal agentic positions. This concept of neutral middle ground is constructed within the context of Western reason which assumes individual agency without the incumbencies of race, gender, ethnicity and class. When these constructs are added, ideas about scientific neutrality and attendant constructs of middle ground become defunct. In this sense the construct of a raced, classed and gendered baby of a migrant parent being the centrepiece of a neutral middle ground and the capacity of a parent socially identified as marginal to white middle class society to participate on equal footing can be interpreted as a grand taken-for-granted assumption.

Friendship and friendliness

Another common way that participants approached forming relationships with parents was through a discourse of friendliness and friendship. The majority of participants drew on the strengths of personal relationships in defining their professional approach to forming relationships with parents. They spoke of being friendly to parents; that is, speaking to mothers and fathers as if they were friends. Participants also spoke of the lack of time available for getting to know aspects of parents' lives other than those that specifically related to their babies and children.

P3, for example explained how she felt comfortable to share personal information with parents to strengthen relationships. She stated, '*Sometimes I tell them some of the things that have happened to me just as you would talk to a friend about it*' (interview 3 050920). Similarly, P12 spoke of communicating in a friendly manner to convey her acceptance of cultural difference, saying:

I hope that I speak nicely and friendly and not in a manner that, I don't know, be friendly and not making statements that are detrimental to their culture or frowning or something if they say they do something. (Interview 12 051213)

P12 clarified her position as friendly helper in intercultural situations by drawing on her observations of self in the DVD. She said she brings with her to the consultation a:

relaxed, friendly manner, see I'm turned facing towards them rather than sitting at the desk and looking down or something and just lifting up every now and again, so I'm turning around and trying to engage with them. (Interview 12 051213)

P12 further explained that she did not have to work towards being friendly, suggesting that this approach was intrinsic to her personal being when she said, '*I think that I have a friendly, open, relaxed manner and those sorts of things, I'm not threatening, I'm not dictating to them*' (interview 12 051213).

In another example, P11 also spoke of the benefits of being friendly, particularly when struggling to engage a parent. Watching herself interact with a parent on DVD, P11 said:

Well physically she looked a little bit down, and the way she was holding herself ... I think she's, she had a barrier, that she held up; a little bit of a barrier to me. I was finding it probably a little bit difficult to get out some things, but then she was talking, but she was talking quite a bit but she wasn't openly talking that easily. So I was probably at that stage trying to be the almighty, all friendly nurse. (Interview 11 051129)

When asked if she thought it important to be friendly P11 replied

Definitely, I wouldn't go into a home and look drab and sad. I'd go in and try and be as supportive as I could initially. I don't want to be Mary Poppins but...I think it's, a lot of it's to do with the way I am. I am a fairly positive person. I don't have very many down days really so I probably bring that to families. (Interview 11 051129)

For P11, as with P12, the notion of being friendly extended from an intrinsic sense of self. For P11 this also related to an explicit position of not being drab or sad. Being friendly also meant being positive and supportive.

Bringing a personal approach of being friendly to a professional encounter seems appropriate in these examples. The purposes of being friendly here were stated as, firstly, to demonstrate a position of acceptance and, secondly, to be supportive and positive. This friendly approach to community child and maternal health care, particularly through nurse home visiting, has a historical context where in the United Kingdom nurses originally came from the neighbourhood of families in need and were welcomed as a knowledgeable friend (Symonds 1991).

Many participants used 'small talk' to develop this friendly relationship. Small talk seemed peripheral to the core business of the consultation but worked to establish commonalities and points of interest such as the weather, the garden, or the colour of cushions on a couch. P3 explained the importance of 'small talk' in developing a relationship in the following excerpt:

I think if you could really build that relationship, sometimes I mean, they invited us to have biscuits and drinks and I think it would be just really nice if you had the time to just sit down and have those biscuits and drink and talk about who's going to win the footy this week ... or whatever, rather than focus on them and the baby and ... just on anything, just so that you could form a relationship where it's not personal but it's just everything. (Interview 3 050920)

While P3 talked about this approach not being personal, it appears that perhaps this was somewhat contradictory. It is the personal small talk about people's lives, the getting to know how people talk about things which reveal their situatedness in the world. P3 had worked in child and family for health for over 20 years. She had experienced a work culture when there was time to develop a more intimate relationship with parents. She mourned that there was no time for this approach and believed that the relationship would be enhanced if there was time to incorporate this aspect of developing a relationship.

There are, however, inherent problems in interpreting a professional position through a personal framework. Friendship assumes that both people within the encounter understand the relationship as based on friendship. Can one have a friendly approach without offering friendship? A dictionary meaning of friendship suggests that being friendly means 'showing friendship', being 'like a friend; kind',

being 'favourably disposed; inclined to approve, help, or support' (*Macquarie Dictionary* 2008). Professional relationships are not generally assumed to be based on friendship. However, a professional can behave in a friendly manner. It was clear from the text of interviews and my observations that participants did not intend to make friends of their clients. However, there seemed to be some professional naivety in how friendliness was employed. A problematic assumption of a friendly approach is that it assumes equal relations of power. A discourse of 'friendly' relations may blinker participants from looking at the very unequal relations of power where they represent a voice of state authority entering the private sphere of the home and family.

Exploring this possibility further, I refer to an interview with P19. In this example P19 explicitly suggested that she had a clinical mandate to be friendly as a community representative of the Children, Youth and Women's Health Service. She expressed her practice through a lens of primary health care, claiming friendliness as an essential component of engagement. P19 said:

Well I kind of think of how I would like it to be when somebody comes into my house if I had a UCV and I just think it should be relaxed and friendly because we are the gateway to the organisation and we're there as the forefront and if we're clinical and stiff and starchy and really unapproachable we're going to give that message across that we're still those old midwives that are only pro breastfeeding and never think of anything else but you must breastfeed your baby. And that's still around that Mothers and Babies old way of doing things. I still believe that's what people think and I think that we need to change that focus. And if we're going to use a primary health care model getting in there and being in the community focus then we need to act as part of the community and be that friendly forefront. (Interview19 060328)

In saying this, P19 highlighted her belief that in a primary health model of care it is important to act as part of the community. As part of the community the personal self is engaged. It follows that if one is engaging the personal self then being friendly is validated. Interestingly, P19 distanced herself from saying that she 'is' part of the community, saying rather that child health professionals need to 'act as' part of the community.

It seems there is there is nothing overtly wrong with acting or behaving in a friendly manner. Being friendly is preferable to being '*drab and sad*' (P11), '*grumpy and rude and nasty*' or '*stiff and starchy*' (P19). Discourses of friendliness are only

problematic when participants do not consider the embedded assumptions about relations of power in friendships that are very different in professional relationships.

P19 saw that being friendly might distance the child health profession from historic portrayals of midwives as superior and directive. A range of responses from parents in consultations were observed during field observation and video data. Most were cautiously responsive and accepting of support. Child health professionals' intent to offer support in a friendly manner seemed clearly understood by the majority of parents. Some parents, however, appeared confused by participants' acts of friendliness (for example, DVDs 9 and 3). This was demonstrated by an awkward glance to a partner (DVD 3) or shifting physically away from the health professional (DVD 9).

I considered alternate possibilities to explain parent responses to overt attempts at friendliness. Ideas of 'acting' as part of the community and being a friendly face to the organisation, for example, could be interpreted as inferring a trap or a deceit where tools of friendliness are used subversively rather than the overt manner of previous practice generations. P19 understandably did not want to portray an officious stereotype of controlling nurse or midwife. Discourses of friendship may also be interpreted as a socially acceptable means of shielding child health professionals from exploring the existent nature of relations of power in professional intercultural communication encounters.

In this section, I have related how participants explained their use of friendship and strengths based care to enact partnership in the intercultural health care encounter. Deconstruction of the assumptions within these approaches suggests that while the intent to form a relationship built on trust is present in all of these approaches, participants did not consider the embedded cultural framework of their personal and professional reasoning that act to disguise relations of power. Participants' ideologies, which are usually formulated in the context of their own lives and cultural circumstances, may not always transfer across intercultural encounters where the situated constructs of race, class, ethnicity and gender intersect with care.

While framed in the context of partnership, it seems that the formative task of developing a relationship remains underpinned by an agenda to transfer information from the child health professional to the parent. While this is an important aspect of health promotion within the context of primary health care, it also enables the unsolicited transfer of unexamined and taken for granted cultural position of the child

health professional. The nature of this information will be explored in greater depth in chapter 11. Participants did not seem to recognise the complementary nature of knowledge and skills of both health professionals and parents, even though it is a fundamental premise of partnership. Used in this way, partnership as a framework for friendship and strengths based approaches enable child health professionals to develop trust based relationships without having to negotiate minority migrant parenting alongside normative white Western practices.

Observing and enacting respect

All the big kids in the playground

They acted pretty strange

With their black and their white,

Their talk and their fights...

And it seemed, with all the different shades of

Cream and brown and freckles,

Why couldn't we all just play?

R.E.S.P.E.C.T

They taught us how to spell 'respect' when we were in grade three

We're always gonna get some things right and some things wrong

But for most of us grown-ups, that word can be a little bit too long.

Life has it's [sic] riddles, but I had always thought

That growing up meant things got easier to understand

We heard grown-ups saying things

They thought white ways were better than black ways

They had all their theories, like only grown-ups can

(Excerpt from Martin 1997)

When asked about how they approached communication with people from cultural backgrounds different to their own, most participants talked about being respectful. Like previously discussed approaches to communication, respect as an underpinning code or quality was described as shaped within the personal life experiences of participant lives, such as the playground in grade three. Respect was underpinned by a belief in the goodness of human kind, where humans have an essential self that can be discovered and supported when shown respect. How participants showed this respect seemed to be understood at a superficial level of checking their behaviours without a sense of the cultural complexity of the term, as suggested in the in the excerpt from Martin's popular song above. This section explores how participants framed ideas of respect and how this links with the respect as presented in the Parent Advisor Model. Following this, examples of how participants showed respect are discussed and analysed to explore alternate possibilities of meaning.

Participants did not identify learning respect from any professional sources but did acknowledge that the Personal Health Record¹⁸ (PHR) states that all parents have the right to respect. P1, for example, explained that respect is something that is now professionally mandated when she said, *'The cultural issues, you've got to respect them, it's a big clause in our thing now isn't it. "We hope that you will be treated with respect"'* (interview 1 050721). The PHR explicitly states that an aim of the Children, Youth and Women's Health Service is to:

work in partnership with individuals, families and communities in South Australia to enhance the health status of children and young people, focussing on the promotion of health and the prevention of ill-health and to support those parents and families who are primary carers of children and young people (Children Youth and Women's Health Service 2004, p. 24).

Following this, the Personal Health Record lists 20 rights of parents as consumers of the service. The first two of these rights are 'to be treated with respect' and 'to have your ethnic, cultural and religious practices and your beliefs respected' (ibid, p. 24).

¹⁸ At the time of their baby's birth all parents in South Australia are given a Personal Health Record to record their baby's personal growth and development. It is commonly referred to as 'the blue book'.

Respect is also identified in the Parent Advisor Model as one of the six qualities required by a helper to enact partnership (Davis, Day & Bidmead 2002). The other qualities are genuineness, humility, empathy, personal integrity, and quiet enthusiasm. Davis et al. rename these qualities as attitudes as they represent a 'general and pervasive stance taken by skilled helpers towards the people with whom they work and themselves' (ibid, p. 57).

The unstated assumption is that professionals will hold or acquire these attitudes. However, nowhere in the professional world described by participants did they identify these attitudes as being learned. They overwhelmingly talked of these attitudes coming from personal life experience, mostly from their family of origin. In most cases this was represented by white middle class and Western experiences. It seems that what can be learnt is the ability to demonstrate, for example, attitudes of respect through the core communication skills of attending, facial expression, body orientation and posture, movement, paralinguistic cues, and active listening (Davis, Day & Bidmead 2002, pp. 66-71).

Davis et al. further suggest that where these attitudes are present then the person receiving care will change. In stating this, they follow Rogers' binary formulation of an 'if..., then...' model where if certain characteristics are met 'including the helper being congruent, showing unconditional positive regard and empathy, and the person seeking help is aware of them, THEN the person will change beneficially' (Davis, Day & Bidmead 2002, pp. 57-58). Discussed in chapter 4, Rogers (1959) offered a helpful approach that enabled warm communication between helper and helped. However, it does not seem to go far enough by asking how that help is understood by the helper as experienced by the recipient. Martin's lyrics demonstrate that while we can be taught respect, how this is enacted becomes more problematic as we are socialised into collective norms and the competing ideologies of adulthood take shape. In following Rogers, Davis et al. promulgate an assumed linear progression whereby presenting behavioural characteristics of respect will necessarily lead to parental behaviour change. This supposes, firstly, that the professional has the quality and, secondly, that they can demonstrate it, and finally that this will lead to an enlightenment outcome for the client.

In the next section I explore if respect can be universally understood and experienced in a multicultural. I ask how we can visualise respect through participant experiences and what that respect might look like. Further, I explore how respect relates to other attitudes such as humility and genuineness.

During my time in the field I observed genuine respect as an often intangible, fleeting connection between mother and child health professional. Often this had no relation to the content of information shared or given. It seemed to be about having an authentic respect for another person's place in the world alongside one's own recognised cultural positioning. Respect was sometimes sensed but, in the moment, was not translated into a clear function or action that could be described as respect. In this next section I attempt to describe and clarify these moments.

P18, like many participants, spoke about the need to show respect, saying:

I suppose, I think it has to be important that you respect all cultures and stuff and I think even like my family we had our own little cultured way of doing stuff, so I think like we just need to respect that something that they're doing is probably something that they've been taught to do or they've been surrounded by a long time so you don't have any right to go into someone's place and just spread your own way of doing something, you need to be respectful like whether they've got furniture or whether you have to remove your shoes, so it could be my own family I'd expect that same level of respect. (Interview 18 060317)

In this example, P18 described showing respect by recognising the more tangible signifiers of cultural difference, such as taking off shoes. She justified this by citing the golden rule of treating others the way you would like to be treated yourself, as discussed in chapter 8.

P3 demonstrated respect in another way. During a universal contact visit, P3 was completing the Pathways to Parenting questionnaire (P2P) with the mother. The baby had wanted to breastfeed and the father, who had been sitting in the room observing the consultation, left the room for the mother to feed. When the baby had finished feeding, P3 wanted to complete the P2P. She had initially showed respect by suspending the P2P while the mother fed, and then asked the mother, 'Do you want me to wait until your husband comes back before we continue this?' (field note 050920). The mother said not to wait, as her husband was in a hurry to get ready for prayer. In doing this, P3 navigated her professional needs alongside the needs of the mother and father and the needs of the baby. She showed respect for the needs of this family by minimising her needs to complete administrative tasks.

Similarly, in another example, P10 suggested that respect involves listening to hear what the mother talks about and the immediacy of responding to those presenting issues. P10 said:

I guess again that I just want to respect that person, you know I don't want to cause them any more trauma than potentially they've already gone through but if you're digging up stuff that perhaps they've dealt with for example and you know I'm just going to make it worse, yeah so I guess again wanting them to feel comfortable. (Interview 10 051128)

In this example, P10 spoke of using her professional discretion not to ask the P2P as it might raise issues that were not of immediate concern to the mother. Instead, she focussed on respecting the immediate needs of the mother and making her feel comfortable. Like P3, P10 demonstrated respect by privileging the needs of parents over organisational needs.

Similarly, P17 described how she showed respect, in the framework of partnership, by prioritising mothers' identified needs. Watching herself on the DVD, P17 said, '*I did say "are you concerned about [your son]" and gave her the opportunity to start*' (interview 17 060323). While this may seem an obvious and straight-forward strategy, not all participants followed this approach. Many gave the parent a plan for the consultation which left room for questions at the end, stating that if they gave this opportunity at the beginning of a consult they would not get through their set tasks. As P8 explained of her approach, '*It's certainly not "What would you like us to do today?" ... cause if you ask that then you're never going to get anything done*' (interview 8 051123). For P17, giving the parent the opportunity to lead in the consultation and then following this lead demonstrated respect. Importantly, P17 also managed to complete all the set tasks of her consultation even though she began by metaphorically 'opening the gate' for the parent. This unsettles the assumptions made by P8.

P4 also demonstrated respect by remaining partnered with a parent when the parents made decisions that were contrary to professional best practice standards. In the following example, P4 explained how she responds when a mother wants, for example, to feed her baby solids before the baby has reached the recommended age of six months:

we need to explain to them what our guidelines, Australian food guidelines [recommend] ... and this has been proven da, da, da, da, da, and then if they still insist on that then I guess we just have to sit back and observe ... [I'd] present them with the written material and then let them have a think about it and then next time [they] come back ... if they still insist on that then it's their strong belief then you just have to support their belief. (Interview 4 050921)

While P4 stated her need to explain currently accepted professional information about introducing solids, she maintained her stance in supporting the parent in their belief. It seems a problem arises only when a parent has to 'insist' on their belief. This suggests that P4 might take for granted that the parent is agentially able to challenge the status quo to such an extent that they would make a stand against a health professional to privilege their own position. In this way parents who might already be marginalised because of their history of resettlement and/or cultural identity are potentially further marginalised when they have to 'insist' on specific parenting practices. Further, when they are put in a position of having to insist, they risk being seen as 'resistant' and obstructive; of not belonging.

Participants demonstrated respect in their intercultural communication through a range of strategies. These included privileging the mother's needs over organisationally directed professional needs, joining with external cultural practices such as removing shoes, and by accommodating difference in parenting practices when parents actively resist normative Australian practices.

Respect for the world of parents and their children was also noted during home visiting. On these occasions participants were given insight into parents' whole way of life. Participants demonstrated their respect for parents' situated environments in subtle ways described in the following example (from field note 050729 part A). P4 had already visited this family a number of times and had established a relationship with the mother, father and infant. The mother and father were new arrivals to South Australia and had had their first child since their arrival. On this home visit, P4 asked through the interpreter if the mother wanted the infant weighed. P4 followed the mother's lead and proceeded to squat on the floor where they were by the front door and weighed the baby. The home unit comprised one bedroom, a kitchenette, bathroom/laundry and a sitting/living/dining room. Large couches, a coffee table, small dining table and wall unit filled this space. The tables had various items on their surfaces. P4 didn't ask where to weigh the baby, she simply put the scales where there was some space and proceeded with the task.

P4 could have initiated the normative position of clearing a table to put the scales onto, but followed the mother's lead to the floor. She at once interpreted the mother's cues and squatted. Similarly, P1 explained that she tries not to impose herself on families. By adapting to their way rather than imposing her own, she shows respect. P1, for example, said:

you just adapt to the situation, and I think that's part and parcel of me doing ... home visiting. You've got mattresses everywhere, you've got kids everywhere; you've got dogs and cats. You've got to clear your way through the lot and make the best of the situation ... so you know, you sort of adapt to the situation ... you don't impose by say ... going into the kitchen or things like that 'cos those doors were shut weren't they ... so she didn't want us there. So you make the most of the situation and adapt their way. (Interview 1 050721)

P1 recognised and expressed what she believed was important. P1, like P4, demonstrated respect for the parents' environment and the choices parents made within these environments. This was demonstrated by following parental cues within a partnership model. In most of the above examples participants explicitly stated their personal belief in not imposing themselves on others. In these examples, personal beliefs about intercultural interactions were demonstrated through professional behaviours. The only time where a participant's ability to respect parental choices occurred was when P4 determined that she would need a parent to actively resist professional information before she could accept the parent's lead. Discussed in chapter 11, the politics of knowledge and power hold their own set of intercultural challenges.

In these examples, participants held personal values of respect that aligned with their professional behaviours. It was, however, a taken-for-granted assumption that they would have gained this understanding from their personal life experiences as there was no explicit place in the professional sphere where these attitudes were taught or interrogated. Challenging this taken-for-granted assumption, one wonders what happens when participants do not hold these fundamental attitudes. What would practice look like if health professionals did not have attitudes of respect for difference associated with, for example, class, gender, sexuality or ethnicity? Discussions in chapter 8 indicate that not all participants were genuinely comfortable with notions of multiculturalism and how this intersects with their personal lives. In chapter 8, participants explained how they attempted to follow the common practice of leaving their personal values and beliefs at the front door when giving information to parents. Observation and deconstruction of practice indicated that participant personal values and beliefs found ways to enter into the consultation uninvited and unnoticed. While participants may have learned core communication skills, does this necessarily equate to respectful practice that is *regardful* of difference?

Genuineness

In the following section I discuss the issue of genuineness. Genuineness is noted as the second attitude required for effective helper relationships in a context co-partnership. Davis et al. state that 'people who are genuine are not acting a part or pretending, deliberately or otherwise' (2002, p. 60). In chapter 8, participants talked about having a genuine desire to do good in humanitarian terms. While practice underpinned by this ideology was argued to result at times in the perpetuation of democratic racism, I asked how participants reconcile this desire to do good, in terms of genuineness, when it conflicts with their beliefs and values about race and ethnicity within the multicultural of Australia. How do they at once demonstrate respect when genuineness is at best uncertain or absent?

Through communication skills, professionals can learn to appear genuine. In the following example, P14 hesitated when she described how she demonstrates interest in clients. This is tricky ground, as P14 recognised that she isn't always genuine but would like people to think that she is. This thought was based on P 14's personal experiences of seeking professional health care. She said:

P14: You engage from the minute you say 'hello' if you gen... look interested.

R: And you were going to say genuine?

P14: Genuine yeah.

R: ... is that something that you've learnt to do or what?

P14: I think it's life skills, because we know ourselves when people haven't been interested when you've gone to seek a service, and we are a service, you come away thinking 'I wouldn't do it like that'.

For P14 and others, it was a deep conflict that one must be respectful and genuine but one doesn't always feel this way. I questioned if what we learn clinically might be to 'act as if' we were genuine. And does this matter? It seems a necessary part of professionalism to learn how to mask our selves in certain circumstances, and we do so for very genuine reasons. While this may or may not work to the extent that we think it does, we are nonetheless expected to be polite and attentive. While we sometimes acknowledge what is happening in our own personal lives, we do create an artificial separation in order to be professional. The idea that we have multiple selves is ever present.

It seems that this multiplicity of self is difficult to manage. This is demonstrated when participants like P14 struggled to recognise the genuine intent of their attention alongside possibly competing and conflicting ideological views. Within health care discourses we do not prioritise challenging the conflict or unravelling the tensions. Learning to clarify, listen and reflect within communication practice without a concurrent deconstruction of implicit beliefs and values may increase the veneer of superficiality and pretension. This thesis questions if it is enough to play act respect or genuineness. Can partnership or respect really exist in the absence of genuineness? Further, what mechanisms exist to support professionals to challenge the potential superficiality of these positions?

Summary

In this chapter I have explained how personally constructed ideologies and professional discourse of partnership inform child health professional approaches to communication. For some participants, professional discourses represent a personal-professional fit with their personally held ideologies, for others it represents a renaming of knowledge already held and believed to be enacted.

The most commonly discussed aspect of approaches to communication was the importance of relationships and relationship building. The primary goal of this was to establish a right of return for the mother to the service. At times, relationships were also seen as a strategy to establish the right of return for the child health professional. This seems appropriate within a partnership model where a right of return ought to work both ways. It could also be interpreted as being problematic when partnership is understood to be client led and the platform established by the health professional is predominantly constructed to direct information to parents. Further, when participants continue to see their role to facilitate knowledge transfer, this suggests instead that they use a transplant model that assumes behaviour change following information giving. Some participants explicitly enhance their professional status by using an identifying label of 'consultant'. While this may helpfully enable health professionals to step into the authority of their role it, like a transplant model, cements unequal relation of power inherent in the traditional provider-client relationship and it further serves to privilege Western reason and authority.

Participants use a range of strategies to develop relationships. These include strengths based approaches and friendliness or friendship. Overtly, these

approaches appear sound; however, they can also be interpreted as professionally naïve. Additionally, these strategies protect the child health professional from reflecting and acting on the inherent relations of power within intercultural relationships.

Respect was claimed as the most common attitude to communicating in intercultural encounters. Participants recognised respect as a key quality of working in partnership. Davis et al (2002) identify respect alongside genuineness, humility, empathy, personal integrity and quiet enthusiasm as the fundamental attitudes of helpers. Some participants demonstrated respect by placing the needs of the mother before their professional needs to complete organisational business. However, this was not the majority. Participants also responded to and followed parents' cues in the home setting. Interestingly, parenting strategies that fell outside normative practices were only respected when parents actively resisted child health opinion.

Participants who experienced a personal-professional fit with concepts of partnership used this discourse to prevent themselves from having to contend with conflicting personal values and beliefs. It seemed that through skills of core communication, fundamental attitudes could be disguised rather than attended to.

My concerns over genuineness crept in with universal assumptions made about the presence of respect as an attribute of child health professionals. As demonstrated in chapter 8, some participants held values and beliefs that were challenged by the increasing diversity of Australia's population. It seemed that these participants learn through core communication behaviours not how to deconstruct their ideologies but how to develop skill sets whereby they might disguise and hide their values and beliefs. Davis et al. (2002) suggest that people who are genuine are not acting a part. This deconstruction suggests that at times participants might take up this position in the absence of strategies to manage their multiple ideological understandings of self and culture. Where participants recognise the importance of being attentive through a well learned set of core communication skills, this does not attend to underlying ideological conflicts. The only way that some child health professionals can appear respectful is indeed to play act.

In the following chapter I deconstruct more fully the concept of partnership in practice. Participants appeared torn between their professional expertise, and adhering to the authority of their professional information and how to legitimise

partnership at the same time. What emerged was another binary in practice where participants constantly tried to locate themselves along a binary of expert or partner.

CHAPTER 10

COLLIDING APPROACHES: EXPERT OR PARTNER

Introduction

When conversations with participants moved from building relationships through the personal values of being respectful, building trust and being genuine to professional approaches to communication, partnership was named as the most influential discourse. Partnership is the key framework in the Parent Advisor Model (Davis, Day & Bidmead 2002).

Participant discussion of the PAM was mostly in relation to the underpinning approach of moving away from an expert model towards a partnership model. Participants did not overtly discuss the process of 'helping' or the skills for communication as they were presented in the model. A point of confusion for participants seemed to be how to enact the directive, to move their position from expert to partner.

While many participants experienced a personal-professional fit with the concept of partnership, at the same time they also struggled with how to enact partnership when they understood it as incompatible with professional expertise. A binary of expert/partner was created. This chapter explores how participants created and operated within this binary. Further, it demonstrates how the binary construct contains and restrains child health communication practice.

Participants seemed to struggle with how to position themselves on this binary. I observed them paying attention to being a partner and yet denying themselves as experts. However, all the time they looked for ways to legitimise their expertise. By claiming partnership, participants appeared to protect themselves from recognising that they actively maintained their authority within relations of power. When they did this, 'expertise' that was denied seemed to creep in unnoticed.

Critique in chapter 4 suggests that within the Parent Advisor Model, Davis et al. (2002) refer to power as something that can be shared and given away. Enmeshed in this liberal humanist understanding of power through their use of the PAM, participants did not recognise that relations of power always exist in communication interactions. These power relations existed not only within overt communication

behaviours but within intrinsic participant ideologies. Problematically, like Davis et al. these included a belief in power that can be owned, given away or shared.

In this chapter the expert/partner binary is identified through participant conversations. It is then described and discussed using examples that demonstrate how at times participants slipped into the binary and used it or were used by it to restrict engagement, particularly with families who came from cultures different to their own.

On being an expert

Many participants went to lengths to explain how they worked in partnership, actively resisting working as an 'expert'. P2, for example, said that she communicates '*without thinking about it, but working in partnership as opposed to working in an expert model*' (interview 2 050916). Many participants identified the expert model as an oppositional referent to the approach they wished to enact, that of partnership. Decentering the health practitioner as expert is fundamental to partnership (Cunningham & Davis 1985). This sits alongside recognising parental expertise within partnership (Davis, Day & Bidmead 2002).

Davis et al. explain that the expert model is where one sees an

implicit or explicit set of assumptions about the expertise of the helper being superior to that of the parent, with relative power accorded to the helper for control of their interaction and decision making. (Davis, Day & Bidmead 2002, p. 47)

Within this model, professionals believe that their educated ability to make sense of people's problems, and come up with solutions that will lead to an expedient and effective resolution of the problem. Davis et al. (2002) point out that even though some expert practitioners are warm, respectful and caring, the implication is that the helper is in a position of power that renders them superior to the parent. They suggest that further shortcomings of the model are limitations of the expert in exploring the problem thoroughly, an assumption that the problem might be identified obviously and solved immediately, and a lack of acknowledgement that the parents have to implement the problem management strategies not the helper. These limitations do not account for the centrality of parents' role in managing their own problems (ibid).

While participants in this study denied their position of expert, assumptions about the nature of power as described in partnership discourse made it difficult for them to cast aside the relative power of the helper and move towards acting in a way that was outside this expert position.

Expertise within partnership

Davis et al. state explicitly that partnership as a collaborative model is not intended to:

deny the expertise of the helper, only to acknowledge that parents also have expertise and that successful outcomes are dependent upon the complimentary knowledge and skill of both being combined appropriately. (Cunningham & Davis 1985, p. 51)

Participants' desire to locate themselves at the partnership end of the partner/expert binary often meant that they did not seem to know how to find a place to bring themselves as expert health professional into the room with the parent as partner. In order to maintain partnership, many denied themselves as expert and in the process also denied their expertise of professional knowledge and authority (see chapter 11 for further discussion). Participants talked about power and relations of power but, like Davis et al. (2002), they mostly spoke of power in the modernist sense. As demonstrated in the following sections, through examples of discussions and observations on DVD, most participants did not recognise how micro-relations of power played out during the child health encounter.

Jordan and Weedon state that 'all signifying practices – that is, all practices that have meaning – involve relations of power' (1995, p. 11). These meaning making practices offer various subject positions and modes of subjectivity and 'most often involve relations of domination and subordination' (ibid). Participants were not clear about how they were able to recognise and take up a position of expertise and at the same time recognise their inherent authority in the communication encounter without subordinating the client.

Within nursing Patricia Benner (2001) celebrates the expert practitioner as one who has a deep understanding of the total situation, who no longer needs to rely on formalised analytic principles to connect situational understanding to action. The expert practitioner does, however, recognise the need to return to explicit formal analytical problem solving when events are outside one's realm of expertise (Benner 2001). Expertise needs to be recognised, valued and used in ways that distinguish

and address the inherent authority of child health professionals' position within the intercultural relationship rather than denying one or other of these subject positions. Expertise is only a problem when it is used as a position of dominance to subordinate the other. Expertise can be used in ways that mindfully recognise the health professionals' dominant subject position and continue to work for points of resistance that shift relations of power within the intercultural consultation.

In the expert model of communication the subject position of dominance inherently subordinates others. Participants overtly rejected this position of dominance, and also the expert model. The problem this raised is that when the expert model is confused with expert practice, expertise is also rejected, thus disabling or disregarding professional knowledge. Without alternate plural positions this confusion often resulted in seepage of unrecognised and unintended expressions of domination within professional relationships.

Partnership as intrinsic

In this section I briefly present participants' understandings of themselves as partners. This approach is understood as deeply personal and related to an intrinsic understanding of themselves as working in a framework of equality. As explained in chapter 9, participants embraced models of care that reflected a personal-professional fit with their way of being in the world. P12, for example, said, '*Partnership training confirms that's the way you should go, but I've always been like that*' (interview 12 051213).

Returning to a previous example, P2 said that she communicated '*without thinking about it*' (interview 2 050916). For P2 this meant that she could be herself, as her natural way of communicating was in partnership. P2 explained that having previously worked in an '*illness model*' she had changed to a '*wellness model*' since working in a community health role (ibid). She said that a partnership approach is inherent to a wellness model implemented with families in a community setting. In saying this she implied that it was easy for her to switch to '*working in partnership as opposed to working in an expert model*' (interview 2 050916). This change in approach reflected what she was looking for when she changed practice setting and nursing roles. P2 wanted to find ways of working in nursing that synchronised better with her personal beliefs and approaches. P2 confirmed, '*I'm not finding that difficult to change at all*' (ibid).

P2 believed that she could undo years of working within an 'expert' model because the 'wellness' model that she now works in fits with her personal belief system. Subsequently, P2 believed that her practice would naturally transform into a partnership approach to communication. Not only did participants identify partnership as innate, they also argued that it is an essential component of care and thus went to lengths to locate themselves as partners and not experts.

In the following example, P18 spoke with enthusiasm about her position at the far end of partnership in the expert partner dualism. She said:

I'm actually very passionate about it too, it's not just important ... I feel like this is like my religion kind of thing, like I feel so strongly, and I know most people say well that's the way we've doing it for years and years and blah, blah, blah and I must say I totally disagree with that because I think that basically the health profession is working from an expert point of view and we're 'the masters of the universe'; we know the secrets of parenting, and I won't edit this out ... it's a very, very powerful role and we're not actually working with people with their needs and sort of trying to build up their confidence and stuff. (Interview 18 060317)

In likening her belief to a religious experience P18 enthusiastically defended the introduction of the partnership approach. She was equally passionate about moving away from an expert positioning within communication and working 'with' parents not 'on' parents. She seemed to understand the power dynamic inherent in child health work. P18 looked forward to a time when the expert approach to communication is ended. She positioned herself at the end of the binary as a partner who also has expert knowledge and authority.

P18 believed that the majority of health professionals see themselves in a superior position by nature of their professional status and the relative power arising from their disciplinary knowledge. In stating that health professionals hold 'secrets of parenting' she suggested that their knowledge base is a professionally owned body of knowledge, access to which is restricted to those in the profession. Indeed, Hugman (1991) suggests that a separate body of knowledge is one of the key tenets of a group's capacity to claim professional status. P18 saw that this power/knowledge nexus establishes a situation of unequal relations of power. For P18 the introduction of the PAM legitimised her approach to working with parents.

Partnership and power

The majority of participants stated that they worked as partners because this fitted with their way of being in the world. Many also argued that they used partnership as it addressed issues of power. Key to this was a belief in their inherent desire to do good, and be of service to people in greater socio-political need than themselves. How power was understood and worked with, however, was not often compatible with a pluralistic understanding of partnership. Further, when talking about the arrangements of power in their work, most participants relied on personal understandings rather than engaging in contemporary communications theory as an aid to reflexive practice related to partnership. A range of examples will be used in the following section to highlight particular problems with participants' understandings of power and how these understandings are reinforced by theoretical underpinnings of the PAM.

In the following example, P18 was watching herself on DVD working with a mother who arrived from a politically unstable country to join her husband, recently released from detention. During our interview over the DVD, P18 spoke a lot about power and empowerment. I asked if she could explain a bit more about what she meant, and she replied:

I think if you're confident in your own ability as a worker then you should be able to give that power back so like inside is the power. 'I know what I'm doing, is happy and safe and it's sort of current and whatever' but you should be able to then give the power over to the woman because the expert model is completely disempowering ... it's building women's power in their own ability to mother so they're confident, and letting them be the expert of the baby instead of saying well I am the expert of children. (Interview 18 060317)

P18 was very clear about the need to empower women's beliefs in their ability to parent. She seemed to do this through an understanding of power that is epistemologically based in a critical social theory paradigm around ideas of power and powerlessness. This is evidenced though P18's commitment to redressing the imbalance of power between the professional and the parent. She talks about giving 'power back' to the mother. A limitation of this approach is that she did not see that by trying to give power in this way it undermined her intentions to be a partner. In modernist assumptions of power, even in the critical paradigm where at least power is talked about in terms of the nexus between agency and institution, her right to power is reinforced by her own recognition of her ability to have or hold it and give it

away. Further, this works to centralise the place of power as the professional's domain and does not centralise the existing knowledge power of the parent. So does this matter? P18 was passionate about partnership and it fitted with her personal/professional ideology.

While P18 positioned herself at a partnership end of the binary, her ability to fully step into partnership is constrained by this modernist application of power. This was demonstrated in the following example. Watching herself talking with the mother on DVD, P18 explained how she supports women to care for themselves. P18 said, *'One thing that I teach all my mums too is that "you must do things for yourself, you must reward yourself"'* (interview 18 060317). For P18 this was underpinned by a Western assumption of the universal burden of motherhood. While P18 said her goal is to empower the mother and vehemently denied the expert model, she showed that practice is always somewhat contradictory; this is evidenced through the choice of words she used to describe her practice. For example, on the one hand P18 worked passionately towards sharing power with parents, and then later her words told something else when she said in a dictatorial manner, that she tells *her* mothers what they *must* do to take care of themselves. This approach evoked feminist and critical theory ideas about power and empowerment; however, it also worked to centralise P18's authority and ideology. In this way the tensions between a modernist episteme of power within partnership was made theoretically visible where it was not always visible in practice.

P18 believed that she was demystifying professional 'secret parenting knowledge' and opening up access of this knowledge to parents. Moments at which she will offer this information were particularly important for P18, for these were identified by the parent, thus positioning the parent as leader in the partnership process. This was an essential point of resistance for P18 where she moved away from the formulaic approach of the consultation to centralise the parent's needs and thus partner the parent rather than dictate process to the parent.

By doing this P18 implicitly held her expert knowledge position and relational position of power by prioritising her belief in the professional nature of the information she has to share and its importance. This makes sense, as she has spent many years developing her vast professional body of knowledge. P18 walked the tightrope of expert/partner by holding her parenting knowledge as expert but claiming her way of delivering this knowledge as partnership.

Changing the process of a consultation to centralise parental concerns is, however, only a partial redress of relations of power in a consultation. Understandably, P18 implicitly maintained a belief in the authority of her professional knowledge. The difference was P18's delivery of professional information based on her belief that parents have the right to freely access this knowledge. However, the critical missing point seemed to be a recognition of the knowledge power of the parent, the central position of parental beliefs and valuing parental 'secrets of parenting'.

It could be interpreted that P18 inadvertently perpetuated the power knowledge of the child health profession and her own personal beliefs and values by prioritising the very need to 'give' this knowledge to parents. While language and meaning are slippery, P18 did not seem to realise the inherent limitations of her way of addressing power relations in practice. If P18 could take the various understandings of power, and relations of power as a third body to unsettle the expert/partner binary, we might make visible for understanding the various forms of parental knowledge and power. In this way P18 might find space to also position herself to hear and value parental knowledge. It is not that this understanding and usage of power, for example, is hidden, rather that these understandings are so taken-for-granted in everyday practice that, as practitioners, we do not critique or examine them. In this way they are glossed over.

Across intercultural encounters, issues of gift giving are also historically attributed with colonist implications of imperial power. By not making these historical, cultural considerations, even in her passion for working as partner P18 put herself and her professional knowledge at the centre of the interaction. This was evidenced by the way she was conscious of the professional power she holds, her belief that she can give it away, and her capacity to decide when that might occur. In this way it seemed that P18 might be trapped in the expert/partner binary because of the modernist assumptions underpinning the PAM. These have not yet been redressed to accommodate a pluralist approach required for working in a multicultural as implored by Anderson (2004), Anderson et al. (2003), Browne et al. (2005), Aranda (2005), and Hodge and O'Carroll (2006) .

Power and privilege

One of the ways that participants appeared to manage their relations with power was to overtly recognise the privilege inherent in their position of child health professional. For example, participants spoke of being invited into parents' homes to visit with them and their children. They then appeared to follow this belief to assume

that parents initiated this process of their own free will. In addition, they seemed to hold the belief that being 'invited in' places the professional in a position beholden to the parent in whose home they undertake a consultation. In this way, to be invited is to be privileged. P11, for example, said:

the most important thing for me when I go and home visit, is I think it's an absolute privilege for me to be able to go in to a person's home in the first place. I've been invited in there, virtually, and I go into that home and I will take it exactly as it is, there and then. (Interview 11 051129)

While it is indeed a privilege to be invited and accepted into someone else's home, how this privilege was perceived did not always accurately reflect the relations of power embedded in professional intercultural encounters. To deconstruct P11's understanding of *invitation* it is important to look at the whole context and history of the invitation. To do this I refer to the process of enrolling a family into the service. The process of enrolment generally begins in a hospital setting during the vulnerable first 24 to 48 hours after the birth of the baby. Usually a midwife or administrator approaches the mother to sign a consent form to be contacted regarding a home visit. After the parent has signed the form and returned home they usually receive a phone call from an administrator. If noted on the consent form, the administrator will use an interpreter for this call. The parent is then telephoned and told what time a nurse can come to their home for a universal contact visit (UCV). While this process is ethically sound, the visiting nurse's assumption regarding the agency of the parent to invite them into their home was somewhat illusory.

The first aspect of this illusion was that the parent had initiated the process of invitation, when it was clear that all parents of newborn babies are offered a home visit through the implementation of government policy aimed at increasing the health outcomes for those families most at risk (South Australia Department of Human Services 2003). This provided health professionals the opportunity to take up positions of surveillance and control regarding the health of children. In another example, P4 spoke of the privilege of being let in the door, saying:

I feel that being able to share or to get through people's door, that privilege there is that they open the door for you and so you can be in it, be part of the child's growing up or whatever, or just even a one time visit is still you know they open the door to you, they welcome you, I just thought how nice, how nice to have people accepting you, welcoming you and sharing with you their experience. (Interview 4 050921)

In many ways P4's understanding of how 'nice' it is to be welcomed revealed an assumption that opening the door is symbolic of the parent agentically welcoming the health professional into their lives. Indeed, they most often did, but in a qualified way that the professional did not always acknowledge. P4 seemed to believe when parents 'opened the door' this represented her being accepted, and that it necessarily followed that parents would share their experiences. In this example, P4 did not seem to recognise that the parents' decision to let her in may have been related to a range of possibilities, including them seeing no alternative. That these parents were variously positioned by the competing constructs of race, class, and gender was not considered by P4. While she recognised that she is privileged to be allowed into the parents' home, she did not consider that she still carried with her the authority of her position as a representative of a government agency. I asked P4 to explain more about her understanding of privilege. She explained how recognising privilege led to reciprocity, saying:

I guess it's just being, to be there, so it works two ways, they let you in, you share with them what you know and it just works well for just showing them that you do care, you want to share whatever that you know, your knowledge, your experience, parenting is something that is a learnt experience and especially with a first time parent and be able to be sharing whatever you know with them and then they on the other hand they will teach you ... their culture or their way of doing things. (Interview 4 050921)

P4 seemed to believe that by being let in the door a frank exchange of ideas would necessarily follow. I wondered how this construct fitted with a discussion held with P4 in chapter 9 that related to parental preferences about parenting practices. In this discussion, P4 explained how she would happily support parents to follow their own practices. However, first they must listen to current Western practices, be given time to consider these, then '*really insist*' if they do not wish to follow normative practices. It seemed that, in spite of her belief in reciprocity, P4 did not recognise how her privilege, within the relations of power, shaped the subject positions available to the mother and the choices she might make. In this she relied on the decontextualised dynamics of a transmission model of communication (*see for example Lewis & Slade 2000*) that is stripped of cultural contexts.

The multiplicity of parents' positioning as migrant or refugee places them tenuously between the desires and expectations of a better life for themselves and their children due to resettlement and the discourses of acculturation, belonging, and

enacting alternate ways of being a parent in a new culture. The choices they make along the way will variously affect their experiences of belonging and marginalisation in Australian society. Child health participants seemed blinkered to this range of possibilities through the very use of the word 'privilege', believing that if they overtly used the word and stated their recognition of privilege, appropriate behaviours would necessarily follow.

It seemed that P4's understanding of privilege rendered her understanding and practice of reciprocity in partnership little more than rhetorical. Reciprocity cannot be claimed when it is dependent on the mother's agency to actively resist normative parenting trends, particularly when the mother might be in a subjugated position in relation to the health professional.

Privilege exists as a 'special right or immunity granted to persons in authority or office' (*Macquarie Dictionary* 2008). Neither P11 nor P4 recognised the authority inherent in privilege or how this may be interpreted by parents, particularly those who are culturally or linguistically different from them.

They referred to privilege as akin to being honoured. That is, they felt honoured to be given entry into the house, not that the parent might see them in a position of advantage or prerogative or that the health professional sees herself in a position of higher status. To be honoured may also imply that one is seen as being of a higher social and cultural status. This aspect of privilege was not recognised or addressed by any of the participants in this study. P11 and P4 retained the modernist belief of Immanuel Kant (1724-1804) that 'we do not see things as they are but as we are', suggesting that if we do not see ourselves as elevated we therefore are not. This turns talk about privilege into idiom.

Maintaining partnership against expert practice: Reinforcing the binary

P18, like others, often maintained her position by denouncing those who adhere to 'expert' ways, saying, '*Even after doing the training a lot of people still are doing the whole expert model stuff*' (interview 18 060317). P2 similarly said, '*Some people are more ... are still very ... "I'm the professional and you're the client and I'm here to tell you how to do it"*' (interview 2 50916). This professional pressure to be seen to be practicing in partnership appeared to rhetorically reinforce participants' desire to locate themselves as partners rather than experts without a great deal of reflexive consideration of how this transition might be made in practice. When the difficulty is

located in others' behaviour, as expressed above, it prevents us from seeing how we are all captive to the same hegemonic discourses and need to look at how it plays out in our own practice.

At times the need to maintain partnership, where expertise is denied, seemed to interfere with the introduction of expert opinion or evidence into the child health consultation. To demonstrate, I return to a previous example of an interview with P2, who was watching herself in a consultation with mother who was a new arrival to Australia and was known by P2 to be in a physically violent and controlled relationship. P2 reflected on her dilemma in raising the issue for discussion with the mother, saying, *'Yeah I was waiting for her ... I ... cos, I don't want to ... I didn't want to push it. I wanted ... she knew that I knew ... and I was trying ... I wanted her to bring it up'* (interview 2 050916).

In this example, where the mother was in a situation of domestic violence, aspects of partnership such as waiting for the client to lead are counterproductive. In the above extract, the ellipses refer to hesitations in speech. It seemed that P2 may have used the rhetoric of partnership to cover her own hesitations, discomforts, or lack of skill to raise the hard issues of domestic violence. While in best practice for consultation it may be respectful to initially wait for the mother to raise an issue, respect in this instance can be seen as negligence. When P2 did finally raise the issue, the mother was preparing to leave. P2 asked the mother, using whispered tones, if she was alright, and the mother assured P2 that she was. The mother then left.

P2 recognised her own sense of powerlessness in the situation in that she could not make the mother leave her violent partner, saying, *'I can't make her leave'* (interview 2 050916). She did not, however, recognise the influence or responsibility inherent in her professional position, or the possible messages that her inability to raise the issues may have conveyed to the mother. By avoiding the subject of domestic violence, P2 compounded the issue for a woman and her children in an unsafe environment. If she, in the dominant position, did not explicitly raise the issue, then the mother, in a subordinate position, may have understood that she also should not raise the issue overtly with others. The mother, as a new arrival, may also be looking for cues about the cultural norms within this new society. How, from this interaction, did she learn from P2 that domestic violence in Australia is unacceptable, and how might she access the human and legal services necessary to remedy the situation?

Health professionals are unable to recognise these issues unless they recognise and act on the potential power dynamics in the relationship. Davis et al. claim the PAM addresses relations of power between the client and professional. They talk about power sharing in the following way:

We assume that neither partner is in overall control, that they both have power and share decision making, and that they attempt to work by consensus wherever possible. This does not mean that they have equal power necessarily, and the balance is likely to shift over time, and will vary in different areas (e.g. in terms of their positions, their personal power, and their control over resources). However, it is assumed within our model that parents are in reality the senior partners under almost all circumstances (unless this is changed by the court), since the helper is supposedly there to provide them with a service. (Davis, Day & Bidmead 2002, p. 52)

In relation to power sharing, Davis et al. seem also to discuss 'power' in its modernist formation. The possibility of shifting relations of power between the fields of child health professional and migrant, between the state and cultural other, are not considered.

Davis et al. do note the shifting *nature* of power, but by continuing to refer to this as a shifting of balance they imply that there is a point that an equal balance might be reached. If power is viewed in terms of power relations it is forever fluid and changing, and imbalance remains in postmodern perpetual motion. In this way, valuing the position of the migrant/refugee parent, power would continually ebb and flow in relation to topics under discussion and the strength of the communication interaction. Further, such an approach helps to challenge the linear construct of power, where there are few if any avenue for lateral movement outside the parent professional dyad.

In the PAM Davis et al. explicitly state that 'parents are in reality the senior partners under almost all circumstances' (2002, p. 52). While an interesting ideal, it was very rarely observed in this study of culture and communication in child health practice. Even when participants believed themselves to be power sharing there was little awareness about how parents might perceive their approaches.

Fundamental to this problem in the PAM is that Davis et al. assume that participants will have the capacity to enact power sharing. Participant child health nurses seemed to be bound on two occasions. Firstly, if they tried to enact power from the

basis of the PAM with a modernist underpinning of power as possessed, they risked reinforcing their own hierarchical authority, or in modernist terms, power over. A fundamental flaw of an approach where power is offered as a gift is that it verges on paternalism. Further, when they exercised the authority to distribute and withhold this gift of power, the act of communication remained embedded in the expert model. Secondly, if participants resisted this notion and tried to work with relations of power as fluid and changing, they were given no opportunity within the theory of the PAM to understand the various socially and culturally constructed discursive positions, because the subject parent in the model is assumed to be universal.

Another strategy that participants used to maintain a sense of partnership was to reiterate the parental position of expert. Elevating mother to expert within a binary, there seemed to be an inverse need to deny professional expertise. Most participants saw little room for joint expertise in the one room. In this way participants were limited by and limited themselves to binaries in order to name their professional approach to communication practice. They could only see themselves as expert or partner.

The challenge of deciding whether to claim oneself as expert or not was demonstrated in the following example, where P3 traced her decision making through to a final place where she questioned her own expertise in order to position mother as expert. P3 was watching herself helping a mother with breast feeding. P3 then spoke about her uncertainty regarding how to help the mother with her feeding, using her expert knowledge while also using a partnership approach. This conversation followed P3 watching the mother on the DVD putting the baby back to her breast. P3 said:

P3: And you think ... 'just leave it' ... sometimes you just feel like saying, 'That's enough don't put the baby back on again'.

R: And do you?

P3: No.

R: And why not?

P3: Only if they ask about it. 'Is the baby unsettled?' I usually ask, 'How is the baby settling?'

R: OK, so ... what stops you doing it?

P3: Sometimes I do, sometimes I don't ... but sometimes I don't. It's just that some people like to do that [return the baby to the breast on and off frequently throughout the day], I usually ask them, 'Is the baby unsettled, how are you feeding?' and then sometimes I'll say to them, 'You know most breast fed babies get most of the feed by the first five minutes on the first side; the rest is for comfort' ... and all that stuff and leave it up to them to make the choice about not ... but if they like to comfort feed (shrugging shoulders).

R: So what would you say it is about you that says, "I'm not going to tell them what to do", because ... a lot of people would

P3: Who says I 'm the expert? (Laughing). (Interview 3 050920)

In this example P3 recognised that the mother may want to return the baby to the breast often even though she knew that this is not necessary for nutritional purposes and may cause the baby to become unsettled. She offered the mother some evidence based information about the mechanics of breast feeding and determined to explore with the mother if she is having any broader settling problems with the baby. In this way P3 can examine if the unsettledness might be attributed to the feeding pattern. If there is no indication that the approach is troublesome for the mother or the baby, she did not suggest that the mother stops feeding. At the time, the only explanation P3 was able to give for this reasoned clinical approach was to question her position as expert.

By asking '*Who says I 'm the expert?*' P3 questioned her own expert position, rather than acknowledging the coexistence of herself as having expert knowledge on the processes of breast feeding and the mother as developing expertise in the care of her baby. The inherent binary of expert or non-expert meant that P3 while recognised the expertise of the mother, she was unable to claim her own expertise at the same time. She instead challenged it, albeit with a laugh. The laugh, however, seemed to suggest that she may not have been happy about her lack of clarity or ambivalence about her role as expert.

It could be that P3 recognised that her desire to take the baby off the breast was due to her knowledge of the mechanics of breast milk production and feeding alongside a recognition that the time spent at the breast enhances infant maternal attachment. She may be conflicted in finding a validated place to recognise and process these multiple *expert* realities. P3 seemed to question her expertise in order to give expertise to the mother. If we could imagine P3 using a third body of

relations of power, for example, she might have been able to validate her decision of not telling the mother what to do, without the accompanying unease of positioning herself as non-expert. She might have been able to articulate that in determining not to tell the mother what to do, she might hold her expertise, and also actively work the relations of power within the intercultural relationship, enabling the mother to determine her own pathways to attachment and breastfeeding. In this way she might have stepped into the authority of her role while working with multiple pluralities.

Seepage of expert practice

The talk of most participants showed their belief that they practised within a partnership model. The organisational mandate to practise in this way, and beliefs about their person, fit with this approach, reinforced participants' claims of enacting partnership. The binary of expert/partner reinforced a determination by many not to be labeled as being an 'expert'. Despite the best attempts of many participants, communication within an expert model continued to seep out. This was observed in a number of ways, including disregarding parental concerns, and being unable to show how they positioned the parent as a partner in the consultation. Further, communication behaviour of some child health professionals was at times observed to take on an inherently paternalistic flavour.

In the following section I use examples to demonstrate how participants used discourses of partnership to describe their practice. However, more often than not, an expert model was observed in their communication practices. The examples given are at times small. They represent the minutiae of practice that is often not called to question as it is part of our taken-for-granted everyday way of being in the world. These critiques are offered, as they have throughout this thesis, not as truth claims but as alternate possibilities of meaning or understanding, the subtle and discreet behaviors that work to maintain the ongoing effects of colonisation.

The subtleties of 'dissing'

The effects we have on others by what we say and do can be difficult to discern. I pondered how we might know if what we say or do adversely affects another and how might we know what colonising effects are and how they might flow from your communication. During the time of working with this thesis, a heated encounter with my teenage daughter ended with a door slamming followed by a loud scream of 'stop dissing me!' It occurred to me, at the time, that I did not think I was dissing her,

and in any case I was confused about what 'dissing' actually meant. During a later family discussion over dinner with both children I was told that 'dissing' meant putting down, disregarding, disrespecting, and generally all of 'those diss words' rolled into one. The children couldn't believe that I wanted the term explained because they assumed my partner and I would know about disrespect and what it meant.

I then tried to understand what I had done that indicated that I had dissed my daughter. This was more difficult to explain and to understand. It seemed that I had not listened, or not listened properly enough, to her story and was seen to have dismissed the importance of it. I had not been sufficiently interested (probably distracted by some meaningless task such as cooking tea) and had not engaged with her about what was important to her in that particular moment. I had put my life and the importance of my tasks first. It seems that youth culture has coined a collective term for a concept where adults get hung up on the specificity of singular meaning. They were talking about the *sense* of being put down and disrespected, not the actual word itself. Used as a verb, it implies a seemingly commonsense range of meanings that are *felt* as having the self negated.

It is this sense of dissing that I was explicitly looking for in the data to explain those times when I *felt* a parent's discomfort alongside my own, yet could not describe it, as the communication skills I observed appeared generally sound.

I certainly felt that I had shown sufficient respect by listening to my daughter's story, albeit with 'one ear' while the other was attuned to the cooking. In the past this approach had been viewed as acceptable within the role of mother. Possibly it may never have been acceptable and was simply left unsaid because my daughter did not have the language with which to express this feeling. Perhaps it was the emergence of 'raging teenage hormones' and a burgeoning sense of self that enabled her to challenge the relations of power between us and that made space for the conversation to arise that might address the change.

These intimate moments of discovery are not often available within the public place of work. Without these moments of disruption, how are we to understand what it is to diss someone through a communication encounter?

The following observation of a consultation suggests how dissing might be understood in the clinical context. The encounter was a consultation between P8

during a UCV with a mother who had recently emigrated from a European country. The mother was parenting this baby for the first time in a new country. She had recently experienced a relationship breakdown with the father of the baby. P8 used an open, friendly tone in establishing a relationship with the mother, sitting comfortably close to the mother and completing administrative work in a lounge room setting. She had outlined the purpose and procedures of the visit, but had not asked if the mother had any initial concerns. We all moved to the dining area to use the table for the child health assessment. Throughout the assessment P8 explained her actions conversationally, for example:

‘I want to look at your eyes, but you will need to open them for me’. P8 was smiling and laughing and engaging the mother when she was checking the walk reflex. She was talking with the baby constantly: ‘Look at your little wrinkles’. She gave a warning: ‘are you ready to go on the scales?’ (Field note 051025)

The mother had asked a range of questions about child growth and development throughout the assessment, which P8 had answered. P8 reassured the mother at the end of the assessment that the baby was growing and developing well. At this stage the mother began talking about her own mother, still living in her country of origin. She talked of the challenges of talking long distance over the phone and of the conflict she experienced with her mother due to differing parenting practices and beliefs.

P8 did not use this opportunity to explore with the mother any of the concerns she had raised, but instead returned to her set tasks. P8 disregarded the mother’s concerns. P8 had walked with the mother to gain respect and trust so that a therapeutic relationship was established, but when the fruits of this engagement were made real, P8 retreated. As an observer I was taken aback. This seemed like a rupture in the flow of the consultation. P8 had established a relationship in such a way that the mother felt at ease to raise personal issues of concern related to her parenting and P8 avoided them. These issues were specifically in relation to the experience of migration, parenting in a new country, and forging one’s way in making cultural choices about parenting.

This unsettling encounter was not dramatic or obvious. P8 completed her set tasks, the baby received a health check, and the mother was informed of the location of local services. Overall, this encounter appeared respectful. However, the mother was subtly disengaged through disregard for parent led concerns. P8 used her

position of authority to determine the agenda of the consultation and thus disempowered the mother. Particularly when the mother's issues related to cross cultural parenting strategies and isolation, P8 reinforced the mother's marginalisation from normative Australian society.

In another example, P3 was videoed on a UCV with a mother who had arrived in Australia from a Middle Eastern country not long before the birth of her first baby. Field notes were recorded in the car immediately after the consultation. These notes record:

At times, P3 spoke directly to the mother, at other times she spoke to the interpreter. For example, she said to the interpreter, 'Does she understand what the percentiles mean?' (Field note 050920)

P3 generally spoke with the mother face to face, sitting beside the mother in a familiar way on a couch in the living area. Field notes record:

she sat next to the mother on the couch and in a very familiar way rolled into the mother or tapped her on the shoulder in a joke or inclined her head to the mother in a very familiar and comfortable way as one would with someone who completely understood not only the words used, but their intonation or the feeling behind the words, such as comforting support. (Field note 050920)

An interpreter was positioned diagonally across from the mother and P3 on the other side of a coffee table on a single couch chair approximately one metre away. At times P3 squatted down beside the coffee table to write in the baby's Personal Health Record. P3's approach of talking with the interpreter to ask questions about the mother's understandings was not her dominant approach, but was employed when she was uncertain of the mother's response and seemed to want a quick answer so that she could progress the consultation.

In these moments of communication P3, like P8, undid her work in relationship building by reverting to an expert model that disregarded the mother as partner. P3 privileged her own authority and that of the interpreter by asking a third person in the room rather than clarifying this with the mother, albeit through the interpreter. In this way she subjugated the mother by deferring to the interpreter. Referring to someone in their company denies the very presence of that person in the room. This was contrary to the intention of partnership in child health practice of positioning the mother and baby at the centre of a consultation. It was also contrary to best practice of communication when working with an interpreter (Mayer & Villaire 2007).

During the consultation P3 spoke to the mother about how she was assessing the baby during the child health check. This was done primarily in a friendly and collaborative way, with P3 explaining the process to the mother. P3's explanation of her recording on the health assessment form, however, again demonstrated her positioning within the expert model. Field notes record:

another time she said, like a school teacher 'I'll give her all the ticks'. She was referring to the baby, saying that she would give her all the ticks for her weight and her measurements. (Field note 050920)

While this statement may seem relatively benign, it emphasised P3's position of authority in being able to assess the baby as passing a test for which there was no personal effort. Considering this possibility after interview, I reflected that the baby's health was being assessed for the purposes of early detection and intervention of potential problems, not assessed for a competency that might be prepared for. The relative power of the assessor seemed to be unintentionally flaunted in this example, which again denied any control the parent might have in contributing to the outcome of the assessment and centralised P3 in the role of assessor.

This last example may be explained away by P3's friendly familiar approach in which she was intending a joke to lighten the situation. Where cultural differences exist, so too do differences of interpretation. P3, unaware of her own cultured approach, moved into a moment within an expert model, without considering the potential impact of how she might be affecting relations of power within the intercultural communication encounter.

Paternalism

Within a framework of partnership participants spoke about 'walking alongside parents' and trying to 'get into their shoes' using empathy. Empathy is required as a 'general attempt by the helper to understand the world from the viewpoint of the parents' (Davis, Day & Bidmead 2002). While participants described themselves as being empathetic in their communication with parents, paternalism was more often observed. To patronise is 'to treat in a condescending way' (*Macquarie Dictionary* 2008). To condescend is 'to behave as if one is conscious of descending from a superior position, rank, or dignity' (ibid). Paternalism is representative of an expert position which seems to creep out under the cover of empathy within a partnership framework.

To explain this position I draw on examples from interviews with two participants: P2, whom I have introduced previously, and P9. In the first example P2 was tearful when retelling the story of the newly arrived mother she was consulting with who was living in a situation of domestic violence. She said:

Oh heart breaking stuff (laughter). Oh how awful, I didn't cry then but you know it was just heart wrenching to think she's got nobody to touch her except, except to hit her, or to tell her that she's a stupid ugly old... (Interview 2 050916)

P2 explained how important touch is to her family life and said, *'I don't know why I'm getting upset, oh well, I'm not really getting upset about it now you know it's just...'* (ibid). Unable to complete her sentence, it seemed as though P2 had over-identified with the concerns of the mother. We watched the DVD together and P2 was observed to listen attentively to the mother, turning her body toward the mother and maintaining eye contact. P2 then patted the mother on the knee, telling the mother that she wanted to listen to her, not discuss the needs of the baby.

During interview I asked P2 about patting the mother on the knee, and P2 explained that she was demonstrating empathy through this gesture. I watched the mother recoil at the pat and felt uncomfortable myself. Through the observed experience of the mother, the act of patting the mother on the knee could alternately be interpreted as patronising (ibid). P2 did not seem aware that she was being patronising towards the mother. My unease settled in as I tried to decipher why this act might signify a paternalist response to one, and empathy to another.

Understanding the historical context of patriarchy and paternalism offers a theoretic stance from which to critique these alternate possibilities of meaning. Patriarchy is represented in power relations of dominance and subordination premised on the 'natural' biological and physiological constitution of women rendering them ineligible for life outside of the private domain of home and family (Jordan & Weedon 1995). While challenged over the last 100 years, superiority of men over women, legitimated by the American Psychological Society in the early 1900s, remains largely intact (ibid).

Patriarchalism particularly refers to the authority of a master over his household, where patrimonialism refers to the political authority of a leader over his territories (Abercrombie, Hill & Turner 2006). In both of these latter terms loyalty is given to the patriarch in return for protection. A paternalistic relationship reflects the relationship between a father and a child. It describes economic relationships between the

owners of a means of production and their subordinates (ibid). Paternalism like patriarchy assumes a natural order of dominance and subordination where one is subordinated in return for protection.

Women were only legitimised in the public sphere when they aligned themselves in relations of power with men of authority. For middle and upper class women this historically meant aligning themselves with the privilege of wealth, which most often necessitated aligning themselves through marriage with the wealth of men. Through this they assumed patriarchal authority and economic and social protection. Women nurses sought legitimisation in the public sphere outside of the home by aligning themselves with medical men of authority. Through this their practice was sanctioned and thus authorised within dominant medical discourses of the historical period. In child and family health nursing discussed in chapter 3, nurses were sanctioned to care for women and their babies following the scientific rational mandate of contemporary knowledge. In this way, women nurses were able to enact the authority of the male. Clinical practice with mothers and babies was then premised on the nurse assuming the authority of the male, thus paternalism was enacted by the nurse onto the mother.

Strongly represented in colonising societies through institutions of religion, law and health, paternalism assumes two key features of interest to this discussion: firstly, that 'there is an ideological dimension that justifies subordination, emphasising the caring role of the paternalist' and, secondly, that paternalism 'assumes inequality of power' (Abercrombie, Hill & Turner 2006, p. 286).

Applying this critique to P2's intercultural encounter, P2 patted the mother as one might pat a child. This implied a subordinate relationship that was reinforced by the implicit authority of the pater. While both P2 and the mother were seated at the time, P2 was sitting erect and in front of a desk and the mother was sitting slumped to the side of the desk. P2 moved across the desk towards the mother, patted the mother's knee, and then moved back into her previous position.

Following Davis et al's ideas about empathy, outlined above, the health professional aims to have an appreciation of the condition of the other. P2 was telling the mother that she wanted to listen, but her physical gesture indicated that she remained in a position of authority which blocked her ability to be with the mother. The gesture was indeed a sincere demonstration of concern from P2 towards the mother, as indicated by her emotive response. What was missing was her awareness of

relations of power inherent in this type of interaction, where she demonstrated an inadvertent representation of paternalistic caring.

The second example is drawn from an observation introduced in chapter 7, of a UCV between P9 and a mother newly arrived as a refugee from a country of political unrest and violence. The mother had four older children and, along with caring for her newborn baby, she was also caring for the children of an uncle who had sponsored her to come to Australia. The mother had not seen her husband for many years. She did not know where he was and was uncertain if he was alive.

The following extract shows my discomfort at witnessing P9 behaving in a paternalist way towards the mother but struggled to make sense of my feelings as observations. I was troubled over how to find the words to adequately describe how the paternalism I felt could be expressed in my field notes. Similar to my daughter's notion of 'dissing', I could feel it, but could I describe it? I wrote:

The main thing I noticed was P9's tone of voice. It was the sort of voice that I would use with only a very young child. And even then, it's the sort of voice that I will try not to use; it's like a bit of a putdown where it is very clear that the person sees themselves as holding the balance of power. Interestingly, it could also be that P9's way of being in the world is just to speak quietly and to be hesitant and to inquire in a high-pitched tentative tone. I also felt uncomfortable at how P9 laughed uncomfortably and giggled uncomfortably when she wasn't sure of how to interpret the mother's behaviour or words. (field note 050922)

I had thought P9 to be uncomfortable because she looked around the room and to me as she laughed, distracted and disengaged from the mother and unsure how to proceed. At this time the mother was speaking in English to P9, occasionally checking with the interpreter. Her tone of voice was sad and low and she spoke slowly, punctuated with many sighs and readjusting of her shoulders. She was describing her deep sadness about the war in her country and her dislocation from her husband and older sons and her fear that they might never be found or already be dead. P9 was sitting beside the mother on a double bed with the PHR on her lap. The interpreter was standing to the side, between the door and the bedside table next to the bed (DVD 9). I was sitting on a stool in front of a dressing table opposite and towards the foot of the bed.

When the mother spoke of the number of children she was caring for, she explained her situation slowly, using her hands to gesture up and out as if to describe a sense

of hopelessness and burden such as 'what can I do but wear this burden?' P9 missed the point this mother was making when she seemed more interested in expounding how wonderful she must be in having the capacity to care for such a large number of children. This seemed to make light of the mother's sense of burden, especially when P9 giggled. All of this time, P9 was looking furtively across to me, then to the interpreter and then to the mother. Her gaze did not settle long enough to engage the mother. P9's light and high tone of voice contrasted with the speed and tone of the mother's rather than reflecting it.

When the mother talked of the uncertainty around her husband's life and those of her sons, P9 said '*oh well*'. She did not seem to know how to respond to the enormity of what this mother was saying to her. She then shrugged her shoulders and rolled her eyes and looked towards me, appearing to seek direction, and then looked at the PHR on her lap. P9 then moved onto explaining the PHR to the mother (DVD 9).

This seemed an ill-equipped response for a professional clinician working with a traumatised mother. In not being able to respond to the mother with empathy, P9 appeared to dismiss the gravity and the centrality of this experience to the mother. Bolton clarifies that in using empathy another person's story is heard as that person chooses to present it and the person hearing the story recognises the special significance of that story for the other (1986, p. 270).

Despite being a nurse with over 20 years of experience, P9 behaved in a way that perhaps indicated she was out of her depth. It also suggests that P9 implicitly used a paternalistic approach that made explicit the unequal relations of power in the relationship. This was demonstrated through regulators such as gaze, vocal pitch, head position, raised eyebrows and posturing alongside adaptors such as giggling, eye rolling and shoulder shrugging. According to Lewis and Slade (1994, p. 61) regulators are 'nonverbal signals that provide cues for verbal interactions' and adaptors are 'nervous, unconscious nonverbal displays'. They suggest we have little awareness of these mechanisms. A question that arises from the example of P9's lack of empathy is: what strategies do, or might, child health professionals use towards reflecting on communication practices?

When P9 was communicating with the mother, she frequently did so by speaking to the interpreter; asking the interpreter a question about the mother, the mother's understanding or to ask the mother an explicit question. Like a previous example

with P3, this discounted the mother as central to the communication encounter. When P9 did this, it looked and sounded condescending. She did not seem skilled in working with the interpreter; her behaviour did not display partnership with the mother but relied on a traditional expert approach to communication.

In doing this the very nature of the interaction was paternalistic because the voice of the mother was overridden by P9 when she spoke instead to the interpreter, when she dismissed the mother's trauma with non-verbal behaviours and when she led the consultation back to her professional agenda of filling out the baby's PHR.

The implications of paternalism are even greater across intercultural communication interactions. The history of colonialism is embedded with patriarchy whereby the strength of a nation was built on that nation's ownership of peoples from a range of countries. Unequal relations of power were embedded in paternalism when colonial leaders made socioeconomic decisions, purportedly for the altruistic beneficence of the peoples within those countries because of the assumption that they had more right to make those decisions than did the people themselves. The colonists' knowledge and way of being in the world was regarded more highly than that of the people native to the land. When participants like P9 centralise their own position by marginalising the voice of refugee mothers, as in this example, they demonstrate how neocolonialism is enacted through paternalism.

It seems that perhaps both P2 and P9 displayed sympathy rather than empathy. P9 could also possibly be described as displaying apathy. Both represent externally signified but unrecognised relations of power. P2 said *'oh how awful'* of the mother's situation (DVD 9). Here sympathy is self-serving in that it returns the situation of concern away from the interests of the other to the sentimentality of the self. The needs of the child health professional self are privileged. While sympathy does not necessarily come from a position of strength, it is often condescending (Bolton 1986). This may be because the external representation of the act of sympathy positions the helper as superior.

In addition to demonstrating sympathy to the mother, saying things such as *'oh poor you'*, P9 also demonstrated apathy through missing essential cues presented by the parent and failing to link P9 to essential resources. The consultation videotaped with P9, while not representative of all participants, did indicate how seemingly obvious non-empathic communication can appear but how difficult it is to describe using the available discourses of communication. P9 was sitting next to the mother. She was

asking questions of the mother and baby. She *did* work through the tasks of the UCV. But the question remains' how does such practice evidence partnership in the terms intended by Davis et al?

My frustration with how P9's lack of empathy played out in practice and my limited range of language with which to describe my sense of paternalistic expression of care was recorded in the following field note:

This is the first time I have felt very angry in my role as researcher observing a consultation. My [hand written] notes say 'P9 is condescending. She's not working with the interpreter; she is discounting the centrality of the mother'. (Field note 050922)

This discussion and extract also says much about not only my lack of words to describe and critique my observations, they also indicate my sense of anger at what I was seeing and feeling. As an observer I felt impotent in this situation where the needs of the mother required a much greater response.

I continued to try to understand the relationships between partnership, empathy, paternalism and authority and how it was understood by participants. In contrast to P9, P16 explained a process for reflecting on her capacity to embody empathy when she said:

I mean you can only get so far into somebody's shoes sometimes, I mean it doesn't mean I'm doing it all the time but I try to ... from their point of view 'how does that sound to them', 'how is it' and 'do they have any understanding of what I'm talking about' without patronising people as well. (Interview 16 060307)

P16 then explained how one needs:

to be careful about when you're speaking, particularly in terms of cultural and those sorts of things you've got to be very careful not to be patronising to assume that they don't know things. (Interview 16 060307)

These are just the sort of reflective questions that may have been useful for P9. However, P16's explanation of 'getting into somebody's shoes' was also somewhat unsettling. She did not talk about getting into their shoes to understand the mother's position, she talked of getting into her shoes to ensure that the mother has understood the nurse's position. Thus empathy was portrayed only in the context that it met the needs of the child health professional to be heard. In this way it was almost negated as empathy. This seemed to be only one aspect of what Davis et al.

(2002) and Bolton (1986), for example, present as empathy. The understanding of the lived experience of the mother seemed to be missing.

When P16 spoke of being careful around cultural issues she suggested the need to not assume that clients don't know things. I asked P16 what 'things' she was referring to. She explained that this related to anything to do with how 'we' care for babies and children (interview 16 060307). The 'we' seemed to intone a meaning of child and family health nurses, which situated the 'things' perhaps as normative discourses about parenting, within a white Western world. In this way she seemed to unquestioningly privilege this way of knowing the world over any alternate position the parent may wish to take up. White Western knowledge seemed privileged even in talk of *not* being patronising within a model of partnership.

Despite these possibilities it could also be considered that, like myself, having trouble finding a language to represent my observations and feelings, so too might P16 and many other participants. In this case the question arises as to how child health professionals might find meaningful ways to reflect on intercultural practice that demonstrates the depth of possibilities of interpreting their taken-for-granted practices.

Summary

In this chapter I have analysed how participants approached communication interactions with parents who were culturally different to themselves. The fundamental problem that emerged seemed to be the challenge of applying theory to practice. Participants took up positions within a binary where they explicitly talked about working in partnership with parents in order to resist being positioned as an expert. An expert/partner binary was thus created.

The majority of participants felt a personal/professional fit with discourses of partnership and explained how they actively resisted working in an expert model and positioned themselves unambiguously as partners to parents. Participants resisted presenting overtly as experts by trying to give their authority, understood as power, to parents. In giving away their power many participants could not reconcile a way to retain their professional expertise. As a result, this was at times denied. Even though Davis et al. argue that joint expertise is required for partnership, the way power is theoretically conceptualised seemed to restrict participants' ability to see a

place in the room for joint expertise. The binary was thus reinforced as communication behaviour that was named as either partner or expert.

The model of power conceptualised by Davis et al. follows a long tradition of liberal humanism in health care where power is understood as possessed, as flowing from top to bottom and as primarily repressive. Embodying this understanding, participants tried to resist a power that was assumed as repressive. To do this, many recognised themselves as being able to give power away; however, they did not recognise that in this construct it followed that power must necessarily flow from top to bottom. Where this act was perceived as addressing an imbalance of power, it inversely reinforced the status of the child health professional representing the state at the top.

When participants worked in this way, expert or overtly superior practice crept out unnoticed out in the form of paternalism and expert centred care. In these approaches health professionals seemed to deny the mother as partner. They did this primarily by leading the consultation, focussing on professional needs, by not following best practice when working with interpreters, and by subtle non-verbal acts of condescension. Rather than facilitating partnership, these acts served to reinforce and perpetuate the marginal position of the mother. In the case of parents who were already marginalised in white society due to visible cultural markers such as skin colour, language and religion, this usage of power in partnership becomes a complicit form of democratic racism.

Reflecting on a three body analysis we might imagine that participants attempt to use power as a third body to mitigate the authority of their position. Unfortunately, use of power in these terms seemed to trap professionals into an unending position of resistance. If partnership is to be more than rhetorical, then more supportive strategies for reflexivity and professional development are required. In the situation of intercultural communication we are not looking to overcome forces and have a clear winner. We are looking for a place of mutual coexistence of ideologies, knowledge and practice.

If we are to understand power from a postmodern perspective, 'we're never trapped by power: it's always possible to modify its hold' (Foucault 1980a, p. 13). Power that is exercised exists everywhere in the social field as an open system of unstable and heterogeneous relations of power.

A useful third body, then, is not power itself but perhaps child health professional understandings and use of power as a concept. If child health professionals' understandings of power were pulled out for examination as a third body, we might critique notions of expert and partner through the historical and cultural positioning of the child health professional. Once explicitly known and brought into the room this might open a space to examine how these ideologies interact with relations of power at both the expert position and the partnership position. This might then facilitate mutual coexistence of expertise and partnership.

Participants seemed to use rhetoric of partnership when talking about their intercultural communication practice. If partnership is to be useful, the process of moving from theory to practice requires more attention. In the theory/practice binary, academic theory is meant to inform practice 'in a linear causality, as "reason" traditionally informs action' (Hodge 2005, 123). This linear causality is present even when theory emerges from practice in the form of praxis, as each is understood as formed by the other (ibid). These linear approaches are often found not to work because they contend not just with the two bodies of theory and practice but with many more often assumed and uninvestigated bodies. Theory of the Parent Advisor Model, for example, does not directly move to application in a linear fashion; it contends with use. Following Hodge, 'use', in this sense, involves child health professionals making sense of knowledge and truths within their own personal and professional life experiences and in diverse practice settings. Assumed and uninvestigated bodies in this scenario are the ideological constructs of child health professionals.

The practice/theory binary reproduces itself in practice, as seen in the creation of an expert/partner binary. In order to move out of this binary we need to critically evaluate the underpinning ontologies on which theory builds itself and question its currency for application in the pluralist working environment of Australia as a multicultural alongside critical investigation and understanding of the assumed ideological positioning of child health professionals as partners or experts.

CHAPTER 11

COLLIDING KNOWLEDGES WITHIN INTERCULTURAL COMMUNICATION

Introduction

In this chapter I introduce and discuss some of the elements within a kaleidoscope of professional knowledge. The first element highlighted by participants was knowledge that is explicit and able to be publicly declared. Within the scope of professional practice, most participants adhered to authenticated versions of professional child and family health knowledge. However, great variety existed in how participants managed and integrated the plurality of knowledge from within the spheres of their private lives. Rather than work together within the scope of a kaleidoscope, these knowledges appeared at times to collide. In the collision, lay knowledge was at times bordered from professional knowledge through a professional ethics of information giving. At other times this knowledge was offered to parents in the same way as professional knowledge. At other times still, participants explicitly stated that they left this knowledge out of the encounter but, despite their best efforts, the analysis of interactions between child health professionals and parents showed that this lay knowledge nevertheless slipped seamlessly into communication interactions. Where public knowledge was subject to rigorous examination before it is given to parents, knowledge from personal spheres was not subject to an equivalent examination. This seemed problematic when the nature of the personal information exchanged was premised on personal cultured experiences.

Most participants appeared unaware that they brought with them to the practice setting their deeply held personal beliefs and values. When participants became aware of this personal slippage into professional practice, they were at times confused about how to discuss and manage this presence. Where participants did recognise the involvement of personal values and beliefs, they accepted them into practice without questioning their universal applicability. For example, personal experiences of mothering, alongside cultural knowledge and value systems developed in early childhood, were justified as valid knowledge to share with parents.

Given that all but one of the child health participants came from white middle class families, I questioned the appropriateness of bringing deeply cultured beliefs and values *unexamined* into the professional arena and claiming them as legitimate universal knowledge for a culturally and linguistically diverse population of families. Bringing personal experiences into the encounter is not in itself problematic, as doing so has the potential to enrich communication encounters. However, where personal experiences are not used reflexively, and values and beliefs enter without a cultural consciousness, there is potential for perpetuating democratic racism, for example through homogenised discourses of motherhood.

The unconscious use of personal experience in this way masks the micro-dimensions of power inherent in any contact between professional and client. The way health professional participants understood power appeared to be from a modernist perspective whereby they could give power to parents through information. The analysis in this chapter will show that the power/knowledge binary implicit in relations between child health professionals and parents was not well understood or considered in decisions about what and how information is given to parents. Instead of engaging directly with power as a positive force of engagement, participants said they attempt to transcend power using professional discourses of judgement. In this way they exempted themselves from the need to consider the intrinsic asymmetry in existent relations of power in all health practice.

Qualifying knowledge in child health practice

So what is knowledge? In a professional capacity, knowledge is what we learn through discourses of disciplinary learning. For child health professionals this usually builds on disciplinary knowledge of nursing, medicine, social work, or psychology. Continuing education adds specific knowledge through postgraduate courses such as child, adolescent and family health nursing or health counselling. Professional development adds skills as well as an opportunity to be reflexive about the state of our knowledge for practice. As shown in chapter 5, the formal qualifications held by participants involved in video reflection, demonstrate that they all had significant formal disciplinary knowledge with which to practice. In addition, these participants had the opportunity to develop significant intercultural communication experience and knowledge through their many years of practice.

Disciplinary knowledge is based on scientific or rational truths presented as such to those within specific professional domains. We all learn the episteme of our chosen

discipline. In health this episteme is based primarily on premises of scientific rationality (Lupton 2003, p. 22). Scientific rationality requires evidence or truth through which it can be verified; once verified this truth becomes knowledge. In exploring relational epistemologies Barbara Thayer-Bacon argues:

Only that which is absolutely True is Knowledge; if we are not sure if something is True, we must call that something a *belief* instead of *knowledge*. Beliefs are not necessarily true, but Knowledge is necessarily True. (2003, p. 17)

One of the assumptions on which a truth claim in this paradigm or way of thinking is made is that it is universal in application and holds true across the sphere of a particular work practice. Alternately, a belief is usually determined as individual rather than universal and therefore relative. For example, while parenting and child health is a sphere of expert professional knowledge and practice, it is also experienced individually, and is relative to all that a family might call cultural such as structure, class, and ethnicity. This study shows that in this nexus the dynamics of the borders between private and public knowledge used in child health practice are not well understood. Questions need to be asked about how participants might support the plurality of the experience of parenting within a discipline that primarily privileges rational truth claims as knowledge.

For example, how did participants make sense of the knowledge they used to give information to parents; where did they draw this knowledge from; and how did they validate its veracity as knowledge? To explore these issues with participants, we (participant and researcher together) looked at the DVD of them communicating with parents. During the viewing I asked many questions about what they did and didn't do, and why they might have made the choices that they did. I asked about how they reconciled information given with their personal ideas and values. In this way many aspects of knowledge brought to practice were explored with participants. The following section relates specifically to the highly visible and central task of giving information.

Information giving

Information giving featured highly in child health consultations. For analytical purposes, information giving was understood as comprising approaches to communication and the content of information given. This chapter deals most explicitly with the content of information given. This follows the examination in chapters 9 and 10 of how child health professionals approached communication

encounters and how they made sense of these approaches.

The dominance of information giving within the communication encounter was as surprising as it was expected. Historically, child health professionals have a traditional role in information giving, so why be surprised? Parents go to a child health service necessarily to ask questions of a professional. I had imagined that with the emergence of primary health care and its emphasis on partnership, the dominance of information giving within the child health role might have subsided. This would allow room for greater exploration of parental constructs and inquiry into parental preferences, joint problem solving and partnership approaches.

Davis et al. introduce the activity of information giving when they describe the concept of 'challenging' (2002, p. 119). It is presented as a tool to help people change their behaviours. It seems to form only a small component of activity within the small category of challenging within the 'the helping process' (Davis, Day & Bidmead 2002). Why, then, did it still occupy such a dominant position in the child health care encounters in South Australia? I asked participants what they saw as their role while they watched themselves on DVD. P4, for example, said that she was '*giving information; instructions*' (interview 4 050921). The section we were viewing was at the beginning of the consultation where P4 had only just begun the consultation. She was not visibly giving instructions at that time. We discussed differences between roles and tasks and P4 clarified that her role was:

giving information to ensure that they understand it and [understanding] what it means to them and whether they're comfortable with what we're trying to give to them; offer to them. (Interview 4 050921)

Participants suggested that they mostly gave information, as a component of care, prior to tasks such as performing child health assessments, and monitoring growth and development. Observations of practice confirmed this assertion. P4 also found it important that the mother understood the information she had to offer. In this way, she privileged the authority of her knowledge. P4 did not, however, consider the constructed nature of the information she offered, nor did she question the implicit messages she gave about 'accepted' parenting practices in Australian culture.

Similarly, P16 confirmed her role within a primary health care agenda, thus:

you want to get some basic stuff through even if you don't do anything else you've got to achieve that; the key messages. I do have a sort of thing to always get across

some key messages ... that people don't walk away feeling completely dissatisfied and that it [was a] waste of time etcetera, etcetera. (P16 interview 060307)

P16 suggested that her beliefs about the importance of key messages were reinforced by parent responses. In this way, she considered that parents' satisfaction with the service is predicated on the messages provided by the child health professional. Positions such as those held by P4 and P16 raised questions about how participants determined the information or key messages that they give to parents. I wondered where personal beliefs and values might fit with the information that was given.

Valid correct information

I asked participants about how values and beliefs might shape the information that they shared with parents. P12, for example, was watching herself giving information to parents who were marked as culturally different to her by skin colour and language. On the DVD were the mother and father with the baby sitting on the lap of the father. The father was at times interpreting for the mother. P12 was giving the family information related to food choices for babies. The parents asked about how to get their baby to eat more fresh foods. P12 did not ask the parents about the familiar practices of baby feeding in this family; she proceeded to give information as though to a blank page with no existent knowledge. I asked P12 about the place of her beliefs and values in giving information. P12 suggested that she did not bring any of her own values or beliefs about food or culture into the consultation, saying:

I would hope that I use valid, correct information rather than my perception of how I see things, rather than making a judgement that certain people are this way because they're this culture, I would hope that I don't because I think then you would become very judgemental. (Interview 12 051213)

P12 explained that she does this by using information from the CYH internet site, referring to organisational policy documents and reading the NHMRC *Dietary Guidelines for Children and Adolescents in Australia Incorporating the Infant feeding Guidelines for Health Workers* (National Health and Medical Research Council 2003). This was knowledge that was explicit and able to be publicly declared. The recommendations in these documents are based on truth claims within child and family health practice. These are based on evaluating best available research evidence and application to practice. As such, P12 draws on the validity of scientific reason to justify the information she gives to parents.

P12 suggested that if she were to use her own judgement she might lapse into stereotyping behaviours based on cultural specifics or an anthropological view of culture. P12 believed that she countered stereotyping by sticking to scientific reason. Following this, I questioned whether using scientific reason can prevent us from being judgemental. Is this possible or even desirable? This encounter also raised questions about the cultural appropriateness of the information that P12 relied on. It also seemed that the personal beliefs of the parents did not feature in this encounter. It seems that P12 did not consider the need to negotiate difference in supporting health choices.

In aiming to be non-judgemental, P12 drew on disciplinary knowledge specifically related to child health practice and communication. Within the Parent Advisor Model, Davis et al. suggest that managing judgement is part of being respectful. Respect in this approach:

refers to the helper trying to suspend judgemental thinking; valuing parents as individuals; thinking positively about them without imposing conditions, and regardless of their problems, status, nationality, values or other personal characteristics. (2002, p. 58)

I asked participants how they managed to do this. P12 said she managed it by sticking to scientific reason and not letting her own ideas in. P12 said that she focusses on *'talking to a family whether they're [from another ethnicity] or not, and that's the way I really treat my families'* (interview 12 051213). In trying to avoid cultural stereotyping P12 appeared instead to homogenise families. Her homogenisation, however, was unquestionably premised on personal experiences shaped within the context of middle class white Australia. While disregarding issues of nationality and cultural values, P12 appeared to impose conditions of white normality.

In another example, P19 laughingly said of her values and beliefs, *'I try and leave them at the front door'* (interview 19 060328), explaining that if she took them in with her she would be imposing her ideas onto someone else. P19 said:

I try and keep my ideals and things out of it because I don't believe that I should be imposing my ideals and view points and things on other people, unless they ask me specifically, if they said, 'Oh well, what do you think?' or, 'How would you do this?' then I would add it but I don't believe that it's my role to be imposing our views or my

views or anything, any values or mindsets on them. So I would only ever do that if they asked me. (Interview 19 060328)

From these examples, we might understand that both P19 and P12 used clinical knowledge to answer questions and that they ‘bracket’ or ‘suspend’ their thinking as directed in the PAM. One wonders where ideas go when they are ‘left outside’.

While P19 tried to keep her ideals to herself as part of her professional role, P19 would be asked by parents everyday ‘*how would you do this?*’ and ‘*what do you think?*’ What was not asked during the viewing of the DVD, and is of interest to this research, was how P19 indicated to parents that she has left her own ideas at the front door and is answering from a position of scientific knowledge.

Of judgment and humanity

In another example, while watching herself on the DVD during a UCV with a mother, P11 commented, ‘*I sort of go into a home and I put myself on, as a human being*’ (interview 11 051129). P11 said she achieves this by:

being accepting and non-judgemental whatever is happening, not to even bat an eyelid about things ... no reactions about [anything], ... coming and being interested in their lives, coming down to their level. (Interview 11 051129)

P11 ‘*put herself on as a human being*’, yet she exercised strict self control in attempting to show she was not judging and tried to come ‘*down*’ to the parents’ level. Like knowledge, judgements are usually believed to be ideologically neutral. Similar to the binary of public and private knowledge, managing judgments is also most often placed on a binary continuum. To be judgmental is seen as counter-professional and politically incorrect, and to be non-judgmental is what is aspired to through professional discourses of communication. In this way judgements are often seen to speak about explicit or noticeably negative client attributes or conditions.

P11, while claiming not to be judgemental, brought her judgements inside when she judged the house to be in disarray but chose not to comment. Being non-judgemental appears to be treated as a rhetorical commandment of ethical practice and yet there is little ongoing attention to how we negotiate/mediate the implicit judgments and assumptions we make in our daily practices.

P19, who said she leaves her values and beliefs ‘*by the front door*’, talked later in the interview about suspending her judgments until she had worked out how much

the parent understood about what she was saying. She said, '*I tend to not make judgements straight off if they don't actually understand what I'm discussing*' (interview 19 060328).

It seemed that what P19 said earlier about leaving beliefs and values at the front door was contradicted later when she spoke of formulating judgements. P19 did bring her values and beliefs into the room; however, she did not seem to have a professional discourse with which to openly declare this. If P19 was suspending her judgement one wonders what she might be using to determine how to answer questions and how to frame up her responses. Assessments are continuously being made but are not understood in the same sense as judgment. Perhaps the professional lexicon of 'judgment' seems to be held in the same regard as it is in Christian doctrines of mortal sin.

In areas of judgment, participants turned again to the binary of judgemental/non-judgemental to make sense of their conflicting world views. In professional discourses child health professionals are instructed to be non-judgemental, but they are not instructed how to go about doing this when practices keep colliding with contextualised knowledge from the private sphere that holds private values, beliefs and assumptions. Surely it is a question about how we mediate our judgements in practice, and with what knowledge we bring to bear on understanding the judgments that we do make.

Drawing on discourses of humanism, P11 saw herself as performing her professional role when she put herself on as a '*human being*' (interview 11 051129). It seems P11 believed that the essential similarities of their humanness formed a place for equity in the power dynamics of sharing information. Notions of equity within liberal humanist theory are 'both egalitarian and inegalitarian' (Parekh 1986, p. 82). In saying this, Parekh argues that liberalism simultaneously supports the unity of humankind and the hierarchy of cultures. For example, when P11 called on an essential aspect of humanism to form a platform of equity, she might be understood to have simultaneously denied relations of power inherent in any intercultural encounter. This is particularly relevant when she was positioned both within the dominant group and the bearer of authoritative child health knowledge.

P11 may well be seen as having attempted to transcend relations of power when she puts her '*human being on*'. Mulholland argues that within nursing literature, humanism is presented in an extreme form of methodological individualism (1995).

This is seen clearly in the example provided by Sarvimaki, who suggests that 'that nursing consists of interactions between unique individuals with unique experiences, and it always takes place within unique situations' (1988, p. 465). Mulholland maintains that this understanding 'precludes an understanding of social formations and collectivities, however extensively qualified the representations of these may be' (1995, p. 22). If these social formations are excluded it then becomes difficult to recognise or examine relations of power in the relations of health service provision.

Humanistic discourse, like all others, can be seen as locating the individual within a web of power relations (Mulholland 1995). In attempting to transcend power, P11 contended that difference is a surface phenomenon that disguises a common essence between persons. From this position, she was then not called upon to critically examine 'surface' phenomenon of race, gender and class within the context of care.

Following Mulholland, individualism-informed practice was seen in the majority of participant child health nurses. For nurses it is embedded in disciplinary guidelines for ethical practice that suggest a registered nurse 'accepts individuals/groups *regardless* of race, culture, religion, age, gender, sexual preference, physical or mental state' (Australian Nursing and Midwifery Council 2005, p. 2). Following this ethical belief the ANMC competency standards suggest that the nurse 'ensures that personal values and attitudes are not imposed on others' (ibid, p. 2). There is, however, no pluralistic directive as to how this might be achieved.

In attempting to present a fair and just experience to the mother, P11 said that she had to consciously stop herself from reacting. Human beings react and are responsive. It is the very nature of this spontaneous lived reactivity that marks them as different to machines. Perhaps P11 was using judgement as a tool to mask her values and attitudes to the mother, in which case she was still judging the mother but judging her situation negatively to such an extent that she was compelled to hide her values.

It seems confusing to understand that when educated to be open in forming relationships, that we might be, at the same time, perhaps learning to hide values and judgements. In hiding values and judgements yet another binary is created. Perhaps it is only acceptable to be judgemental when those judgements are seen as a positive reflection of the parents' situation. Being judgemental is acceptable when a nurse comments, for example on how nice the cushion covers look on a couch in

a parents' lounge room, but it is not acceptable to be overtly judgemental when observing dirty dishes in a sink. In order to attempt balance within the binary of judgement/non-judgment participants asserted that they try to present as value neutral. P11 did this by showing no emotions with '*no reaction to [anything]*' and yet at the same time '*being interested in their lives*' (interview 11 051129).

Watching the DVD, P11 and I discussed relations of power. P11 recognised that in '*coming down to [the parent's] level*' she was positioned as holding authority and positioned herself above the parent (interview 11 051129). P11 then used discourses of equity to state that she saw herself as equal to the parent and not in any way above the parent. It seemed that P11 had inadvertently emphasised and secured unequal relations of power by attempting to transcend power through an imagined state of non-judgement. In this way P11's personal knowledge or judgement is held, but can it be hidden?

In attempting to be non-judgemental, participants worked around not letting their personal opinions, ideas and beliefs into the encounter, either by hiding them or leaving them at the door. I looked at the data and questioned how well this worked.

Recognising subjective knowledge

In order to examine how participants recognised subjective knowledge I return to P12, who explained that in order not to be judgemental she presented only '*valid correct information*' to parents without personal values (interview 12 051213). P12 watched herself on DVD giving the mother and father tips for getting their baby to eat more fresh foods rather than the predominantly tinned food that the baby was familiar with. I asked P12 where the information she was giving might have come from. P12 said:

Most of my practice I feel is life experiences, obviously I've had training along the way but those sorts of things, the basic things of feeding a baby in that respect it's life experience. (Interview 12 051213)

This seems to contradict P12's previous statement about only giving '*valid correct information*'. It appeared that P12 may believe this information is also valid and correct, but at the same time did not recognise that in bringing this personally constructed knowledge into the room she brought with it her personal values and beliefs; those things that she claimed to '*leave outside*' to avoid being judgemental.

From postcolonial and feminist perspectives, multiple sources of knowledge position individuals in many and competing ways and always within relations of culture and power. While we might imagine that all participants considered the socio-political and historical contexts of their lives, and integrated these understandings into communication practice, analysis from chapter 7 reminds us that this is not always the case. In this example, P12 drew on her life experiences as mother. Understandings from the interplay of multiple subject positions are argued as 'constructed knowing' (Belenky et al. 1986). Gendered positions, such as that of mother, intersect with race and class, shaping women's everyday lives (Anderson 2002) and thus the multiple knowledge positions of women. In this example, P12 unquestioningly presented to the parents constructed knowledge that incorporated her personal motherhood experiences.

Participants often drew on personal life experiences in giving information to parents. Most commonly, the personal knowledge referred to by participants was that of motherhood. Interestingly, most participants believed that motherhood knowledge added value to their role. P2, for example, said:

and you know having had children each with a different experience you know it just gives you a much more depth of understanding and knowledge to what you're bringing to your role here. (Interview 2 050916)

So how do we account for this depth of understanding and knowledge? Sara Ruddick identified 'maternal thinking' as a type of disciplined reflection 'with identifying questions, methods and aims' (1989, p. 24). Maternal thinking is centred on the concrete daily concerns of family and others (Ruddick 1989). Where maternal thinking accounts for the process of disciplined reflection, maternal knowledge perhaps constitutes the subject of that reflection. It is knowledge of practical human need; the daily concerns of family and others. While this knowledge seems to be valued in professional life, I wondered how it could be brought into practice more consciously and judiciously.

In another example P14 expounded the values of maternal knowledge and maternal thinking, claiming it to enhance practice, when she said:

it's personal experience and that's probably why they can relate to us ... because we have personal experience as well we're not just saying 'in the book it says'. We're not always giving them information from a book, we're actually saying, 'I know what

*it's like, kids are fussy eaters. I know what it's like to have kids who don't sleep'.
(Participant 14 060208)*

In this example, P14 differentiated the value of her maternal knowledge from scientific or 'book' knowledge, arguing that personal experience at times counts for more than scientific knowledge. Ruddick (1989) also argues that rational thinking is abstract compared to the concrete knowledge of experience and practice. As such we can imagine abstract knowledge may not always readily translate to practice. Ruddick additionally claims that unlike maternal thinking, rational thinking privileges objectivity. It is, however, the very subjective nature of knowledge that P14 used to validate her use of maternal knowledge. She said further:

I've brought up four kids, we've all had kids ourselves and I've tried many different styles and talked with other parents and when you think, sleep deprivation is something you have to really feel I think to understand that ... [there's] nothing like it. It's the worst thing and you try everything. (Interview 14 060208)

In this example P14 emphasised her belief that one must feel the subjected experience of sleep deprivation to fully understand and thus know. Her feelings validated the claim to knowledge. Two things are implicit here: firstly that mothers make better child health professionals, and secondly that in relation to maternal thinking the 'book' is not always helpful. It seems that there is little place to explicitly and legitimately learn from mothers, at work, about the experience of childrearing. This raises more questions about our assumptions relating to partnership in the intercultural context. It also reflects unhelpfully on how the personal within professional, or the mother at work, is professionally marginalised.

Unsettling the binary

Belenky et al's (1986) ground breaking work on *Women's Ways of Knowing* is useful to make sense of participants' explanations of information they choose to give to parents. They detail five different ways of knowing. Goldberger (1996, pp. 4-5) summarised them as follows:

silence is a position of not knowing where one is powerless, mindless and voiceless

received knowing is where knowledge and authority comes from knowing and powerful others 'from whom one is expected to learn'

subjective knowing is a position where knowing is 'personal, private, and based on intuition and/or feeling states rather than on thought and articulated ideas that are defended with evidence'

procedural knowing comprises two modes of knowing. These are *separate knowing* characterised by distance from that which one intends to know and *connected knowing* characterised by entering into 'the place of the other person or idea that one is trying to know', and

constructed knowing is

'the position at which truth is understood to be contextual; knowledge is recognized as tentative, not absolute; and it is understood that the knower is part of (constructs) the known'. (Goldberger 1996, pp. 4-5)

In reviewing Belenky et al's original presentation of these five ways of women's knowing, Goldberger (1996) explained that they were not intended as a feminist framework to oppose constructs of masculine thinking. Rather, as themes, they suggested implicit agendas of power within societies, which at the time were researched through gendered constructs of knowledge available in feminist methodologies of the early 1980s. In the light of postcolonial methodologies, Goldberger suggests that these categories 'might be modified with the inclusion of a more culturally and socioeconomically diverse sample of women and men' (1996, p. 7).

P12, for example, initially claimed the validity of *received knowledge* when she talked of the 'correct information' that she hoped she gave to parents. She then entered into a position that valued subjective knowing from the personal position of mother. However, at the same time, P12 denied that she would use personal values and beliefs as she felt this would present her as judgemental. Perhaps P12 did not recognise that values and beliefs are implicit within positions of subjective knowing. P12 worked within a personal/professional binary, trying to align herself with rational received knowledge while denying the subjective nature of her personal knowledge. In this way she was unable to take up the plurality of constructed knowing where multiple approaches (received, subjective, separate and connected) are valued and central to the knowing process.

I asked why P12 might continue to work within this binary rather than embracing a position of constructed knowing. To explore this question I looked to the ontological

and epistemological positioning of authorised discourses of child and family health and communication.

Episteme of scientific child and family health

Child and family health practice primarily draws disciplinary knowledge from biomedicine and psychology. Ontologically these knowledges are embedded in liberal notions of humanism. See, for example, the quest to find the 'right' way to sleep a baby safely, described in chapter 1, and the enlightenment perspective of the Parent Advisor Model in helping parents to change their behaviour discussed in chapter 4. In these professionally sanctioned discourses, multiple agentic positions of self are denied because at the level of ontology, humanist notions present the self as singular, linear and rational. In practice this often translates into the commonly used metaphor of the self as an onion that can be peeled back to reveal an essential/true self at the centre of our being. From a humanist perspective, presenting multiple possibilities denotes the self as vulnerable, irrational and subjective, and therefore unable to practice in an objective scientific fashion (Davies 1991).

Of particular interest to this discussion is the way in which the Parent Advisor Model uses George Kelly's (1955) *Theory of Personal Constructs*. Presented in chapter 4, this theory offers an explanation of how people make sense of information and create personal knowledge. Constructs operate through a binary system called constructive alternativism (Kelly 1955, p. 105-107) which proceeds along a linear continuum (ibid, p. 128). The process of constructive alternativism is 'embedded in the traditions of rationalism' and 'conforms to the basic tenet of modern scientific experimentalism' (1955, p. 22). Ontologically this means there is a singular truth to be discovered along the binary continuum. From this humanist perspective, Bronwyn Davies (1991) suggests that individuals who do not make rational choices along the continuum are defined as deficient and lacking in their humanness. In this way we are perceived as conditioned to a metaphysical binary for fear of being assumed emotive, subjective and non-rational.

Participants spoke privately of valuing subject positions of mother when they viewed themselves drawing on this knowledge. However, when asked about values and beliefs, they returned to professional/rational discourses that labelled subjective knowledge as unprofessional.

Kelly contends that as dichotomous constructs are useful in the scientific world, they are therefore equally useful in psychological theorising (1955, p. 110). Thus mechanistic and scientific analogies of 'self' confine and define the self to liberal Western constructs of normality.

In presenting the Parent Advisor Model, Davis et al. make no attempt to challenge these binary assumptions within the formation of personal constructs. They present the analogy of the person as a scientist where, through the progression of experiments with hypothesised outcomes, individuals validate or modify their constructions in linear progression (Davis, Day & Bidmead 2002). Davis et al. go so far as to suggest the status of science within society renders the approach attractive (ibid, p. 104). They suggest applying this approach to practice enables us 'to predict accurately what will happen' (ibid, p. 104). What this analogy leaves out are the complexities of lived experience. In leaving these considerations out of theory, differences according to gender, race and class, it becomes difficult to validate and utilise and effectively use them in practice. We see the omission of these considerations when Davis et al. entreat helpers to act toward clients in ways that are 'regardless of their problems, status, nationality, values or other personal characteristics' (2002, p. 58). This entreaty urges helpers to facilitate access to fair and socially just services is historically and culturally well meaning. However, one of its unwitting ontological effects is that helpers implicitly ask clients to *unbe* who and what they are. In the 'messy swamplands' of practice (Street 1990), participants are left without a legitimate ontological space in which to consider the subjective constructs of status, nationality, values and other personal characteristics.

We can see this absence in P12's response. She used liberal notions of individuality to prevent her stereotyping and thus judging parents. While P12 attempted to treat the parents as individuals by not assuming their collective status of ethnicity or nationality, she paradoxically denied their individual status by assuming the universal applicability of the knowledge she brought to practice. A further problem relates to the assumed universality of all knowledge presented to parents and a belief that cultural values can somehow be exempted from this knowledge. P12 did not question the universal applicability of this scientific reasoning with these parents. Paradoxically, she then presented information to the parents from a position of subjective knowing while at once denying the presence of her cultural values within this knowledge. Further, P12 assumed the universal applicability of this subjective maternal knowledge. Where Belenky et al. acknowledge the value of this personal

and private knowledge, they also argue that it is not generalisable. By unquestioningly offering her own cultural experiences as a truth claim P12 asserted her subjective knowing as a generalisable scientific claim capable of overwriting any individual differences.

When P12 authenticated her experiences of motherhood as the basis for professional sources of information to parents, the universality of white Western maternal knowledge was culturally reproduced and maintained. While we can appreciate that birth and motherhood are universal events shared by women around the world, without their historical and cultural context the terms become tautological (Young 1992). To explain this idea Robert Young (1992, p. 247) refers to Chandra Talpade Mohanti, who stated, 'That women mother in a variety of societies is not as significant as the *value* attached to mothering in these societies' (1984, p. 340).

Mohanty explains that the use of the word 'women', for example, as a stable category of analysis:

assumes an ahistorical universal unity between women based on a generalised notion of their subordination ... this move limits the definition of the female subject to gender identity, completely bypassing social class and ethnic identities. (ibid, p. 344)

To this end it is not helpful to assume a stable universal understanding of the category 'mother'. To do so would overwrite the multiplicity of each individual's historical, social and cultural positioning. In seeking stable common essences this application of humanism functions to override difference (Barthes 1972).

Universalising beliefs about motherhood

Understandably, participants commonly drew on personal beliefs about motherhood and womanhood to inform their professional practice in child health. For P18 these beliefs also constituted a truth claim about motherhood, women and the nature of parenting. Because of the emancipatory nature of these beliefs, P18 considered them the subject of universal desire and saw her role as liberator through education. She based these beliefs on liberal feminist discourse of equity. While an emancipatory agenda has accompanied nursing and midwifery practices in women's health for many decades, questions remain around some of the populist assumptions around equity and equality drawn in the following example.

P18 stated that *'in today's society ... mothers are really neglected, especially [with] funding and everything'* (interview 18 060317). She continued, saying:

I think a lot of it is taken for granted that if you're middle class or if you're intelligent, if you've got parents around you or whatever then you should be okay, they don't sort of factor in about the whole self esteem, tiredness, things like that. Even the fact that you're doing universal home visits it's pretty much trained that we're supposed to focus on the baby. I don't know, there just seems to be this gap there that it's almost taken for granted. And unless the mother is crying out for help then that's, I don't know, to me it's really neglected and I think from being a mum myself and not having, I'm not an alcoholic, Aboriginal, refugee whatever that we're supposed to be okay and get on with it. (Interview 18 060317)

It is fair to assume that mothering is at times difficult for most women around the world. From personal experience, P18 described a political belief that some aspects of motherhood such as self esteem and tiredness cross boundaries of race, class and social circumstances. As such, she believed that some aspects of motherhood were universal and should be attributed universal support.

P18 explained how she strategically brings this political and subjective truth claim into practice by placing the mother in the centre of the child health encounter. P18 said:

my biggest thing that I always hone in on as number one is maternal confidence and the general health because as I said you can have a happy healthy baby but if mum is falling down in a heap then everything will eventually fall in a heap, so right in on first contact I want to build a trusting relationship with the woman. (Interview 18 060317)

Maintaining a central focus on the woman/mother within practice provided P18 with a point of resistance in negotiating the private/public subjective/objective knowledge binaries. While the practice is family centred in nature, it goes beyond this idea to make explicit that parenting is a deeply gendered activity. This belief is authorised both professionally and within the domain of personal private experiences. In this example P18 saw herself as acting in a professionally responsible manner. She explained how she also enacts this knowledge when she runs Getting to Know Your Baby groups (GTKYB) groups, saying:

I always say, 'This is a group about mothers and that the babies are actually separate entities and they're the reason why you've come as a group but in fact it's a

mothers' group so you're here to support everyone as a mother'. (Interview 18 060317)

P18 explicitly told mothers that they are separate from their babies and that they have come to the group to focus on the separate self of woman within motherhood. This notion of separateness deserves exploration with clinicians beyond the scope of this study, as the most recent professional discourse of parenting and attachment suggests that for an infant to grow and develop psychologically they must be supported to experience life as deeply connected to their mothers and only separate off when they are developmentally able (Marvin et al. 2002). P18 alternately suggested that mothers must continue to view themselves as separate from their babies in order to maintain an individual sense of self. It could be said that in encouraging mothers to see themselves as separate P18 was privileging subjective knowledge over scientific knowledge, or that women's health knowledge at time conflicts with knowledge on infant growth and development, or that the literature and P18 are unsure how to advocate both at the same time, separate and connected.

I asked P18 where she thought this knowledge came from and she suggested that she had always been a *'kind of feminist'* (interview 18 060317). P18 was videoed doing a UCV with a mother, father, toddler, and interpreter. The family had immigrated to Australia from a Middle Eastern country. The mother was the most recently arrived family member. She brought with her their first born son and arrived in Australia before the birth of her new baby. The father had come some years earlier as a refugee. Following a period in detention he found employment and housing and was attending night school. Watching herself working with this family P18 explained how she uses knowledge from this *'feminist position'*. She said:

there are a lot of cultures out there who don't respect women and stuff, I suppose being kind of a feminist in a way that really sort of breaks my heart. So I suppose for me I see these opportunities, absolutely golden opportunities because you get to meet these women, and sometimes the women choose to stay in their own world, you know they don't want to change anything about the way they work but at least they get to see a different way of life. (Interview 18 060317)

Tenets of liberal feminist theory are those most often found in equal opportunity policy and practices. As well, they have long been advocated in popular culture as a valid and necessary position for the advancement of women in a predominantly male dominated society. However, like any other doctrine or belief system, they are

socially and culturally constructed. For P18, a middle class white woman, these beliefs were located from within a position of structural advantage or race privilege.

P18 saw it as her moral duty to work with women to improve their oppressed position in society. She used a liberal feminist argument to encourage mothers to see themselves as separate from their babies where there is no scientific evidence to suggest the mutual benefit of this practice. It may even contradict current research imperatives. However, for P18, helping mothers to view themselves as separate from their children enabled women to become independent and thus respected.

This desire for maternal independence may well stem from the historic feminist cause to liberate women from historical patriarchal practices. In Western nations such as Australia these have been present since early settlement where the growth of a nation was dependent on white mothers having white babies to raise a population of the 'best immigrants' (Mein Smith 1997; Smith 1978). Discourses of selfless motherhood were perpetuated into the 20th century through child care doctrines of Frederick and Mary Truby King (Truby King 1921; Truby King 1934) and Benjamin Spock (Spock 1946). In these approaches the baby took central place. A mother's position was subjugated within society and family by the needs of her baby. The mother was also called to account for all perils and untoward outcomes that befell the child's development.

In intercultural encounters, the liberal account of white women as saviour to less fortunate or less civilised women is long held. Introduced in chapter 3 nursing and particularly child and family health nursing were seen historically as platforms through which working class and unmarried white women could maintain and at times develop status through work. Key to this positioning was the misfortune of those for whom they were caring. The lower social position of the less fortunate other was key to maintaining the relatively privileged status of the white woman saviour. And, at the same time, these women were reminded of the consequences of fate that might befall any woman who did not conform to the societal norms of femininity and did not have an independent income. Where this history is primarily a critique of class, Inderpal Grewal (1996) used colour and ethnicity in critiquing how nineteenth-century English women used images of victimised Indian women to maintain the superiority of their English citizenship. Grewel argues that many contemporary feminists continue to enact these colonial relations by positioning themselves as free and enlightened. P18 saw the UCV as a '*golden opportunity*' to

show the mother *'a different way of life'* (interview 18 060317). As such, P18 positioned herself as free and enlightened, identifying the mother in some way as in need of emancipation.

In viewing herself working with this family, P18 said it *'breaks my heart'* (interview 18 060317), expressing a strong emotive response to her understanding that some cultures don't respect women. It also suggested that she saw this particular woman as culturally disrespected and/or subjugated. It is not clear from the transcript or my notes what P18 used as a cultural marker to suggest that this woman might be in this category.

Sherene Razack (1998, p.6), writing in North America, argues that female genital mutilation (FGM) and the wearing of a veil are the two 'arch-symbols' of Southern¹⁹ women's inferiority. These markers of difference signify women's bodies as victims of less civilised 'patriarchal culture or religion' to be 'saved by benevolent and more civilised Europeans' (ibid, p. 7). These markers have become so widely disseminated that there is little room for alternate or more complex understandings (Razack 1998).

P18 appeared to use a culturist approach to determine how she might understand the needs of this mother. In this approach historic and situated issues of gender, race and socioeconomic inequalities are played down in order to construct and problematise difference according to 'cultural' and ethnic affiliations (Culley 1996; McConaghy 2000). The veil worn by the mother may have signified to P18 that she might be oppressed within her cultural or ethnic group or even her family. She approached the consultation with concern and care. However, this concern perhaps arose from an unidentified and unspoken location of structural advantage and race privilege that left untouched historical and cultural power relations identified earlier by reference to Culley (1996), McConaghy (2000) and Razack (1998).

Of further interest is the nature of the information that P18 gave to mothers about maternal independence. Drawn from her feminist emancipatory stance, P18's instruction to mothers to experience the parent group independent from their infants was presented as a truth claim. What then are the potential consequences of enacting a social justice agenda underpinned by a liberal feminist ideology that espouses a personal and private belief as a universal truth claim?

¹⁹ Razack (1998, p. 6) explains how the media reports FGM as representative of a 'barbaric' South which incorporates 'Islamic' and Asian states and contrasts this presentation against a civilised North which claims Western superiority.

Emancipation has long been held as a goal of social justice and a wide range of civil liberties agendas, including feminist. Emancipation arises out of the critical paradigm and conflict social theories as a strategy to diminish social inequities. Social justice principles also underpin the policies and practices of the new public health and primary health care. There is nothing inherently wrong with enacting a social justice agenda in our professional work with clients less privileged than ourselves. Our organisations and government promote it as desirable. However, according to Razack, it is concerning when it is enacted without due consideration of the ideological and cultural assumptions underpinning our actions and the power relations inherent in the ensuing relationships. If we are unaware of these ideological foundations we cannot begin to consider how they produce and reproduce particular relations of power. Razack argues that that:

Encounters between dominant and subordinate groups cannot be 'managed' simply as pedagogical moments requiring cultural, racial, or gender sensitivity. Without an understanding of how responses to subordinate groups are socially organised to sustain existing power arrangements, we cannot hope either to communicate across social hierarchies or to work to eliminate them. (1998, p. 8)

P18 suggested that she attended to relations of power by physically sitting on the floor, thus placing herself on the same physical plane as the parent (interview 18 060317). While this was an important strategy of non-verbal communication, it failed to attend to P18's subject position of implicit liberator. According to Razack, this lack of appreciation of power arrangements will paradoxically mean that, continuing in this way, P18 cannot work to emancipate minority groups; she will instead continue to mark them as peripheral.

Imperative to this analysis is not only the unattended or unexamined nature of relations of culture and power but also the nature of the knowledge offered within the relationship. Examples include P18's knowledge on the separateness of mothers, P12's knowledge on infant feeding and P14's knowledge on the nature of sleep; all were drawn from subjective positions offered as universalised truth claims. Even though participants such as P19 suggested that information of a subjective nature was offered only when asked for, this assumption seems to deny the coexistence of multiple and competing knowledge claims or constructed knowledge of the subjected professional.

By determining which information is given to parents about how to raise children, child health professionals have a fundamental role in shaping and reshaping culture.

According to Love (1998), all knowledge, be it rational scientific, subjective or even constructed knowledge, inherently draws on the historical, social and political position of the knower. As such, the knower presents their constructed ideologies to parents on a daily basis. These ideologies put forward value laden claims about the nature of humanity, science, freedom and social justice. Liberal humanist assumptions of equity, individualism, and essentialism are deeply lodged in narratives of the participants presented in this thesis. Following Abdul R JanMohammed (1985), in child health practice it seems that humanistic assumptions are inadvertently used as a form of ideological control, whereby the essential nature of humanness is valued as only that of civilised western humanity. It is clear from the way participants talked about how they know about culture and communication in their work with parents that they have been exposed to few strategies that may assist them in such an examination of their practices.

Annette Browne (2001) argues that liberal concepts such as individualism, egalitarianism and political neutrality have shaped knowledge development in nursing. She proposes that these principles have 'diverted our attention away from social, economic and political structures and practices that give rise to inequalities' (ibid, p. 127). Liberal humanist ideology purportedly construes individualism essentialism and equity without regard to the contextualising social, economic and political forces within society. This gives rise to a paradox where outward commitments to justice, equality, and fairness exist alongside and in conflict with covert beliefs and values that result in discriminatory outcomes for minority groups (Browne 2001; Culley 1996; Henry & Tator 2006). The following section threads a consideration of democratic racism in child health communication alongside analysis of participant reflections on the nature of the information they chose to give to parents.

Locating Western ideologies

In child health, much knowledge is based on the best available research evidence, such as nutritional requirements of infants and the benefits of breast feeding (see, for example, National Health and Medical Research Council 2003). Evidence based practice (EBP) brings a three pronged approach to the management of knowledge in practice by combining clinical expertise and patient values with the best available research evidence in order to better meet individual needs (Sackett, Straus & Richardson 2000). By using clinical expertise, child health professionals are encouraged to enact knowledge they have reflexively learned in practice, and link

this with the best research evidence available while remaining mindful of the health beliefs and values of the client. Courtney (2005) suggests that health professionals take a critical approach by asking questions about practice, systematically searching for answers to these questions, applying evidentiary knowledge at the clinical interface, and then evaluating the effects of this evidence informed care.

Often, knowledge gained through professional channels such as courses or from other health professionals on-the-job are accepted as truth claims without critique. During a home visit with P4 I observed the mother asking how to make her baby sleep for longer periods. P4 told the mother that the best way to do this was to wrap the baby to sleep. She explained that wrapping keeps the baby's arms down and stops the baby from startling, therefore the baby wakes less often. Returning to the office in the car I asked P4 why it was that she gave this particular information to the mother and not other ideas about how to encourage a baby to sleep longer. P4 replied, *'I hadn't really thought about it, it was said to us in the course'* (field note 050729). P4 was referring to a professional qualification in child and family health that she had undertaken five years earlier. Rather than appreciate the evidence base for the practice, P4 understood wrapping as best practice because she remembered being told about it in the course.

For another example, I return to P19, who was cited earlier as guarding against imposing her own values onto parents by only giving personal information if requested to do so by a parent. P19 explained the conflict she experiences in determining the content of information to give parents and the cues she uses in determining this choice. She said:

I would hate it if someone came in and said 'well this is how I believe you should be doing it' [parenting] or 'this is how I was brought up', I don't think it's advantageous, I don't think it actually helps anybody if we're all putting our two bobs worth in unless it's warranted, unless they've [the client] said 'well how did you do this?' or 'what would you think?', and if they say 'well what would you think?' then I would take that as a cue that I could put my feelings towards that. (Interview 19 060328)

It seemed that, for P19, offering one's own opinion is synonymous with a dogmatic or directive approach that tells a parent what they should do. She did not seem to recognise that subjective content can just as easily enter a consult without the sledgehammer of a dictatorial approach. P19 said that there were times when subjective information is *'warranted'* but believed that there is a clear delineation around when this might happen.

During the videoed consultation the mother said she was concerned that her baby might be too hot. P19 gave the mother information about how to tell if her baby had a fever that warranted taking the baby to the hospital. As a paediatric and child health nurse, I was not familiar with the content of the information given. I was curious about where it came from and wondered if my own knowledge may be out of date, so I asked P19 where this information might have come from. P19 explained that her ideas came from something that *'they'* always did it at the hospital (interview 19 060328). P19 reflected that things might have changed since then, but did not stop to critique the relevance of her material or reference it with formal sources such as the practice guidelines available to all staff on the CYH website. Because her information was originally gained in a professional context it was accepted a static rational truth and thus authorised to offer to the parent.

From observations of practice, when a parent asked a question such as *'how would you do this?'* or *'what do you think?'*, the *'you'* they were referring to was the multiple embodied persona of the child health professional, who at once occupied a place of child health professional who also brought with them a range of life experiences. In relation to making judgements about the quality of evidence for practice, these child health professionals seemed to confine themselves to a narrow interpretation of what constitutes authoritative evidence for practice. In doing so, they continued to deny the intrinsic presence of the personal alongside the professional. They also seemed unsure of how to manage the veracity of knowledge developed over time from expert practice.

This knowledge, sanctioned as truth because of its origin within professional encounters, sat alongside knowledge claimed from the personal and private sphere of mothering. Both encountered no inquisition into the evidence surrounding their usage. Knowledge in these situations was taken for granted or assumed to be commonsense.

Stuart Hall states that culture is 'the contradictory forms of "common sense" which have taken root in and helped to shape popular life' (1986, p. 26). Through child health practice, popular life in Australia is shaped by the commonsense knowledge of predominantly white women child health professionals. Commonsense, used in this way, is problematic because it is more often than not falsely attributed as scientific knowledge or, where it is claimed as personal, it is most often validated as a truth claim by universalising the experience of motherhood. The motherhood that is universalised is that of white Western society. Ruth Frankenberg states:

White women are, by definition, practitioners of white culture ... Whiteness as a set of normative cultural practices, is visible most clearly to those it definitively excludes and to those whom it does violence. Those who are securely housed within its borders usually do not examine it. (1993, pp. 228 - 229).

Of concern to those parents located in minority cultures in Australia is that there is no place within child health professional pedagogies, nor within organisational structures, to examine the taken-for-granted nature of this commonsense knowledge. P8 noted from personal experience that it is not until you go to a different country that *'you realise how much of what we do is actually our culture'* (interview 8 051123). When we know that culture and cultural ideology is mostly unrecognised and unexamined (Frankenberg 1993; Henry & Tator 2006; Heywood 1992), how can we manage it without understanding its base?

Critiquing knowledge for practice

Participants explained that they had little opportunity to reflect on practice, and no opportunities were observed where participants could examine ideologies or belief systems that shaped practice. I did not need to ask participants about their opportunities for critical reflection on practice. The research process of videoing consultations followed by reflective interviews prompted participants to explain how they had little opportunity to reflect in meaningful ways on their practice. P10, for example, said of watching herself on DVD, *'We don't really do any peer appraisals anymore, we used to but we don't do that anymore'* (interview 10 051128). P10 also explained that peer appraisals could not really be relied on as effective appraisals because team members tried to maintain the status quo. She explained that managers previously had a role in assessing practice but that this was no longer the case (ibid). Participant responses can be summarised by the words of P5, who said, *'I guess one of the big disadvantages of doing things on our own [is that] we're not getting this outside ... peer review on what we're doing and this I find is useful'* (interview 5 051025).

Participants primarily talked of organisational or structural barriers to reflective practice, suggesting that there was no time or staff allocated to take on the role of clinical supervision to facilitate critical reflection. Sonya Osborne and Glenn Gardner confirm that few Australian health care organisations provide the 'infrastructure, resources, support and incentives necessary to develop and sustain a culture of inquiry' (2005, p. 136). Participants used case discussions to review client needs but

not necessarily to critically review practice. Reflection on practice was observed to be a peripheral aspect of a case conference undertaken only if people chose to take it up, if there was enough time, and if the social worker chairing the group was amenable to it. They reflected more on actions and outcomes for clients rather than on their own or others' beliefs and values (memo interview 3 050920).

This structural problem is only one of a cluster of reasons why there is not a clearer culture of inquiry in the workplace. Participants were not observed at any time to challenge in constructive ways the dominant sources of scientific knowledge purported as truth within the child health environment, nor were they observed at any time to question their own subjective understandings presented to parents as truth claims. By doing this they did not step into the authority of their role and as such did not advocate for clients who presented with parenting and child health frameworks outside the normative standards dominant within the organisation.

Evidence based practice may be a useful platform from which participants might reflect on the nature of knowledge used to give information to parents. It is purported as not only making decisions based on scientific evidence but also considering patient values and clinician expertise, thus moderating and contextualising science. Even though its presentation is multimodal, like other theories of scientific and psychological knowledge it continues to leave unattended the ideologies and cultural context of the health practitioner. Perhaps it assumes, as does the Parent Advisor Model, and transcultural approaches to care, that the child health professional self has been examined thoroughly within the domain of 'clinical expertise'. Unless this is explicitly attended we are more likely to assume that the ideology of the health practitioner is assumed to be within the normative white Western standard and thus not subject to investigation. In this case, the way in which evidence based practice is approached within the organisation might not be sufficiently rigorous to critique the ideologies underpinning knowledge given to clients as truth claims. As such, the status quo will remain and normative white Western standards will prevail, relegating differences of knowledge to the margins.

Summary

In this chapter I have primarily presented two colliding realities or bodies, that of professional knowledge publicly declared and that of knowledge formed within the private sphere of the cultured self. Generally participants tried to fit themselves somewhere along the continuum, trying to present publicly using professional

rational knowledge while guarding against letting in the complexities of self, then paradoxically locating at the private end of the binary by giving personal information and claiming its universal application. While trying to locate themselves within the rational scientific axis of the binary, participants experienced a constant pull to incorporate knowledge from the professionally personal end of the binary deemed unethical because of its potentially value laden content. The problem of determining which knowledge to give to parents was magnified by the very nature of binary thinking that reaffirms an oppositional position of personal private knowledge against what little is sanctioned as scientifically correct.

Within Western systems of reason we are all conditioned by a 'metaphysic of asymmetrical binaries' (Hodge 2005, p. 119). Binary systems dominate scientific reason and professional practice, which we are encouraged to apply to all aspects of health care, including knowledge about how to raise and parent a child in Australia. On one hand, participants claimed to give parents only correct information that has an evidence base and is considered through the eyes of clinical expertise. By doing this participants guarded against bringing personal knowledge into the professional domain as required by professional competency standards (Children Youth and Women's Health Service 2006a).

Scientific knowledge is valued within professional discourses because it claims truth without intersections with race, gender or class. Knowledge is applied 'regardless' of these considerations. It is this construct to which participants aspired. Personal knowledge crept in unexpectedly, however, and was at once denied in order to maintain a belief in one's position of giving only authoritative health knowledge that has its basis in scientific reasoning. Yet personal knowledge was also expressed as highly valued due to its capacity to provide depth of experiential understanding to parents. The most common subject position from which personal knowledge was offered was that of mother.

Ironically, participants offered knowledge derived from their own experiences of motherhood as if it were universally acknowledged as rational, which scientific knowledge is assumed to be. While some aspects of birth and motherhood as events in women's lives may be universalised, the way people experience and live birth, motherhood and parenting is deeply cultured. Mothering and parenting are complex cultural and embodied experiences that constantly intersect with race, class and gender. When personal knowledge is assumed as generalisable it becomes racist practice by overwriting the subjected knowledge of others with truth

claims from within the dominant cultural group. Participants assumed the universal validity of middle class white women's knowledge as desirable to all those mothers and families located at the margins.

Participants relied on a range of humanist discourses to defend the choice of information given to parents. Individualism was called on to prevent stereotyping parents into a particular ethnic collective, rather than actively working with the dynamics of culture. In doing this participants paradoxically overwrote cultural considerations with those from the dominant white cultural group. Humanity was essentialised to argue a narrowly interpreted appreciation of equal place for relations of power between professional and client. In doing this, participants mistakenly believed that they transcended power and judgement, thus removing any personal responsibility to acknowledge and examine the inevitable and inherent asymmetries always present in relations of power between dominant and minority groups and health professionals and those receiving care.

Liberal feminist discourses were also called on to justify information given to mothers. Mothers who were marked as culturally different by symbols such as wearing a veil were assumed as subject to paternalistic cultural and religious regimes. Again, applied universally, this discourse presented child health professionals as democratically racist. They positioned the mother as in need of emancipation, thus reinforcing their own position of superiority; child health professionals assumed they were capable of rendering that help.

In using these humanist discourses to justify the content of information given to parents, child health professionals left relations of power unattended. Participants used concepts of power in modernist terms, where power is seen as tangible and can be held and given in the form of child health information and emancipation. There was little evidence of understanding about how the micro-dynamics of power operated within the professional relations these participants conducted with mothers and their families. Power/knowledge is interwoven into all communication interactions. While participants recognised at times the power/knowledge inherent in scientific information given to parents, they did not apply the same considerations of power when giving information that is of a subjected nature. Both of these sources of information at times represented an unrecognised and unexamined agenda of assimilation into normative white Western parenting practices.

Knowledge, while understood as existing within a binary, is always acted upon by other factors. In this chapter I have explored a range of other factors or third bodies, such as discourses of humanism including individualism, essentialism and equity. Relations of power were demonstrated as ever present even though participants attempted to transcend or neutralise this presence. A three body analysis allows us to recognise that the plurality of personal knowledge or the cultural self always overlaps professional knowledge, that we need not only align ourselves with one or the other. We see instead the possibilities in a kaleidoscope. For, in denying the existence of the value of personal knowledge, we may become blinded to how and when this knowledge creeps in or seeps out and how it can be held but not hidden.

Of particular interest is the fact that the notion of judgement presents as a tangible third body that can be understood, like constructed knowledge, as ever present. Judgements are not always negative and need to be incorporated into practice. It is much easier to recognise a judgement made for a publicly declared professional reason, such as when to introduce solids, than to judge the veracity of private knowledge such as disguising fresh foods in tinned food drawn directly from personal experience.

We place a value judgement on the worth of these private ideas when we give the information, otherwise we wouldn't give it. How can we maintain our professional claim to being non-judgemental when we constantly bring the private knowledge of the cultured self into the consultation?

Observations of and discussions about practice suggested that there are avenues to determine how to value information drawn from professional sources such as evidence based practice, but in viewing a three body system there seems to be no platform from which to assess the worth of information drawn from personal life experiences. If we could claim that personal life experience of connected knowing did not have a place in child health practice this would not be necessary, but this chapter has demonstrated that all practice is influenced by the multiple subject positions taken up by child health professionals as cultured beings. Professional discourses based in the modernist paradigm of all things linear and rational, such as Davis et al's (2002) instructions to be non-judgmental, while well intended, are, in the reality of practice, not possible. This call only considers a positioning at the professional end of the binary. Employing a kaleidoscope of three bodies as a metaphor of the colliding scopes of practice might help us think about how practice

can be enhanced by reconsidering taken-for-granted discourses of care, such as trying to be non-judgemental.

In making judgement calls about the quality or substance of knowledge, we always draw on complex and unexamined ideologies. If we were to recognise through a three body analysis that judgement and thus ideology always and evermore exist with knowledge, we create a kaleidoscope of possibilities where professional practice becomes the art of possibility. This kaleidoscope compels us to examine ideologies and their relationship with the multiplicity of knowledges that we construct over a lifetime. Unattended values and beliefs will continue to influence the information given to parents in unobserved ways and thus continue as ideological control, where the essential nature of humanness is valued as only that of civilised Western humanity, and democratic racism will continue unchecked.

CHAPTER 12

RE - VIEWING A KALEIDOSCOPE: SUMMARY AND RECOMMENDATIONS

In this final chapter I draw together the discussions and findings of this study into intercultural communication in the child and family health setting. I consider how we might work towards a kaleidoscope of possibilities to value the plurality inherent in multicultural and constructively manage the relations of power inherent in all intercultural communication encounters.

While exploring with participants the interconnections of theory, practice and use, I identified binaries related to professional ideologies, identity, and approaches to communication and knowledge. Within these I explored the composition and applications of discourses of intercultural communication in child and family health. Key ontological and epistemological positions within dominant discourses of intercultural communication seemed to reinforce the way participants enacted binary thinking during intercultural communications.

Exploring with participants their personal ideologies and how they learned about them, I found that professional discourses seemed to reinforce broader ontological positions developed through early childhood socialisation and adult experiences of national and international events. These ways of being in the world were mostly underpinned by a liberal humanist thinking, dominant in Western culture. At times the binaries within this paradigm acted to limit intercultural communication in the provision of child and family health care. Further, this discourse appeared to support acts of democratic racism creeping into the practice environment unnoticed and unmarked.

Binaries and boundaries are ever present. It was not the intent of this study to destroy or replace the binary with another construct, nor to simply invert the binary. Rather, it is necessary to have strategies that help develop new ways to work with and unsettle the normative position of these binary formations. I have looked for alternate ways to read and disrupt the binaries. Further, I looked for tools that might support a reflective practice for future use, a practice that enables child health professionals to interrupt binary thinking, making a kaleidoscope of possibilities available at any one time. In this way we might value the multitude of possibilities of raising children in a multicultural.

This final chapter is presented in four sections. Firstly I summarise the theoretical and methodological arguments that underpinned this research into culture and communication in child and family health. Findings from being with participant child health professionals as they communicated with parents who were culturally different to themselves in the everyday world of child and family health are summarised in the second section. In this section I present the central arguments within each of the following collisions: professional philosophies, identity, approaches to communication and knowledge about child and family health. I reflect on the challenges presented when binary thinking informs practice. I then summarise key findings. Finally, I present recommendations arising from this study. Considering the nature of critical inquiry I looked for ways that might support child health professionals to recognise and work within relations of power and privilege in intercultural communication encounters. Taking direction from feminist postcolonial theoretical perspectives and three body analysis, I considered how child health professionals might develop tools for reflection that have the possibility to unsettle the binaries within philosophies of practice, identity, approaches to intercultural communication and knowledge of child and family health.

Section 1: Reflecting on the beginning

To begin this thesis, in chapter 1, I presented a case for the need to investigate intercultural practices in the core area of communication in child and family health practice. Children and women, particularly those in marginalised positions of difference, continue to experience health inequalities. I found that the majority of research designed to facilitate change in intercultural practices has focussed on researching the cultural other, to increase depth of understanding of the nature of difference. While this focus is at times useful it also acts to reinforce the borders of difference and the imbalance of relations of power.

Analysis of literature in chapter 1 demonstrated that reinforcing the borders of current practice is unhelpful when a parent is trying to navigate and accommodate new cultural understandings alongside the deeply held socialised knowledge of their country or countries of origin. Following the birth of a baby parents who are also migrants are particularly vulnerable and may also be experiencing the intense emotional consequences of relocation and dislocation. This is intensified when parents may have been relocated by force, spent long periods in refugee camps or detention, and may be grieving the death or loss of loved ones, country and

community through war. Parents in this position are seeking to accommodate the multiple opportunities of a kaleidoscope.

The methodological approach of critical inquiry described in chapter 2 situated this research as transformative. Influenced by a postmodern recognition of multiplicity of meanings, emancipation is understood and enacted as a joint exercise or partnership between individual and community. How relations of power are understood and enacted by child health professionals in intercultural communication encounters is core to both an emancipatory and decolonising agenda.

A central focus of this study was to turn the critical gaze onto child health professionals who work with parents who are different to themselves. A feminist postcolonial framework enabled this approach, along with analysis of data across the intersecting axes of race, gender and class. Coming to grips with theoretical constructs in a clinical environment is not always easy. Three body analysis offered a tangible way to unsettle the binaries at work during intercultural communication. Through three body analysis it became possible to visualise how bodies, or positions or ideologies, move and change in temporal spaces as they collide or engage with a range of possibilities. Together, postcolonial feminist inquiry and three body analysis became a decolonizing strategy, in the child and family health workplace, where binaries can be deconstructed, critiqued and reconstructed to more clearly represent the multicultural that is Australia (Grant & Luxford forthcoming).

Through the use of ethnographic methods such as participant observation, video recording and reflective interviews, this investigation is demonstrated to have been undertaken with rather than on participating child health professionals. In this way the study resisted a colonising agenda of epistemic violence against the cultural other and a group of predominantly women child health professionals. By looking at taken-for-granted assumptions about intercultural communication I was able to explore with participants the relations of power and attitudes that shaped practice. While chapter 4 demonstrated that there was a body of evidence that addresses development of cultural awareness, there is little research evidence to suggest how health professionals construct their approaches to working with cultural difference, nor how these constructs intersect with everyday practice.

In chapters 3, and 4, I created a background to contextualise the research and research findings. In chapter 3 I argued that Australia's history of colonisation has

deeply influenced contemporary child and family health practice. The effects are ongoing. Throughout history, new settlers to Australia of various Anglo origins experienced a health service focussed on the survival of infants in order to 'grow' whiteness in Australia. The nature of this health care included normative white scientific practices of maintaining hygiene in artificial feeding, cleanliness and moralistic teachings core to the maintenance of civilised white Western society of the time.

At the same time, Indigenous families and their children had markedly different experiences. Under colonisation Indigenous Australians experienced the full wrath of various agendas of protection and assimilation which resulted in unprecedented genocide of Australia's Indigenous peoples (Human Rights and Equal Opportunity Commission 1997). Those who survived experienced, under an agenda of welfare (not health), the forced removal of their babies and children, which led to decimation of family, community and culture.

Migrants to Australia who were not of Anglo descent were in a precarious in-between place of neither coloniser nor colonised. There is little historical documentation about the specific experiences of these people's child and family health. It seems as though their colonial histories were subjugated into that of the dominant white colonisers of the time.

In chapter 4 a critique of child and family health practice was applied to contemporary governmental and professional discourses of care. In South Australia child and family health services operate in a public health paradigm. In this paradigm the goal of health care is illness prevention and health promotion through primary health care, community development and surveillance. While health professionals from a range of disciplines are involved in enacting the public health agenda, the majority of face to face care is carried out by community child and family health nurses. In this chapter, therefore, I focussed attention on how nursing competency standards support the practice of child and family health care in a public health paradigm.

Nurses have a key role in the delivery of early childhood services in a public health model. Analysis of Australian child and family health nursing competency documents suggests three core approaches to enact a public health agenda. These are primary health care, population health and partnership. Further analysis of these

documents alongside organisational and government policy frameworks suggested conflicting understandings and applications of all three terms.

Analysis of competency standards indicated that nursing's commitment to primary health care practice is ambiguous and often limited to a selective approach to primary health care. This potentially restricts child and family health nurses' ability to engage fully in the new collaborative public health model of early childhood services. A selective model of primary health care relates primarily to individualised health promotion and intervention based on outcome targets rather than comprehensive care designed to address the broader social determinants of health. Care is mostly determined through a population based strategy that calls for universal care but offers instead universal contact and targeted health interventions within a primarily medically modelled system. While the concept of partnership is advocated it remains ill defined for practical use.

In chapter 5 I situated current understandings and applications of culture and communication in the healthcare workplace. I demonstrated how relations of language, power and culture are inherently entwined and central to all health care relationships. Culture is defined as an assemblage of imaginings and meanings constructed and reconstructed over time. These are the meanings and imaginings that people make of their everyday experiences in the world as they constantly negotiate structural formations and experiences. As such it remains fluid and always occurs within relations of power.

In reviewing the literature on pedagogies of intercultural care for practice I found a dominant focus on transcultural care and cultural competence. A postcolonial critique of transcultural care showed that it reinforces rather than transforms imbalances of social order. As a model it leaves unattended historic and situated issues of gender race and socioeconomic inequalities. Further, this approach plays down socioeconomic inequities. In doing so it constructs cultural difference as problematic.

Cultural competence, as the recognised approach to intercultural care in Australia, flags the importance of self awareness. However, this awareness is only in as much as one can use it to understand the cultural other. It leaves unattended the deeply cultural nature of identity and the way this plays out in all interactions. As such cultural competence returns to a culturalist approach of transcultural care.

Cultural safety stood out as an approach that centralises the need for health professionals to develop critical cultural self awareness. Core to this is an understanding of the unequal distribution of social privilege attached to race and ethnicity within our society. While cultural safety was designed in the bicultural context of New Zealand, I follow Polaschek (1998) in using principles of cultural safety as one of the lenses through which to view intercultural communication practice.

The preferred model of professional communication in South Australian child and family health is the Parent Advisor Model (PAM) (Davis, Day & Bidmead 2002). Critique of this model in chapter 4 indicated discourses of liberal humanism which purport notions of individual freedom and agency. However, in this discourse, agency is accessible only when difference is manifested as sameness. The PAM is underpinned by modernist assumptions of a universal self, constructed within an individual/collective dualism. It does not make explicit the ways in which a self is discursively constructed in response to multiple available subject positions.

In chapter 4 I drew together culture and communication using Hall's (1997a) systems of representation. Through this system Hall demonstrates how language is the medium through which we make sense of things, in which meaning is produced and exchanged. Language is central to culture as culture cannot be represented or reproduced without communication.

Current approaches to culture and communication in child and family health, as critiqued in chapter 4, seemed not to account for the constructed contextual and fluid nature of the individual (whether professional or client) as cultured.

Section 2: From collisions to kaleidoscope

In this section I present key findings from analysis of ethnographic data reflecting the everyday experiences of child and family health practitioners, gathered from two sites of a state wide child and family health service. Data included field notes, video recordings of intercultural communications, and in-depth interviews following viewing of video data. Data was deconstructed to formulate possibilities of meaning around how child health professionals approach intercultural communication and the content of information shared with parents.

From this process I found that participants seemed to enact practice through the use of binary constructs such as 'us and them', referring to the organisation and

themselves as practitioners; 'sameness and difference', referring to the identity of themselves and the cultural other; 'expert and partner', referring to approaches to communication; and 'public and private' referring to the nature of child and family health knowledge. The first two of these themes represent broad societal, structural and professional influences on intercultural communication, while the second two relate more specifically to the processes and content of intercultural communication at an individual level.

Child health professional participants, like all of us, seemed conditioned from early childhood experiences and societal and professional discourses by a metaphysic of asymmetrical binaries. The effects of professional education seemed to have little effect on these ways of thinking. As such they continued to look for spaces within the binary to legitimise practice. Constrained by binary formulations, intercultural practice was found to be at times democratically racist, perpetuating a colonising agenda of assimilation and privileging Western ways of being and knowing about parenting and raising children.

From a feminist postcolonial perspective, McConaghy (2000) argues that it is no longer always helpful to use dichotomies to illustrate the differential power relations and life experiences of those in colonial contexts. She suggests rather that we consider the specific nature of specific oppressions at specific sites to understand current forms of oppression (ibid). Migrant parents do not fit neatly into the coloniser/colonised dichotomy. They present rather as perpetual-foreigners-within (Nicolacopoulos & Vassilopoulos 2004). In this study oppression is specific to the site of the child and family health centre. The specific oppression is the legitimacy of diverse cultural knowledges of parenting and raising children held by parents who are migrants.

To make sense of dichotomies in child and family health practice I drew on Hodge (2005), who suggested that, despite post-Derridean influences, binaries have not been sufficiently unsettled to mark changes in application of theory to practice. Hodge theorised a way to understanding the complexities of oppressions in a particular site. Expanding Bhabha's (1994) notion of cultural hybridity as a space *in-between* coloniser and colonised, the deconstructive strategy of three body analysis encourages a reflexive viewing of the confines of binary thinking. It helps to shift thinking to a location from which we are able to understand the complexities of the intersection between two, three and many more competing and interconnecting points. Further, by taking the analysis outside of the binary, three body analysis

contends with racialised interpretations of hybridity as a mixture of two opposing points of sameness and difference in which difference is always marginalised against the normative dominance of the central position of sameness.

In this thesis I have argued that by drawing on one or more *third bodies* we might unsettle the collisions of binary constructs that work to constrain intercultural communication. The presence of a third body invites the complexities of multiculturalism into the intercultural communication encounter. It accommodates the coexistence of differential power relations and life experiences within specific oppressions at specific sites as implored by McConaghy (2000).

Using three body analyses gave me the idea to use the metaphor of a kaleidoscope. In a kaleidoscope binaries continue to play out but can be unsettled as the various points or bodies interact with the other multiple competing bodies that are often unrecognised, misunderstood or ignored.

Philosophical collisions: Us and them

The first collision presented locates the specific philosophical challenges of practice experienced in the site of practice and within professional understandings of practice. Unlike others, this chapter specifically addresses issues related to child and family health nurses, as they form the majority professional group in this area.

The collision between perceived beliefs and goals of practice between child health nurse participants ('us') and the organisation ('them') was perhaps more noticeable than it otherwise might have been because of the changing times in which data collection took place. Premised on population based strategies to explicitly address health inequities in child and family health, the organisation where the data was collected was in the process of changing service delivery. This change was from a community approach where child health nurses understood themselves to work in teams to meet individual and locally identified community needs, to a combined strategy of universal individual interventions and long term targeted care for those families where children were identified as vulnerable to risk.

Child and family health nurses primarily understood working in *community* health to mean engaging in broad social engagement leading to building community capacity and social capital. While they understood this to be the way of working to meet community need, the most in need regularly slipped through the cracks. In the new population based approach they experienced their links to community being

significantly reduced. This was interpreted as the organisation limiting and constraining their role. Other than those involved in family home visiting, the role of child health nurses was contained to the family home of a client or the child health centre clinic. The role of community engagement appeared to be transferred to social workers and cultural consultants. Child health nurses' capacity to develop ongoing meaningful relationships with parents was limited by what appeared to them to be a fragmentation in service delivery and a prescribed approach to health needs assessment. These changes fuelled a collision of professional ideology between child and family health nurses and the organisation; between 'us' and 'them'. This binary represented a challenge to the core identity of caring held by child and family health nurses.

In chapter 7 I described this binary as operating on two levels. At a structural level changes to a focus on universal service delivery were understood by participants as serving political and fiscal agendas rather than the identified individual needs of parents within their communities. The discomfort of this binary was increased when portrayal of their service through popular media did not match their personal experiences of fragmentation and frustration.

The binary also played out at an individual level during the child health consultation. Increased level of practice directives were felt to limit scope to engage with parents to build relationships and follow through with clinical management. Participants felt compelled to perform in more routine and prescribed ways with a greater focus on bureaucratic tasks. This agenda conflicted with participants' sense of themselves as agents of community care rather than providing prescribed care in the community.

The organisation addressed infant health care outcomes on a continuum. Through a system of universal contact they identifying those in greatest need and who might best respond to an ongoing program of sustained home visiting. In practice, this meant that child health nurses who had previously enjoyed a multifaceted approach to care were fractured into being allocated, for example, to do only universal contact. This was experienced as repetitive and reductionist in scope. This reinforced a professional divide between nurses in the sustained home visiting program who were elevated to a position of highly trained professionalism and those delegated to repetitive generic tasks. It was not the purpose of this thesis to investigate the structure of work, but rather to note that the upset about work changes had important effects on how child health workers thought about their work in intercultural communication.

For example, participants experienced great frustration when this system prevented them from finding spaces to provide individualised care to those families who did not fit the assumed norm of a family referred to mainstream services, or did not fit the definitions for high need in the sustained program. I critiqued this problem through the lens of McDonaldisation, put forward by Ritzer (1993). Following Ritzer, the organisational approach seemed to manifest in homogenisation of the *customer*. The customers in this study were predominantly mothers who did not speak English or have the agency to navigate a complex Western health system. Because of this system, these mothers were understood by child health nurses to be disadvantaged. The system was experienced by these nurses as not accommodating the social construction of race or address issues of privileged and structural racism within practice.

To understand the binary expressed by participants as us and them, I argued that the organisational centre lacked what the supplement of nursing practice marked. To fully define and confirm its identity the centre needs what the supplement offers. The organisational structure at once relies on the skills of child health professionals in meeting the individual needs of clients within the scope of the structure yet at the same time seems to limit the scope of this engagement.

Within this binary many nurses found ways to exercise power in liberatory ways through discourses of care. Personal experience and belief in the importance of motherhood enabled them to enact care despite structural impositions. In doing this they actively resisted organisational limitations. However, much of this resistance was not organisationally sanctioned. Understandably, this was not a position of resistance that all felt able to assume in a professional capacity. Some participants colluded in their own subjugation by calling on organisational limitations as the reason for their inability to enact care. It seemed that nurses found little space, nor did they create spaces where resistance could be enacted as care in an authorised way.

In this chapter I called on discourses of care as a third body to draw out the binary of us and them. Participants could enact care in ways that reinforce the binary of us or them, but they could also enact care in ways that harnessed relations of power. When participants privileged notions of care, empathy and compassion by owning and acknowledging those personal experiences and beliefs that framed their construct of care publicly, they harnessed relations of power. In doing this they were

no longer colluding in their own subjugation; they rather step fully into the authority of their role.

Having identified a third body the goal becomes how to support nurses to claim care, empathy and compassion in a practice world that appears to relegate care to the margins. In stepping into their authority nurses thus empowered can empower parents, particularly parents relegated to universal care when their needs are clearly not universal in presentation. New arrivals of migrants to South Australia experience this gap in care. Nursing often claims legitimacy through focussing on intellectual scientific content. In another epistemological collision this has been undertaken at the expense of its unique efficiencies of care. Like and cultural identity and constructed knowing (discussed in chapters 8 and 11), ubiquitous notions of care are devalued by the profession and as such not offered the same scholarly inquiry as the more 'rational' subject of intellectual property.

Collisions of identity: Sameness/difference

Identity was understood by the majority of participants as a choice within a binary of sameness and difference. There seemed to be little place for the mutual coexistence of both sameness and difference. Calling on the essential nature of humanity, participants wanted to imagine parents as being essentially the same while on the other hand they identified a need to treat parents as individuals and therefore different, but not so much that they might make parents feel uncomfortable because of this difference. These deeply constructed and polarised ideologies did not enable the presence of multiplicity within intercultural communication.

Participants spoke of wanting to treat people the same. This seemed to mean with equal respect, and the same way that they would like to be treated themselves. Participants also spoke of treating parents so that parents might become more like themselves. Interestingly, the majority of participants struggled to identify what this same self might be.

This resulted in child health professionals presenting as colour-blind in intercultural communications; unable to identify themselves as cultured, or to articulate what it is to have an Australian identity, or to recognise relations of power embedded in communication interactions, or to recognise the complexity of culture and its effects for the parents they worked with.

In chapter 8 I developed the construct of whiteness and demonstrated how it seemed to delimit intercultural communication. Firstly, whiteness as an epistemological a priori restricts the multiple subjected positioning of child health professionals and, secondly, through limiting perspectives of the world, whiteness incites child health professionals to deny the identity of others. Most importantly in the intercultural communication encounter, whiteness provided a moral haven of normality that prevented health professionals from attending to the racialised nature of power and privilege.

Within a shelter of whiteness, participants experienced multiculturalism from an external or observational position. Participants used three main themes to explain how they experienced multiculturalism. These included fear, personal enjoyment and active political disengagement. To understand how these positions interacted with difference I introduced the notion of schismogenesis. Schismogenesis is useful to understand how racism comes into being. Most of the time we believe ourselves to be non-racist because we are tolerant and accepting of difference. The construct of symmetrical schismogenesis illustrates that racism can be as easily expressed through discourses of sameness.

In a colonising society such as Australia, it can be argued that all peoples who are not Indigenous Australians are migrants to this country. When a politics of fear is introduced into the normative white society through the creation of non-white, non-Christian 'folk devils', we assume this racism is based on difference. It could be, that if we were to critically examine Australia's violent cultural heritage of settlement/invasion, we could imagine that racism might be based on our own fears; like our forebears, these *new* Australians might be looking to resettle or invade life as we know it. This insight might be helpful for child health professionals to challenge their understandings of racism as a problem of difference. Adding schismogenesis as a tool within intercultural communication practice might engender scope for reconciling difference, where difference itself is seen and valued as a resource for change and building relationships

Sharing external cultural markers such as food and clothing seemed to provide a space for cross cultural learning and engagement. However, taking up and enjoying the external markers of a culture other than one's own brings with it ethical and moral challenges of an epistemological nature. Further, it raises questions regarding authority and relations of power. To examine this dilemma I explored Hage's (2000) assertion that good white nationalists and good white multiculturalists display

tolerance for difference and enjoy difference where it reinforces their own self-identity. It became evident that child health professionals as good white multiculturalists did not always appreciate that they were in a position to choose their engagement with cultural difference, and were not always marked by experiences of racism or socioeconomic disadvantage.

Perhaps examination of the construct of *good white multiculturalist* might offer another tool for child health professionals to critique their use of authority within intercultural health care encounters. It seems that when whiteness is assumed as normative within multiculturalism, there is no requirement for child health professionals who are white to assume a position of anything other than political neutrality. Child health practice is underpinned by theories that seek to treat people the same *regardless* of difference. These discourses of liberal humanism reinforce the moral safe haven where child health professionals are not required to question government policies regarding multiculturalism or how these intersect with their everyday work in a multiculturalism.

While many child health professionals recognised their struggle to balance on the axis of sameness and difference, they practised in an environment where the hegemonic discourse of health is biomedical. The dominance of this underpinning paradigm seemed to deny them a language of interpretation and an infrastructure within which to work *regardfully* with difference. One of the key functions of biomedical discourse is that it seeks to distance the self from contexts of socio-political and gendered personal and collective histories. A further problem for nurses was the prevalence of transcultural theories that aim to understand the exotic other and in doing so compound unchallenged notions of normative whiteness, perpetuating marginalisation of the cultural other.

Whiteness appears to be privileged in community child health practice, where it exists as an unexamined taken-for-granted way of being in the world. To reconcile difference, it would be helpful for child health professionals to find a language through which to name and critique whiteness as part of their cultural constitution. Inherent in this constitution is Australia's colonising history of child health and welfare, and the entwined imbalances of power relations along the axis of race, class, gender and ethnicity. Intrinsic to this construct are understandings of how liberal humanist discourses neutralise requirements for political critique of communication discourses that promote sameness over difference.

Colliding approaches to communication: Expert/partner

Core to communication in child and family health is the notion of developing relationships. In these relationships participants mostly spoke about the importance of being respectful, building trust and being genuine. In chapter 9 I framed participant understandings of how they developed relationships in the intercultural context. Like the content of information given in an intercultural communication encounter, participants explained that their ability to develop relationships was innate, shaped and informed by a complex intersection of individual family and social constructs. In the professional domain this innate ability was reinforced or shaped by the recent adoption into clinical practice of discourses of partnership through the Parent Advisor Model (PAM).

In chapter 9 I explained how participants assumed that partnership and its inherent qualities could be universally applied through behaviours learned and understood within white Western sociological constructs even when their ideological positions conflicted with those with whom they were communicating. I asked if theory could be transferred to practice without contending with the complexities of use in this manner. Does it work to learn skill sets to enact care without concurrent attention to underpinning and at times conflicting ideological positions? Assumed universality of skill sets, devoid of contextualised ideological positions of race, gender and class, did not seem to fully support constructive relationships with parents who came from cultural backgrounds that were different to that of the child health professional. By focussing predominantly on skill sets, without an accompanying deconstruction of ideologies, issues of race, gender and class crept into communication encounters unnoticed and unquestioned. This seemed to restrict the quality of intercultural encounters and thus the health care experience of migrants and new arrivals.

While the PAM identified qualities required by health professionals such as genuineness and empathy, it did not suggest strategies for developing these qualities. They appeared to be assumed. Behaviours were offered as markers that might indicate the presence of these qualities whether or not they were actually present. I argued in chapter 9 that while these markers might be learnt, they were often used in a way that neutralised conflicting beliefs and values. By not explicitly recognising that personal ideologies shape and inform these qualities required by health care communicators, it followed that there was no attempt to explicate how these ideologies might be deconstructed for examination and understanding of communication practice.

Strategies used to develop relationships were summarised as primarily strengths based approaches and friendliness or friendship. In conversation these approaches appeared sound. However, on observation they were at times interpreted as insincere and naïve. Additionally, these strategies provided a cover for not recognising and attending to the inherent relations of power within intercultural relationships.

Key to partnership, in developing relationships, is the mutual valuing and exchange of information. In exploring the purpose of developing relationships a dominant agenda emerged. This was to establish a platform from which to give information to parents, thus contradicting the central focus of partnership as client led. Participants were observed to claim partnership but mostly to practice using a transplant model aimed at behaviour change following information giving. In this way Western reason and authority was privileged over diverse alternate cultural understandings.

In attempting to apply theory to practice, in this case, applying theory of partnership to intercultural health care encounters, the PAM does not contend with use. Use takes into account the ideological position of the child health professional. In considering use, universality of partnership constructs was an assumption; theory cannot be universally applied to practice in a plural cultural context. Without attention to use, unequal relations of power seemed to be reinforced, and Western authority was privileged.

Participants appeared to reinforce constructs of themselves as partners in communication by setting partnership against expert superiority. Consequently an expert/partner binary was created. In chapter 10 I described how participants saw an expert position of communication as dictatorial and an overt expression of superiority. This position was resisted by participants by attempting to give power to parents.

I contended that modernist understandings of power did not easily transpose into plural applications of partnership. Power in a modernist sense can be possessed and given away and flows from top to bottom. This application seemed to reinforce the authority of the person who has the power to give. When participants gave away their power they at times also gave away their authority, seeing no place in the room for mutual existence of joint expertise. Power was therefore repressive for both the child health professional in losing their authority and for parents who were necessarily positioned below the health professional. In reinforcing their position as

partner using modernist applications of power, participants were observed to act not with *expertise* but as oppressive experts.

Expert practice was mostly observed as unmarked, as participants concentrated on attending to important but at times superficial behavioural markers to demonstrate respect and empathy. Attention to behavioural markers distracted participants from paying attention to the relational nature of power. Paternalism also emerged under the cover of empathy within a partnership framework. While difficult to describe using current discourses of communication, paternalism was observed as uncritical use of adaptors and regulators that discounted the centrality of a migrant mother and her infant. Sympathy was at times at work, rather than empathy, which privileged emotional concerns of the health professional over the parent. This behaviour was observed to be condescending. The centrality of the mother was also overridden at times when communication about a mother was directed towards an interpreter in the presence of the mother. This pushed the mother to a third place position in the intercultural encounter.

While participants did not intentionally marginalise parents who were migrants, the result of paternalism, condescension and uncritical use of power relations seemed to be the perpetuation of a colonising agenda to maintain white Australian nationhood. Through discourses of partnership and power sharing in intercultural communication participants manifested democratically racist practice.

In considering ways to deal with democratic racisms in communication practice I called on the construct of power. Placing it outside the binary of expert/partner and inviting critique of modernist understandings, health professionals' use of power was demonstrated as both colonising and democratically racist.

Inviting understandings of power as a third body opens a space to consider the ideological intersections of relations of power at both the expert position and the partnership position. This might then facilitate mutual coexistence of expertise and partnership. Introducing postmodern understandings of the relational nature of power, health professionals might be engaged to reflexively examine the historical and situated ideological positions that shape intercultural communication encounters.

Collisions of knowledge: Public/private

In chapter 11, I discussed how participants appeared always to be trying to fit along a continuum of public and private knowledge. Participants often presented their public self as one who uses only professionally sanctioned scientific knowledge. This was often followed by claims that they did not use privately constructed, connected knowledge, such as their own experiences of mothering, suggesting that this prevented stereotyping. Yet participants were observed on DVD to not be consistent in this position. At times, while watching themselves on DVD, they explicitly defended giving information from the private sphere, claiming the additional value of this knowledge, particularly motherhood knowledge, as having universal application.

While the act of giving of birth is universal, the way people live and experience pregnancy, birth, motherhood and parenting is deeply cultured. Mothering and parenting are complex subjective experiences that constantly intersect with discourses of race class and gender. When personal knowledge is assumed as universal and therefore generalisable it becomes an implicitly and sometimes explicitly racist practice. It does this by overwriting the subjective knowledge of others with truth claims from within the dominant cultural group. Participants assumed the universal validity of middle class white women's knowledge as desirable to all those mothers and families located at the margins.

Professional knowledge based on scientific evidence is essential and useful to support decisions in practice. The example presented to illustrate this was safe sleeping information, which has led to significant reductions in sudden infant death syndrome. Truth claims from scientific epistemes were valued because of their ability to objectify problems regardless of considerations of race, gender and class. This objectified understanding, however, did not move crisply into the clinical environment it contended with. Its application depended on participants being able to intersect this knowledge across constructs of class, race and gender. They were necessarily required to subjectify the limited scientific evidence available through their own cultural lens.

Where child health professionals publicly denied the existence of personal knowledge in the communication encounter, they seemed blinded to appreciating how beliefs and values formed in the personal sphere creep unattended into intercultural communication encounters and manifest as the perpetuation of

assimilation into white Western models of care. A range of humanist discourses were used to maintain this position. These included individualism used to prevent stereotyping parents into particular ethnic groups. By doing this, participants paradoxically overwrote cultural considerations with those from the dominant white cultural group.

Constructs of an essential humanity were drawn on to argue an equal place within relations of power. In doing this participants believed that they were able to transcend power and judgement. Where power was understood as held and given away, once it was given away, participants felt they had completed their task. They no longer needed to consider the inherent asymmetries in relations of power between themselves marked as white middle class women and the women from cultural and linguistically diverse groups receiving their care. In the main, discourses of liberal feminism were appealed to to justify the content and style of information given to parents. Mothers who were marked as culturally different were at times assumed to be in need of emancipation and child health professionals saw themselves in the role of emancipator, thus reinforcing their own position of superiority.

Participants drew on the notion of judgement to argue their position of professional knowledge within the binary. Unfortunately judgement in modernist terms also presents as a binary where one is either judgmental or non-judgmental. In this way judgement, like power, is always understood in negative terms, repressive in its exercise. When participants seemed to ignore the way they used judgement, they also ignored the ways their values and beliefs shape intercultural communications. A key effect of this lack of awareness was that it seemed to reinforce democratically racist practice.

When the professional domain is approached in this way, there is little space to recognise the value of judgement as liberatory, or to acknowledge and understand the personal cultured identity from which this judgement comes. As such, intercultural communication is limited by the cultural underpinnings of Western epistememes that reinforce cultural domination of Western ways of being and Western ways of raising children. To work in a multicultural child health professionals need a language that enables understandings of power and judgement in plural rather than binary terms. In this way practice becomes more deliberately reflexive with theory so that theory is shaped and reshaped for use in a multicultural, where difference is explicitly struggled with as a way of enhancing therapeutic relationships in practice.

Where child health professionals have a theoretical framework for critiquing scientific or professional knowledge for application, as evidence based practice, they do not have a similar base from which to critique personal knowledges that enter the professional domain. Instead they deny the existence of this cultured knowledge. I contend that even though this knowledge is denied it is always present in any intercultural communication encounter as an unacknowledged and unexamined third body.

If constructed knowledge were applied as a third body outside the public private knowledge binary it might provide a framework to enable working with the complexities of using knowledge in practice. In this way the value of personal knowledge could be explicitly critiqued for application. This would offer a range of possibilities to prevent the subjugation of the knowledge of others, through universalising discourses of motherhood.

By imagining a third body of constructed knowledge, truth is always understood as contextual, and the self is located at the centre of the knowing process (Belenky et al. 1986). By introducing a third body that centralises the self, health professionals might then have some tools to undertake explicit reflexive examination of self and the cultured understandings that the self brings to the intercultural encounter. Utilising a third body denies neither professional knowledge nor personal knowledge. Rather, it values both constructs, enabling them to be held together rather than in competition. Most importantly, it facilitates working from a position that recognises the importance of multiple cultural ideologies that inform parenting knowledge.

Judgement is explicitly embodied in constructed knowledge. If health professionals were to critically examine themselves and their practices as cultured, they might better understand their own values and beliefs on which their judgments are premised. As such these values and beliefs could enter the room in a thoughtful fashion where they might be used explicitly rather than hidden or invited in without due consideration. Further, such an examination might engage child health professionals in considering how they present and represent personally and professionally as raced, classed and gendered.

Section 3: Summary of key findings

This inquiry found inherent problems in the application of theory to practice, particularly in applying theories of communication and cultural care to intercultural communication practice in child and family health care. Theories used by child health professionals for intercultural communication included a combination of cultural competence and transcultural care and the Parent Advisor Model. These theories were accepted without critique as they reinforced normative Western ideological frames of reference such as liberal values of individualism, universal truths, and equal opportunity. These pedagogic tools, developed for a Western monoculture, were found to constrain and delimit practice in a multicultural.

It seems that the capacity of theories used to inform intercultural communication to move seamlessly into practice is premised on universality of application, or use. Universality is a myth in multicultural. For application in a multicultural, theory needs to facilitate use of plural understandings of the nature of truth and knowledge, particularly when parents are determining how to raise their children in a global society. The modernist epistemological and ontological underpinnings of these theories seemed to reinforce a colonising agenda that sought to assimilate multicultural into monoculture.

When child health professionals attempted to integrate these modernist theories into contemporary intercultural communications they became trapped by a series of binary constructs. Identified in this study were binaries of knowledge, public or private; identity, sameness or difference; professional ideology, us or them; and communication practice, expert or partner. These binary opposites 'reduce the potential for difference onto polar opposites' (Sarup 1996, p. 57). One term assumes the place of dominant centre while the other term represents the subordinate margin. Public knowledge, for example, is privileged over private knowledge, which becomes subordinate. While private knowledge holds what the centre lacks it is remains essential for the centre to represent itself fully. As such private knowledge is held but cannot be publicly expressed so it, like personal ideologies, seeps out unattended, as it is ever present in the binary.

Seepage of unattended personal knowledge and ideology were presented in intercultural communications in child and family health as democratic racism. Racism is elusive and changing in nature. As suggested by Henry and Tator (2006, p. 16), it functions to preserve 'a system of dominance based on race and is

communicated and reproduced through agencies of socialisation and cultural transmission'. Child and family health professionals are agents of socialisation and cultural transmission. However, they would argue using a range of discourses that they were not racist. Introduced in chapter 8 and presented throughout following chapters, discourses of democratic racism used to support their positions included social justice, equity, and liberal feminism. In other sections democratic racism was manifest by less visible discourses such as colour blindness, denial and whiteness.

Within this contemporary child and family health environment, there seemed to be few spaces where child health professionals might consider the intersection between personal ideologies and knowledge and public discourses of liberal humanism. Binary constructs seemed to limit thinking in such a way that rather than looking to understand this intersection, health professionals continued to fluctuate within the binary. At various times they positioned at one end or the other but never fully represented either end point or the constructed intersections between the two ends. When one end of the binary was privileged, such as managing identity through discourses of sameness, the other end of difference was marginalised and pushed to the periphery. In this way health professionals appeared trapped in a battle with one end, never accounting fully for what the other has to offer.

Section 4: Towards a kaleidoscope: ways forward

In considering how to manage existent binaries in intercultural communications in child and family health, I begin by framing theoretical suggestions to navigate changing practice in changing times. This is followed by a specific wish list of practical possibilities of moving from collisions to a kaleidoscope in practice.

Theory for practice

Hodge and O'Carroll's (2006) deconstruction strategy of three body analysis was introduced as a practical way to work with existent binaries in everyday intercultural communication in the workplace of child and family health. Where postcolonial feminist critique offers a framework to deconstruct the theoretical underpinnings of contemporary pedagogies of communication and intercultural care, three body analysis offers possibilities as to how we might use these insights to shape practice in present-day multicultural. Together they offer a decolonising strategy for child and family health in Australia's multicultural.

For example, in chapter 7, where conflicting ideologies of practice presented between the organisation and the participant group of child health nurses, I drew on the construct of care as a third body. By placing care explicitly outside the binary forming a triad, not only might client needs be centralised but participants might also have the opportunity to create spaces where resistance could be enacted as care in an authorised way. When participants privileged notions of care, empathy and compassion by owning and acknowledging personal experiences and beliefs, they harnessed relations of power.

To unsettle the binary related to identity in chapter 8 that presented as sameness or difference, I called on a third body of the historical cultural self of the child health professional. Whilst claiming a position of sameness, participants were not able to clarify the nature of this sameness or their relationship within it. As such the authority of unexamined whiteness was reinforced. Difference was marginalised as an exotic other and appreciated only in as much as it served the self. Experiencing the child health professional self as culturally unmarked reinforced a stronger dialectical position of culture pervasively subjecting this self. Perhaps if the self remains unmarked and uncultured it cannot influence culture and therefore remains subjected to its influences. In doing this the normative position is reproduced and experienced but not explored. By explicitly inviting a third body of the cultural self into the sameness/difference binary, child health professionals might be required to examine their own historical and situated positions in relation to sameness and difference. In this way the self can actively agentially influence cultural reproduction.

Into the expert/partner collision of communication practice discussed in chapters 8 and 10, I introduced a third body of power. When power is removed from the binary, to be understood as a construct that intersects with both expert and partnership positions, we might be able to critique modernist applications of power that are both colonising and democratically racist. Further, by introducing postmodern understandings of the relational nature of power, health professionals might be able to examine the historical and situated ideological positions that shape intercultural communication encounters.

In chapter 11 I drew on the notion of judgement as a third body to add to the binary of public/private knowledge. This opened the way to validate the constant presence of private knowledges that at times creep in unnoticed and at others enter proudly without critique. By introducing judgement it might be possible to imagine that

knowledge is never either/or but is constructed over time and experience. If we can legitimise the place of judgement in constructed knowing we can then critique it for its efficacy in a multicultural.

All of these third bodies or external referents have a common application for practice. They require the child health professional to undergo a process of critical self-examination in order to know and understand how their very presence in a room with a mother who is culturally different to themselves begins an interaction that is premised on relations of power. To create kaleidoscopes of knowledge, ideology and identity we do not need to remove the binaries, as they will always be present in our frames of reference. We need to open up the constraints of the binary to the multiple and competing complexities of reality in the multicultural that is Australia.

Changes for practice

In this section I offer suggestions as to how theoretical recommendations might be translated into practice. These are directed towards educators at both undergraduate and postgraduate levels and researchers of communication and culture. From a postmodern perspective I consider that these recommendations are only ever partial and incomplete. It is my hope that I might be able to engage further with participating child health professionals to collaboratively develop possibilities for applying this research to practice. In this way ideas might be shaped within the everyday space of child and family health, using a translational research model such as participatory action research. I list the following recommendations:

The primary recommendation from this research is to return to the field of child and family health professionals and work with this group to reflexively develop tools for professional development in the area of intercultural communication. This could mark the development of a sustainable decolonising strategy, heralded through the everyday practices of communicating about child and family health in the multicultural that is Australia.

Build greater opportunities within curricula for developing sociocultural imagination of undergraduate health professionals to enable them to build up understandings of themselves as cultured, and that this cultural self is historically situated within relations of power across axes of race, gender, class, sexuality and socioeconomic status.

Within the construct of a sociocultural imagination, build opportunities to examine the history of Western epistemological assumptions and critically evaluate their application in a multicultural. Alongside this, to examine how these taken-for-granted positions engender modernist understandings and applications of power that are not always helpful in the intercultural communication encounter.

Develop communication models for practice in child health that support pluralism, underpinned by cultural studies theorising. For example, drawing on cultural representation (Hall 1997a), where we necessarily incorporate language into systems of understanding cultural representation. In a two stage process health professional mental mapping might be critiqued as to how it is represented through language. Meanings can then be displayed as not fixed or stable but represented through the dialogue of shared cultural codes.

Build on existing approaches of reflective practice to examine personal ideologies alongside observed skill sets.

At an organisational level, further research is required to investigate the concerns raised by child health nurses in this study about the repetitive nature of some aspects of their work.

In changing economic climate where health services are increasingly being directed toward those in greatest need, population based strategies that provide baseline services do not necessarily cater for 'the worried well'. This large majority of families are not targeted in the new public health. Further research is required to explore the possibilities of child and family health nurses taking up the opportunity to care for this population majority through the development of a nurse practitioner role. With the move in South Australia towards GP plus centres that incorporate practice nurses and allied health professionals there is a place for Medicare funded child and family health nurses. While this may begin a public/private divide in child and family health, it also has the potential to increase funding directed towards high needs families such as young mothers, indigenous families and new arrivals. In this reorientation of health services, health outcomes might be improved for those women and children experiencing health inequities.

Concluding comments

I began this research with an overriding desire to turn the focus of research away from the cultural other and towards working with child health professionals and their

understandings of themselves as cultured. I focussed on intercultural communication, as culture is represented through language. I used a range of data collection strategies to ensure that the information I was gathering reflected both my own interpretations of cultural representation through language and the interpretations of child health professional participants as they watched themselves on DVD. This method of viewing video was most successful in creating scope for reflection on practice.

As a critical theorist I remain uncertain about what might happen to theory in postcolonial Australia, especially when theory is called on to inform practice. In critiquing theory and practice for this study, I found myself drawn into modernist positions and was constantly reminded by supervisors to resist the temptation of transplanting one theory with another, as this replicates the colonising agendas I was intending to resist. I bring this self-reflection to my summary as I recognise the challenges of moving into a 'post' colonial place full of uncertainties and opportunities. It is my hope that this work supports reflective critical use of current theories to enhance intercultural communication, through partnership in practice, within the multicultural of Australia.

APPENDICES

SCHOOL for MOTHERS INSTITUTE.

TO BE ESTABLISHED IN ADELAIDE EARLY IN 1911

**PATRONESS:
LADY BOSANQUET.**

COMMITTEE:

President:— Mrs. J. P. Morice.
 Hon. Treasurer:— Mrs. Delprat.
 Hon. Secretary:— Dr. Helen Mayo.
 Hon. Literature Secretary:— Miss A. L. Tomkinson.
 Mesdames: C. Reissmann & J. R. Anderson.
 Misses Stirling & Lilian Delissa.

AIMS AND OBJECTS:

To bring about A REDUCTION in the rate of INFANT MORTALITY. To promote the education of the MOTHER in all that concerns the physical, mental and moral development of herself and her offspring. The work of the association will be WHOLLY EDUCATIONAL, as distinguished from Charitable, and in no way to overlap that done by already existing charitable agencies.

METHODS:

1. Home Visiting,
2. Lectures,
 - [On: Health,
 - " Hygiene,
 - " Disease,
 - " Care of INFANTS,
 - " Foods and Food values,
 - " Clothing &c.
3. Classes,
4. Clubs.

Mothers' and Babies' Health Association Bound Volume: Newspaper clips, Pamphlets and leaflets.

APPENDIX 2

Key Informants Group

Purpose of the key informants group:

To assist the researcher in shaping the project so that it is:

- 1.1 Ethically and logistically sound
- 1.2 Useful within the practice field
- 1.3 Reflexive in engaging and working with the participant group

(From, Key Informants Group Terms of Reference
May 2004)

Membership

<u>Name</u>	<u>Role/Organisation</u>
Ms Nan Davies	Director of Nursing, Policy and Service Delivery Child and Youth Health (a division of the Children, Youth and Women's Health Service)
Ms Perri Del Asandro	Clinical Nurse Child and Youth Health
Ms Jan Dolman	Clinical Nurse Migrant Health Service
Ms Huyen Nguyen	Parent Support Worker Parenting Network The Parks Community Centre
Dr Victor Nossar	Senior Community Paediatrician Child and Youth Health
Ms Carla Tongun	Cultural Consultant Migrant Health Service
Ms Eugenia Tsoulis	Executive Director Migrant Resource Centre
Mr Bob Volkmer	Strategic Manager, Service Improvement Child and Youth Health

APPENDIX 3

External Consultation

<u>Name</u>	<u>Role/Organisation</u>
Professor Graham Vimpani	Clinical Chair and head of Paediatrics and Child Health University of Newcastle Chair of Niftey (National Investment in the Early Years)
Ms Eve Bigelow	Senior Nurse manager, Community and Allied health, South Western Sydney Area Health Service
Professor Maree Johnson	Research Professor, School of Nursing, Family and Community Health, University of Western Sydney
Ms Gai Moore	Area manager, Multicultural Health Service, Manager Multicultural Families First Project, South West Sydney Area Health Service
Professor Maurice Eisenbruch	Head of Department Centre for Culture and Health, University of New South Wales.

APPENDIX 4A



FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

Social and Behavioural Research Ethics Committee
Office of Research

GPO Box 2100
Adelaide 5001 Australia

Telephone: (+61 8) 8201 5962
Facsimile: (+61 8) 8201 2035
Email: sandy.huxtable@flinders.edu.au

SBRE 3156

23 December 2004

Mrs Julian Grant

Dear Mrs Grant

Project 3156 **How does culture inform child health professionals' communications about parenting, with parents who are experiencing parenting for the first time in a new country?**

Further to my letter dated 15 December 2004, I am pleased to inform you that approval of the above project has been confirmed following receipt of the additional information you submitted on 23 December 2004.

Approval is valid for the period of time requested and is given on the basis of information provided in the application, its attachments and the information subsequently provided. In accordance with the undertaking you provided in the application, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion and report anything which might warrant review of ethical approval of the protocol. Such matters include

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol; and
- unforeseen events that might affect continued ethical acceptability of the project.

May I draw to your attention that, in order to comply with monitoring requirements of the *National Statement on Ethical Conduct in Research Involving Humans* an annual and/or final report must be submitted in due course. If a report is not received beforehand, a reminder notice will be issued in twelve months' time. A copy of the report pro forma is available from the SBREC website <http://www.flinders.edu.au/research/Office/ethics/committees.html>.

Yours sincerely

Sandy Huxtable
Secretary
SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

cc: Prof Phillip Darbyshire, 72 King William Road, North Adelaide SA 5006
Dr Yoni Luxford, PO Box 1769, Applecross, WA 6953

NB: If you are a scholarship holder and you receive funding for your research through the National Health & Medical Research Council please forward a copy of this letter to the Head, Higher Degree Administration and Scholarships Office, for forwarding to the NHMRC.

Location: Sturt Road, Bedford Park, South Australia.

APPENDIX 4B

CHILDREN, YOUTH & WOMEN'S HEALTH SERVICE



Women's
& Children's
Hospital
ADELAIDE

72 KING WILLIAM ROAD
NORTH ADELAIDE
SOUTH AUSTRALIA 5006
TELEPHONE (08) 8161 7000
FACSIMILE (08) 8161 7459
www.wch.sa.gov.au

17th May 2005

Ms J Grant

Dear Julian

Re: Culture, Communication and Child Health: How does culture inform child health professional's communications about parenting, with parents who are experiencing parenting for the first time in a new country? REC1676/4/2008

Thank you for your letter dated 4th May 2005 in which you responded to matters raised by the WCH Research Ethics Committee at its April 2005 meeting. All matters have been addressed and final approval is given for the study to proceed.

I remind you approval is given subject to:

- immediate notification of any serious or unexpected adverse events to subjects;
 - immediate notification of any unforeseen events that might affect continued ethical acceptability of the project;
 - submission of any proposed changes to the original protocol. Changes must be approved by the Committee before they are implemented;
 - immediate advice, giving reasons, if the protocol is discontinued before its completion;
 - submission of an annual report on the progress of the study, and a final report when it is completed.
- Please note it is your responsibility to provide these reports – without reminder from the Ethics Committee.

Approval is given for three years only, and if the study is more prolonged than this, a new submission will be required. Please note the approval number above indicates the month and year in which approval expires and it should be used in any future communication.

Yours sincerely

TAMARA ZUTLEVICS (DR)
CHAIR
WCH RESEARCH ETHICS COMMITTEE

APPENDIX 5A

CONSENT FORM FOR PARTICIPATION IN RESEARCH FOR NON PARENT PARTICIPANTS

I

being over the age of 16 years hereby consent to participate as detailed below, in the collection of data for the research project about how ideas of culture inform child health professionals communications with parents who are experiencing parenting for the first time in a new country.

Please tick the boxes of your choice

(a) I agree to take part in general observations of my daily practice, and general discussions that ensue. I understand that Julian may take written notes or may audiotape conversations for transcription.

(b) I agree to a videotape being made of a consultation between myself and a parent who is a migrant to Australia.

(c) I agree to look at the videotape with Julian Grant and to talk with her about the consultation. I understand and agree to this talk being recorded on an audiotape for transcription and an analysis.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
4. I understand that:
 - I may not directly benefit from taking part in this research.
 - I am free to withdraw from the project at any time and am free to decline to answer questions.
 - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
 - The only people to view the video will be Julian, myself, the parent and possibly Julian's supervisors. The only people to listen to the audiotape of our discussion will be Julian, the transcriber and possibly Julian's supervisors.
 - The transcriber will be asked to sign a Declaration of Confidentiality.
 - All interpreter/bilingual workers involved in the study will be asked to declare any conflicts of interest and sign a Declaration of Confidentiality
 - All video tapes, audiotapes and transcripts will be stored in a locked filing cabinet at Flinders University. Consent forms will be stored in a separate locked filing cabinet.
 - This study is not part of any organisational performance appraisal as such whether I participate or not, or withdraw after participating, will have no effect on any aspect of my employment at _____
 - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
5. I have had the opportunity to discuss taking part in this research with a family member, friend or colleague.

Participant's signature.....Date.....

I certify that I have explained the study to the participant and consider that she/he understands what is involved and freely consents to participation.

Researcher's name.....

Researcher's signature.....Date.....

NB. Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Item 7.

7. I, the participant whose signature appears below, have listened to a copy of the audio tape of my participation and agree to its use by the researcher as explained.

Participant's signature.....Date.....

APPENDIX 5B

CONSENT FORM FOR PARTICIPATION IN RESEARCH FOR PARENTS

I

being over the age of 16 years hereby consent to participate as detailed below, in the collection of data for the research project about how ideas of culture inform child health professionals communications with parents who have become parents for the first time in a new country.

Please tick the boxes of your choice

(a) I agree to a videotape being made of a consultation I have with a child health professional so that Julian Grant can view and discuss the communication in this video tape with the participating child health professional. A child health professional may include people such as a nurse, social worker, physiotherapist, psychologist or doctor.

(b) I agree to look at the videotape with Julian Grant and talk with her about the consultation. I understand and agree to this talk being recorded on an audiotape for transcription and analysis.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
4. I understand that:
 - I may not directly benefit from taking part in this research.
 - I am free to withdraw from the project at any time and am free to decline to answer questions.
 - While the information gained in this study will be published as explained, **I will not be identified**, and individual information will remain confidential. Julian Grant will not talk about any aspect of our interview with anyone other than her research supervisors
 - The only people to view the video will be Julian, myself, the child health professional and possibly Julian's supervisors. The only people to listen to the audiotape of our discussion will be Julian, the transcriber and possibly Julian's supervisors.
 - The transcriber will be asked to sign a Declaration of Confidentiality.
 - All interpreter/bilingual workers involved in the study will be asked to declare any conflicts of interest and sign a Declaration of Confidentiality.
 - All video tapes, audiotapes and transcripts will be stored in a locked filing cabinet at Flinders University. Consent forms will be stored in a separate locked filing cabinet.
 - Whether I participate or not, or withdraw after participating, will have no effect on the service that I or my family receive from any staff member working for
5. I have had the opportunity to discuss taking part in this research with a family member, friend or colleague.

Participant's signature.....**Date**.....

I certify that I have explained the study to the participant and consider that she/he understands what is involved and freely consents to participation.

Researcher's name.....

Researcher's signature.....**Date**.....

NB. Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Item 7.

7. I, the participant whose signature appears below, have listened to a copy of the audio tape of my participation and agree to its use by the researcher as explained.

Participant's signature.....**Date**.....

APPENDIX 6A

LETTER OF INTRODUCTION FOR NON PARENT PARTICIPANTS

Dear Sir/Madam,

This letter is to introduce Julian Grant who is a PhD candidate in the School of Nursing and Midwifery, Department of Health Sciences at Flinders University. She will produce her student card, which carries a photograph, as proof of identity.

Julian is undertaking research leading to the production of a thesis and other publications on the subject of how culture shapes communication between child health professionals and parents who have become parents for the first time in a new country.

She would be most grateful if you would volunteer the time to assist in this project, by agreeing to some or all of the following:

- (1) General observation and discussion in the workplace,
- (2) To permit a videorecording to be made of a consultation with a parent who has migrated to Australia.
- (3) To look at the videotape with Julian and talk about what happened in the consultation. This talk may take about 1-1/2 hours and will be arranged at a time and place to suit you. With your permission this discussion will be audio taped and given to a secretarial assistant to transcribe.

Please be assured that the video and audiotapes will be stored in locked filing cabinet at Flinders University. The following people are the **only** people who will see the video: yourself, the parent, Julian and possibly Julian supervisors. The only people who will listen to the audiotape are Julian the transcriber and possibly Julian's research supervisors. All information will be treated in the strictest confidence. Your name will not be used in any documents arising from the study. Nor will you in any way be individually identified in the resulting thesis, report or other publications. You are, of course, entirely free to stop your participation at any time or to decide not to answer any questions that are uncomfortable. If you decide to withdraw from the research Julian would appreciate having a discussion with you about your reasons.

Julian will seek your written consent, on the attached form, for whichever part of the process you volunteer to be involved in.

It will be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be asked to sign a 'Transcribers Declaration' confirming their agreement to maintain confidentiality of your name and identity. The transcriptions will be used to prepare the thesis and other related reports and publications. Any recorded notes, audiotapes, videotapes or transcriptions will be used on condition that **your name or identity is not revealed**. They will not be made available to any other researchers unless, at the time, you give your express permission.

Any enquiries you may have concerning this project can be directed to Julian, myself or Dr Yoni Luxford. Contact details are provided below.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (SBREC) and the Children Youth and Women's Health Service, Women's and Children's Hospital Research Ethics Committee (REC).

The Secretary of the Flinders University SBREC can be contacted on ph 8201-5962, fax 8201-2035, e-mail sandy.huxtable@flinders.edu.au

The Secretary of the Women's and Children's Hospital REC can be contacted on ph 81616521, email pennyb@wch.sa.gov.au

Thank you for your attention and assistance.

Yours sincerely,

Professor Philip Darbyshire

Contact Details:

Supervisor: Professor Philip Darbyshire Chair of Nursing, Head, Department of Nursing and Midwifery Research and Practice Development,

Children, Youth and Women's Health Service, South Australia

Supervisor: Dr Yoni Luxford, Senior Lecturer in Midwifery, Flinders University of South Australia

Enhanced Role Midwife Project, Department of Health, Government of Western Australia

Researcher: Ms Julian Grant PhD Candidate, School of Nursing and Midwifery, faculty of health Sciences, Flinders University, South Australia

Ph: (08) 8161 6497 / 6468

philip.darbyshire@adelaide.edu.au

Ph: (08) 9222 2185

yoniluxford@health.wa.gov.au

Ph: (08) 8201 5135

julian.grant@flinders.edu.au

APPENDIX 6B

LETTER OF INTRODUCTION FOR PARENTS

Dear Sir/Madam,

This letter is to introduce Mrs Julian Grant who is a PhD candidate in the School Of Nursing and Midwifery, Department of Health Sciences at Flinders University. She will produce her student card, which carries a photograph, as proof of identity.

Julian is undertaking research leading to the production of a thesis and other publications on the subject of how culture informs communication between child health professionals and parents who have become parents for the first time in a new country.

She would be most grateful if you would volunteer the time to assist in this project, by agreeing to some or all of the following:

- (1) To permit a videorecording to be made of a consultation you have with a child health professional. Julian will view this tape with the health professional involved and discuss with that person the communication observed in the tape. A child health professional might include people such as a nurse, social worker, doctor, psychologist or physiotherapist.

Please be assured that the video and audiotapes will be stored in a locked filing cabinet at Flinders University. The following people are the **only** people who will see the video: yourself, the child health professional, Julian and possibly Julian's research supervisors. The only people who will listen to the audiotape are Julian, the transcriber and possibly Julian's research supervisors. All information will be treated in the strictest confidence. Your name will not be used in any documents arising from the study. Nor will you in any way be individually identified in the resulting thesis, report or other publications. You are, of course, entirely free to stop your participation at any time or to decide not to answer any questions that are uncomfortable. If you decide to withdraw from the research Julian would appreciate having a discussion with you about your reasons.

Julian will ask for your written consent on the attached form, for whichever part of the project you volunteer to be involved in.

It will be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that they will be asked to sign a 'Transcribers Declaration' confirming their agreement to maintain confidentiality of your name and identity. The transcriptions will be used to prepare the thesis and other related reports and publications. Any recorded notes, audiotapes, videotapes or transcriptions will be used only on condition that **your name or identity is not revealed**. They will not be made available to any other researchers unless, at the time, you give your express permission.

Any enquiries you may have concerning this project can be directed to Julian, myself or Dr Yoni Luxford. Contact details are provided below.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (SBREC) and the Children Youth and Women's Health Service, Women's and Children's Hospital Research Ethics Committee (REC).

The Secretary of the Flinders University SBREC can be contacted on ph 8201-5962, fax 8201-2035, e-mail sandy.huxtable@flinders.edu.au

The Secretary of the Women's and Children's Hospital REC can be contacted on ph 81616521, email pennyb@wch.sa.gov.au

Thank you for your attention and assistance.

Yours sincerely,

Professor Philip Darbyshire

Supervisor: Professor Philip Darbyshire Chair of Nursing, Head, Department of Nursing and Midwifery Research and Practice Development,

Children, Youth and Women's Health Service, South Australia

Ph: (08) 8161 6497 / 6468

philip.darbyshire@adelaide.edu.au

Supervisor: Dr Yoni Luxford, Senior Lecturer in Midwifery, Flinders University of South Australia

Enhanced Role Midwife Project, Department of Health, Government of Western Australia

Ph: (08) 9222 2185

yoniluxford@health.wa.gov.au

Researcher: Ms Julian Grant PhD Candidate, School of Nursing and Midwifery, faculty of health Sciences, Flinders University, South Australia

Ph: (08) 8201 5135

julian.grant@flinders.edu.au

APPENDIX 7A

10. What will happen if I don't want to take part?

Nothing at all. You have the right to say that you would rather not take part. Please be assured that if you choose not to take part it will in no way affect your relationship with Child and Youth Health or the broader Children, Youth and Women's Health Service.

11. Can I change my mind if I decide to participate?

Yes. You can choose to leave the study at any time. For example if a question feels uncomfortable during the interview you can simply say 'I don't want to answer that question' or 'I've had enough I don't want to do anymore'. It would be helpful if you were able to talk with me briefly about your reasons, as this information could be important for the study.

12. Will the study benefit me in any way?

I can't promise that you will get any benefit from taking part. However, you might feel that by talking about your experiences you may help readers of the study's reports and findings to get a better understanding of how communication about parenting happens with migrant parents. This may lead to ideas that could enhance the way we communicate.

13. Will I be paid for taking part in this study?

Sadly no, we cannot pay people to take part in this research. It has to be voluntary.

14. Have you got permission to do this study?

Yes. I have permission from the Flinders University Social and Behavioural Research Ethics Committee and the Women and Children's Hospital Research Ethics Committee. These groups have looked carefully at this study and have approved it.

15. What if I feel that I would like to talk to someone after the interview about any thoughts feelings or worries that I have?

I am happy to talk with you about anything that comes up from the research. If clinical issues arise you might like to speak to your supervisor or line manager. If issues are more personal you can always contact OCAR Services on 8231 9111. This service is free to all staff at Child and Youth Health and is confidential.

16. What do I do next if I want to take part in the study?

You can contact me any time using the details on the back of this sheet. We can then go through the consent forms together. If you are happy with the information we can both sign them.

Thanks for taking the time to read this and for considering taking part in the study.

Julian Grant



Considering Communication Culture and Child Health

Information Sheet
for
Child Health
Professionals

My name is Julian Grant.

I am a child health nurse and researcher. I have worked in a range of community settings with children and families. I am currently doing research through Flinders University for my PhD. I am trying to find out more about how culture shapes the way child health professionals talk with people experiencing parenting in a new country.

I am hoping that child health professionals working for Child and Youth Health will help by taking part in this study.

This information sheet has answers to many questions that you might have about the study.



Information Sheet for Child Health Professionals

Flinders University
School of Nursing and Midwifery
GPO Box 2100
Adelaide SA 5001

Phone: 0405 45 6776
E-mail: julian.grant@flinders.edu.au

Tel: 0405 45 6776
E-mail: julian.grant@flinders.edu.au



Questions and Answers

1. What is the study for and why is it being done?

I am very interested in culture and the way it shapes how child health professionals provide culturally appropriate services to migrants who are parenting for the first time in a new country. There is research around that tells us about different cultural beliefs and practices. This information helps child health professionals to understand and respond to cultural differences. But there is no information about how ideas of culture such as values and attitudes shape the information that child health professionals give and how they give this information. This study will explore these things.

2. What would I be asked to do if I took part in the study?

This study will happen in 3 stages. The first stage is called 'participant observation'. In Stage 1 I would ask you to allow me to walk and talk with you during your everyday experiences in the workplace. I would not expect to sit in on consultations but just be around the office so that I can find out more about the sort of things you do at work. I will not interrupt you but may during quiet times or tea breaks join in with general conversations.

In Stage 2 I would like to look at communication about parenting between yourself and a parent who is parenting for the first time in a new country. To look at this communication would be difficult unless I am in the room with you.

That might be a bit uncomfortable for all of us. So that I don't have to be in the room and so that we don't miss any important information I would like to video tape a consultation between you and a parent.

In Stage 3 I would like to look at the videotape with you, talk about and reflect on the communication in the consultation. This would be a semi structured in-depth interview because I would like to ask you a few questions, but mostly we would let the contents of the video guide our conversation. The interview would take about 1-1 1/2 hours.

I will also be asking some parents to talk with me about how they found the communication in their consultation.

3. What if an interpreter or bilingual worker is present for my consultation?

They will just be video-taped as well. I'm interested in how the whole process works. They will be asked to sign a form that says they will keep all information confidential.

4. If I am happy to be videoed (Stage 2) where and how would this take place?

Firstly I would need to confirm the consent of the client that you are seeing. (You can help with this if you would like to.) The consultation would take place wherever you have planned, i.e. at the child health centre or the parent's home. I would arrive about 10 minutes early so that I can answer any final questions that you or the parent might have and to set up the video equipment. I will turn it on and leave the room. After the consultation is over I will return to pack up the gear. We can then plan your involvement in Stage 3.

5. If I took part in an interview (Stage 3) where and how would it take place?

It needs to be somewhere that you feel comfortable, maybe in a vacant room at Child and Youth Health, a local library or even in your home. We can arrange a time that suits us both. I will just need to be able to plug in a portable video player.

6. How will you record the information that we talk about?

In Stages 1 and 2 I will take hand written notes. When I get home I will write up these notes into what I'll call a 'Field Journal'. In Stage 3 I will record our conversation on a tape recorder. It is very important that I do this because I really value what you tell me. If I didn't tape the interview I would have to take notes and then I wouldn't be able to concentrate on what you were telling me. I will give this tape recording to a secretary who will type up all of the English language parts of the interview. This will be called a transcript. The secretary will make sure that your real name is not used and that nobody who is reading the transcript can identify you.

I will make a copy of the tape and give it to you. Before I start working with the transcript I will ask if you'd like to give me any feedback from listening to the tape.

7. What will happen to the information that I give you in the interview?

I will read through the notes from Stages 1 and 2 and they will form a background to the information from Stage 3. I will then read through the typed up transcripts from Stage 3 and try to pick out the most important and

interesting things that child health professionals tell me about their communication with migrant parents. I will write up this information along with the information that I receive from parents who have also reviewed videotaped interviews with me. This information will go into the thesis that I am preparing for my PhD. I will also try to write some articles about the study and publish these and to talk about the study at meetings and at conferences. It is important that the findings from this study are read and heard by people who might be able to use the information to improve to the way that we provide child health services to families who are new to Australia, otherwise we might feel that the study is a waste of time.

Please let me assure you that you will not be able to be identified by what you have said in the taped interview or in the written transcript.

8. Will anyone else look at the videotapes, listen to the audiotape or read the transcript?

The only people who will look at the videotape of your consultation with a parent will be; me and yourself so that we can talk about how you communicated with the parent, possibly the parent if they would like to talk about how the interview was for them, and possibly my research supervisors.

If you take part in an interview with me about your consultation the only people who will listen to the audiotape will be me, you, possibly my research supervisors and a secretary so that she/he can type up the words on the tape. She/he will be asked to sign a form that says that she/he will not talk with anyone about what she types.

The only people to look at the typed up transcript of our interview will be me and possibly my research supervisors. They need to have access so that they can help me write up my thesis.

It is really important for me to let you know here that this research is not linked to organizational performance appraisal. What you say or do will not be discussed with or passed on to any supervisors or managers. Also, I will not share any information that you give me with parents involved in your consultation.

9. Do I have to take part in this study?

Not at all. Please only volunteer if you want to help and are happy to take part. You can volunteer for any or all of the stages of the project.

I know it's a lot to read. There's just a little bit more on the other side!

APPENDIX 7B

10. Will I be paid for taking part in this study?

Sadly no, we cannot pay people to take part in this research. It has to be voluntary

11. Have you got permission to do this study?

Yes. I have permission from the Flinders University Social and Behavioural Research Ethics Committee and the Women and Children's Hospital Research Ethics Committee. These groups have looked carefully at this study and have approved it.

12. What if I feel that I would like to talk to someone after the interview about any thoughts feelings or worries that I have?

I am happy to talk with you about anything that comes up from the research. If clinical issues arise you might like to speak to your supervisor or line manager. If issues are more personal you can always contact OCAR Services on 8231 9111. This service is free to all staff at Child and Youth Health and is confidential.

13. What do I do next if I want to take part in the study?

You can contact me any time using the details on the back of this sheet. We can then go through the consent forms together. If you are happy with the information we can both sign them.

Thanks for taking the time to read this and for considering taking part in the study.

Julian Grant



Considering Communication Culture and Child Health

Information Sheet
for
Ancillary Staff

My name is Julian Grant.

I am a child health nurse and researcher. I have worked in a range of community settings with children and families. I am currently doing research through Flinders University for my PhD. I am trying to find out more about how culture shapes the way child health professionals talk with people experiencing parenting in a new country.

I am hoping that people working for Child and Youth Health will help by taking part in this study.

This information sheet has answers to many questions that you might have about the study.



Information Sheet for
Ancillary Staff

Flinders University
School of Nursing and Midwifery
GPO Box 2100
Adelaide SA 5001

Phone: 0405 45 6776
E-mail: julian.grant@flinders.edu.au

Tel: 0405 45 6776
E-mail: julian.grant@flinders.edu.au



Questions and Answers

1. What is the study for and why is it being done?

I am very interested in culture and the way it shapes how child health professionals provide culturally appropriate services to migrants who are parenting for the first time in a new country. There is research around that tells us about different cultural beliefs and practices. This information helps child health professionals to understand and respond to cultural differences. But there is no information about how ideas of culture such as values and attitudes shape the information that child health professionals give and how they give this information. This study will explore these things.

2. What would I be asked to do if I took part in the study?

This study will happen in 3 stages. The first stage is called 'participant observation'. This is the stage I am asking you to be involved in. I will ask you to allow me to be in and around the workplace with you during everyday experiences. I will not interrupt you but may during quiet times or tea breaks join in with general conversations.

3. How will you record the information that we talk about?

I will take hand written notes. When I get home I will write up these notes into what I'll call a 'Field Journal'. I will make sure that you are given a name other than your own and that nobody can identify you in anything that I write.

4. What will happen to the information that I give you in the interview?

I will read through the notes that I take and they will form a sort of background to the next lot of information that I will gather with child health professionals and parents. I will write up a report from the information I have gathered. I will also try to write some articles about the study and publish these and to talk about the study at meetings and at conferences. It is important that the findings from this study are read and heard by people who might be able to use the information to improve to the way that we provide child health services to families who are new to Australia, otherwise we might feel that the study is a waste of time.

Please let me assure you that you will not be able to be identified by any notes that I make.

5. Will anyone else look at the notes you take?

The only people who will look at the notes I take will be myself and possibly my research supervisors. They may need to see these so that they can help me write up my final report.

It is really important for me to let you know here that this research is not linked to organizational performance appraisal. What you say or do will not be discussed or passed on to any supervisors or managers.

6. Do I have to take part in this study?

Not at all. Please only volunteer if you want to help and are happy to take part.

7. What will happen if I don't want to take part?

Nothing at all. You have the right to say that you would rather not take part. Please be assured that if you choose not to take part it will in no way affect your relationship with Child and Youth Health or the broader Children, Youth and Women's Health Service.

8. Can I change my mind if I decide to participate?

Yes. You can choose to leave the study at any time. It would be helpful if you were able to talk with me briefly about your reasons, as this information could be important for the study.

9. Will the study benefit me in any way?

I can't promise that you will get any benefit from taking part. However, you might feel that by contributing to this research you may help readers of the study's reports and findings to get a better understanding of how communication about parenting happens with migrant parents. This may lead to ideas that could enhance the way we provide services.



I know it's a lot to read. There's just a little bit more on the other side!

N.B. Appendix 7A and 7B were formatted as a doubled sided A4 brochure.

APPENDIX 7C

Considering
Communication Culture
and Child health



Information for Parents

My name is Mrs Julian Grant. I am a mature-aged woman and nurse. I have mostly worked in the community with children and families. I am currently doing research through Flinders University for my PhD. I am trying to find out more about how culture shapes the way child health professionals talk about parenting and child health with parents who have become parents for the first time in a new country. I am hoping that parents who are new to Australia will help by taking part in this study.

This information sheet has answers to many questions that you and your family might have about the study.

QUESTIONS AND ANSWERS

1) What is the study for and why is it being done?

I am very interested in culture and the way it shapes how child health workers provide culturally appropriate services to migrant parents who are parenting for the first time in a new country. There is research around that tells us about different cultural beliefs and practices. This information helps child health workers to understand and respond to cultural differences. But there is no information about how ideas of culture such as values and attitudes shape the information that child health professionals give and how they give this information. This study will explore these things. I hope that the research will improve our knowledge about how we provide services to first time parents who are new to Australia so that we can use that knowledge to improve services.

2) What would I be asked to do if I took part in the study?

This study will happen in 3 stages. Child health professionals are mostly involved in **Stage 1**. I would ask you to join in on stages 2 and maybe 3. In **Stage 2** I would like to look at the communication between yourself and a child health worker during a consultation. People communicate with both words and actions, how they say things, even where they say things. To look at this communication is difficult unless I am in the room with you. That might be a bit uncomfortable for all of us. So that I don't have to be in the room and so that we don't miss any important information I would like to video tape a consultation between you and a child health worker.

7) What will happen to the information that I give you in the interview?

I will then read through the typed up transcripts and try to pick out the most important and interesting things that parents tell me about their communication with child health professionals. I will write up this information along with the information that I receive from child health professionals who have also reviewed videotaped interviews with me. I will write a report at the end of the study. I will also try to write some articles about the study and publish these and to talk about the study at meetings and at conferences. It is important that the findings from this study are read and heard by people who might be able to use the information to improve to the way that we provide child health services to families who are new to Australia, otherwise we might feel that the study is a waste of time.

Please let me assure you that you will not be able to be identified by what you have said in the taped interview or in the written transcript.

8) Will anyone else look at the videotapes, listen to the audiotape or read the transcript?

The only people who will look at the videotape of your consultation with a child health worker will be; me and the child health worker so that we can talk about how they communicated with you, possibly yourself if you would like to talk about how the interview was for you, and possibly my research supervisors.

If you take part in an interview with me about the consultation the only people who will listen to the audiotape will be me, you, possibly my research supervisors and a secretary so that she/he can type up the words on the tape. She/he will be asked to sign a form that says that she will not talk with anyone about what she types.

The only people to look at the typed up transcript of our interview will be me and possibly my research supervisors. They need to have access so that they can help me write up my thesis.

It is really important for me to let you know here that while all employees of Child and Youth Health are employees of the South Australian Health Department, they are bound by strict rules of confidentiality. This means they cannot share any information that you give them without your permission to do so. I will also be abiding by these rules of confidentiality. If you take part in an interview with me after a taped consultation I will not tell the child health professional involved in your consultation anything about what we have talked about. The only exception to this point is that if someone was to tell us about any abuse of children that has taken place in this country. As health professionals in Australia we have no choice here and must pass on information about reported abuse. All other information remains confidential.

9) Do I have to take part in this study?

Not at all. Please only volunteer if you want to help and are happy to take part. You can volunteer just to be videotaped during a consultation with a child health professional or to be videotaped and then to chat with me about the consultation.

10) What will happen if I don't want to take part?

Nothing at all. You have the right to say that you would rather not take part. Please be assured that if you choose not to take part it will not affect the services you receive from Child and Youth Health or any relationships you have with staff.

In **Stage 3** I would like to look at the videotape with the child health worker and talk with them about the communication in the consultation.

I would also like some parents to talk with me about how they found the communication in the consultation. If you would like to take part in this part of the study we could look at the video of your consultation together and talk about the communication as we see it in the video. We would call this an 'interview'. I can organize an interpreter to help us. The interview would take about 1-1 1/2 hours.

3) What if an interpreter or bilingual worker is present for my consultation?

They will just be video-taped as well. I'm interested in how the whole process works. They will be asked to sign a form that says they will keep all information confidential. They will also be asked if they have any reasons or conflicts that suggest that we would be better working with a different interpreter.

4) If I am happy to be videoed (Stage 2) where and how would this take place?

The consultation would take place wherever it has been booked with the child health professional. It might be at the child health centre or in your home. I would arrive about 10-15 minutes early so that I can go through the consent papers with you to answer any final questions that you or the health professional might have. I will also set up the video equipment. I will turn it on and leave the room. After the consultation is over I will return to pack up the gear. We can then talk about whether or not you are interested in being involved in Stage 3.

5) If I took part in an interview (Stage 3) where and how would it take place?

It needs to be somewhere that you feel comfortable, maybe a local library or even in your home. We can arrange a time that suits us both. We just need to make sure that I can plug in a portable video player so that we can look at the video. If you'd like to bring a family member or friend to this interview that would be fine. I can organize an interpreter or bilingual worker to help us with our conversation.

6) How will you record the information that we talk about?

I will record our conversation on a tape recorder. It is very important that I do this because I really value what you tell me. If I didn't tape the interview I would have to take notes and then I wouldn't be able to concentrate on what you were telling me. I will give this tape recording to a secretary who will type up all of the English language parts of the interview. This will be called a transcript. The secretary will make sure that your real name is not used and that nobody who is reading the transcript can identify you. I will make a copy of the tape and give it to you. Before I start working with the transcript I will ask if you'd like to give me any feedback from listening to the tape. An interpreter will be available to help us with this.

11) Can I change my mind if I decide to participate?

Yes. You can choose to leave the study at any time. For example if a question feels uncomfortable during the interview you can simply say 'I don't want to answer that question' or 'I've had enough I don't want to do anymore'. It would be helpful if you were able to talk with me briefly about your reasons, as this information could be important for the study.

12) Will the study benefit me in any way?

I can't promise that you will get any benefit from taking part. However, you might feel that by talking about your experiences you may help readers of the study's reports and findings to get a better understanding of how communication about parenting happens with migrant parents. This may lead to ideas that could enhance the way we provide services.

13) Will I be paid for taking part in this study?

Sadly no, we cannot pay people to take part in this research. It has to be voluntary.

14) Have you got permission to do this study?

Yes. I have permission from the Flinders University Social and Behavioural Research Ethics Committee and the Women and Children's Hospital Research Ethics Committee. These groups have looked carefully at this study and have approved it.

15) What if I feel that I would like to talk to someone after the interview about any thoughts feelings or worries that I have?

I am happy to talk with you about anything that comes up from the research. Otherwise you might like to speak to someone at the **Migrant Health Service on 8237 3900** or from **SITARS (Survivors of Torture and Trauma Assessment and Rehabilitation Service) on 8346 5433**. Both of these services can help you with counselling.

16) What do I do next if I want to take part in the study?

You can contact me using the details below, let the person making the appointment know you are interested or speak to your child health nurse.



Thanks for taking the time to read or listen to this and for thinking about taking part in the study.

Julian Grant
Mobile: 0405456776
Email: julian_grant@flinders.edu.au

Flinders University
School of Nursing and Midwifery
GPO Box 2100
Adelaide
SA 5001

N.B. Appendix 7C was translated into Arabic, Dinka, Vietnamese and Swahili. Original pages presented as 4 x A4 format.

APPENDIX 8



Government of South Australia
Children, Youth and Women's
Health Service

Research Secretariat
Level 2 Samuel Way Building
72 King William Road
North Adelaide SA 5006
Tel 08 8161 6521
08 8161 6930
Fax 08 8161 8177

22nd June 2005

Ms J Grant

Dear Julian

Re: Culture, communication and child health: how does culture inform child health professional's communications about parenting, with parents who are experiencing parenting for the first time in a new country. REC1676/4/08

Thank you for your letter of 2nd June 2005. At its meeting on 22nd June 2005 the CYWHS Research Ethics Committee approved the proposed modification to the study.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Tamara Zutlevics', with a decorative flourish at the end.

TAMARA ZUTLEVICS (DR)
CHAIR
CYWHS RESEARCH ETHICS COMMITTEE

APPENDIX 9

INTERPRETER / BILINGUAL WORKER DECLARATION OF CONFIDENTIALITY

I _____

being over the age of 18 years hereby agree to translate for participants involved in interviews for the research project on **How ideas of culture inform how child health professionals communicate about parenting and child health with parents who are experiencing parenting for the first time in a new country.**

Throughout this process I will adhere to the following:

1. I will inform Julian Grant of any potential conflicts of interest in working on this project.
2. Any information that I hear will remain confidential at all times.
3. Any information that I discuss with Julian Grant relating to the interviews will remain confidential at all times.
4. Confidentiality will be maintained throughout the process of translation and after the process of translation is complete.
5. I am aware that I should retain a copy of this declaration for my own records.
6. If I wish to debrief on any issues raised during the translation or interview process I am able to contact Julian Grant to arrange a time to do this.

Interpreter/Bilingual Workers Name.....

Interpreter/Bilingual Workers Signature.....**Date**.....

I certify that I have explained the above to the translator/bilingual worker and consider that she/he understands what is involved and freely consents to translate the research data in accordance with the above specifications.

Researchers Name.....

Researcher's Signature.....**Date**.....

APPENDIX 10

APPROACH AND TOPICS FOR IN-DEPTH INTERVIEW WITH CHILD HEALTH PROFESSIONALS

For the project: *Considering Culture, Communication and Child Health.*

Thank you for agreeing to take part in this project. Is it OK to turn on the audio tape now? Thanks. I would just like to confirm that I have your consent form before we start.

As we have already discussed I am really interested in the way that culture informs or shapes the way we communicate with clients from a range of cultural backgrounds about parenting and child health. The way we communicate is influenced by lots of things such as our educational backgrounds, our ethnicity, our personality and other life experiences. In this project I see culture as a cyclical thing that influences all of these things and at the same time it is continuously re-shaped by these things.

I would like to ask you a few questions to get us thinking about the area of culture and then to look at the video tape. When we look at the video tape either of us can stop it at any point if we notice something of interest about the communication in the consultation that may indicate how culture is influencing how you communicate. We can talk more about how we can do this a bit later.

Do you have any questions before we start?

I'll start then with the questions.

1. *Can you tell me a little about what the idea of CULTURE means to you?*
2. *I am interested in how you have learned about culture and communication? Could you tell me about this? Have you had any formal training in this area, if so what have you done?*
3. *Have you thought about ways that culture might influence how you communicate with first time parents who are migrants to Australia? This reflection could be either your own cultural background or any other ideas about culture. Could you tell me a bit about this?*

Thanks for working through those questions with me. Now it's time to look at the video.

I have grouped the things we could look for in the video into two sections. They include the exchange of information, or the **messages** you are communicating and the **process** or way in which you are communicating. You can add anything else that you see as interesting or relevant.

In looking at both the messages and the process of communication I am interested in your reflections on internal influences such as your assumptions, beliefs or values, and external influences such as your professional knowledge, organizational philosophies and the social/political environment. The interesting thing is how you see these ideas come across. What we are actually looking for are things like the words you use, the tone of your voice and non-verbal communication such as how you use your body. These are only ideas. You may notice a whole range of other things. I would appreciate you sharing these with me.

Do you have any questions before we turn on the video? Let's get started and see how we go.

Please remember;

- you can stop the tape whenever you'd like to
- if I ask a question that you don't want to answer that's OK just let me know
- and if you decide along the way that you've had enough and don't want to continue that is also OK, just let me know.

Thanks so much for taking the time and energy to go through this process of reflective discussion with me. I will now organize for a copy of the tape to be made and ask that you listen to it. (You also have the choice not to do this step.) Once you return this to me I will start data analysis. At the end of the project I am happy to provide you with a summary of the findings of the project.

Are there any other comments you would like to make before I turn off the tape. If you have any other thoughts you would like me to know about in the next week or so please feel free to email me at julian.grant@flinders.edu.au or phone me on 0405456776.

Thanks again. I'll turn off the audio tape now.

APPENDIX 11

TRANSCRIBERS DECLARATION OF CONFIDENTIALITY

I _____

being over the age of 18 years hereby agree to transcribe audiotapes of interviews between Julian Grant and research participants for the research project on **How ideas of culture inform how child health professionals communicate about parenting and child health with parents who are experiencing parenting for the first time in a new country.**

Throughout this process I will adhere to the following:

1. Any information that I hear on the audiotapes and transcribe will remain confidential at all times.
2. Any information that I discuss with Julian Grant relating to the interviews and transcription thereof will remain confidential at all times.
3. Confidentiality will be maintained throughout the process of transcription and after the process of transcription is complete.
4. I am aware that I should retain a copy of this declaration for my own records.
5. If I wish to debrief on any issues raised during the transcription process, relating to audiotape content or transcription process, I am able to contact Julian Grant to arrange a time to do this.

Transcribers Name.....

Transcribers Signature.....**Date**.....

I certify that I have explained the above to the transcriber and consider that she/he understands what is involved and freely consents to transcribe the research data in accordance with the above specifications.

Researchers Name.....

Researcher's Signature.....**Date**.....

PART E: Family History: Questions to be asked of the Primary Caregiver and partner (if present)			
QUESTIONS	PRIMARY CAREGIVER	PARTNER	NOTES
19. In general did you feel cared for as a child? 1. Yes 2. No 3. Unsure	<input type="checkbox"/>	<input type="checkbox"/>	
20. As a child were you placed in the full-time care of others (apart from your parents) for more than a few weeks? 1. Yes 2. No 3. Unsure	<input type="checkbox"/>	<input type="checkbox"/>	
21. As a child were you harmed, abused or neglected in any way (physically, emotionally or sexually)? 1. Yes 2. No 3. Unsure	<input type="checkbox"/>	<input type="checkbox"/>	
22. In the past 12 months have you experienced any form of abuse from a partner (physical, emotional, sexual)? <i>This may include being hit, attempts to control your money, what you do, being prevented from seeing friends or family, or threats to harm you.</i> 1. Yes 2. No 3. Unsure 4. Did not ask	<input type="checkbox"/>	<input type="checkbox"/>	
23. As a parent have you had any involvement with a child protection service? For example Children Youth and Family Services (CYFS). 1. Yes 2. No 3. Unsure	<input type="checkbox"/>	<input type="checkbox"/>	
24. Would you be willing to be contacted by our staff in the future for the purpose of research and/or evaluation of our services? <i>This would be confidential.</i> 1. Yes 2. No	<input type="checkbox"/>	<input type="checkbox"/>	
25. Is there anything that you would like to talk more about or bring up that we may not have covered already?			

CYH 1075 Version 3 - Sept 2005 - Review Date Dec 2005

Page 5 of 7

Post Questionnaire Information

The following information must be completed for each contact. Where more than one contact is required to complete Pathways to Parenting, separate details below must be completed for each contact.

CONTACT ONE:

Date of Service: [] [] [] [] [] [] Time: [] Location responsible for service: []

Contact Type: Home CYH Venue Non CYH Venue

If Contact Type 'HOME' then how much Travel Time? [] hours/minutes

Name of Service Provider: [] Discipline: []

Discipline of Accompanying Person 1: []

Discipline of Accompanying Person 2: []

Time taken on Pathways to Parenting Questionnaire: [] hours/minutes

Total Service Time: [] hours/minutes

Is another visit required to finish the questionnaire? Yes No (If no go to Nurse Assessment)

CONTACT TWO:

Date of Service: [] [] [] [] [] [] Time: [] Location responsible for service: []

Contact Type: Home CYH Venue Non CYH Venue

If Contact Type 'HOME' then how much Travel Time? [] hours/minutes

Name of Service Provider: [] Discipline: []

Discipline of Accompanying Person 1: []

Discipline of Accompanying Person 2: []

Time taken on Pathways to Parenting Questionnaire: [] hours/minutes

Total Service Time: [] hours/minutes

Is another visit required to finish the questionnaire? Yes No (If no go to Nurse Assessment)

CONTACT THREE:

Date of Service: [] [] [] [] [] [] Time: [] Location responsible for service: []

Contact Type: Home CYH Venue Non CYH Venue

If Contact Type 'HOME' then how much Travel Time? [] hours/minutes

Name of Service Provider: [] Discipline: []

Discipline of Accompanying Person 1: []

Discipline of Accompanying Person 2: []

Time taken on Pathways to Parenting Questionnaire: [] hours/minutes

Total Service Time: [] hours/minutes

Is another visit required to finish the questionnaire? Yes No (If no go to Nurse Assessment)

CYH 1075 Version 3 - Sept 2005 - Review Date Dec 2005

Page 6 of 7

Nurse Assessment: (To be completed at Universal Contact)

A No further action - to use general CYH services as required

B Further internal action or referral required (may tick one or more boxes)

Follow-up at CYH clinic Access Home Visit Medical Officer

Breastfeeding Support gTKVB Group Indigenous Cultural Consultant

FAB - Day Service TSS Social Worker / Psychologist

FAB - Torrens House HAC Volunteer

Family Support Coordinator Physiotherapist EI Coordinator

Other (please specify): []

C External referral

CYFS GP Community Health Service

SA Housing Trust Gemmelink Drug and Alcohol Services

Mental Health Services Other (please specify): []

D Refer to:

FHV Case Review if Under 20 and/or ATSI AND in rollout area (may also have additional criteria)

Universal Case Review for all other families (Must tick one or more boxes if eligible for FHV and/or Maternal Criteria)

Eligible for Family Home Visiting because (can tick one or more of below)

1. Mother less than 20 years

2. Child identified as Aboriginal or Torres Strait Islander

3. Mother socially isolated

4. Caregiver expresses poor attribution / relationship

Maternal Criteria

5. Current or past treatment for a mental health issue that is currently impacting on parenting ability

6. Current domestic violence

7. Drug and alcohol related issues

8. Intervention from CYFS

9. Child born with congenital abnormalities

10. Nurse assessment concerns

(please specify concern): []

(eg. stability of parents, exhaustion of mother, family of origin issues, health related stress over other family member (e.g. other child), insurance or ongoing major stress, chronic illness (physical/mental), inability to leave appointments, feeling not being told the truth - things or not being appropriate of secrecy in the family, feeling uncomfortable in the family/home, parental expectations are unrealistic, not much support from partners/spouse, very little self confidence)

E Other (please specify): []

Date: [] [] [] [] [] [] Time: []

Nurse Completing Assessment: [] Signature: []

Discipline: [] Location: []

CYH 1075 Version 3 - Sept 2005 - Review Date Dec 2005

Page 7 of 7

Original pages presented as 7 x A4 format.

APPENDIX 13

Conference and seminar presentations arising from this study

May 2008 'Working with culture in child and family health'. Invited presentation to Australian Confederation of Paediatric Nurses, Twilight Seminar, Adelaide, South Australia.

September 2007 'Challenging the binaries in communication practices of community child health nurses'. 14th International Critical and Feminist Perspectives in Nursing Conference, Vancouver, Canada.

September 2007 'Understanding ourselves as cultured; understanding how we work with difference'. Invited keynote presentation Child and Adolescent Mental Health Service, Cultural Diversity Workshop. Adelaide, South Australia

June 2007 'Colliding realities: culture, child health and communication'. Final presentation, Flinders University, South Australia.

November 2006 'Whiteness in community child health'. Border Politics of Whiteness Conference, Australian Critical Race and Whiteness Studies Association. Sydney, New South Wales, Australia.

October 2006 'Considering communication, culture, and child health'. Flinders University research seminar series. Flinders University, South Australia.

August 2006 'Working with communication and culture in child health' Children, Youth and Women's Health Service, Medical Round, Adelaide South Australia.

November 2005 'Reviewing current practices of cultural care and communication in child health' International Congress on Innovations in Nursing 2005, Perth, Western Australia.

November 2005 'Culture communication and child health: preliminary findings of research exploring how ideas of culture shape child health professionals' communications with migrant parents' International Congress on Innovations in Nursing. Perth, Western Australia.

October 2005 'Reviewing current practices of cultural care and communication in child health' Flinders University research seminar series, Flinders University, South Australia.

April 2005 'Considering communication, culture and child health: linking research to practice' Invited presentation to Australian Confederation of Paediatric and Child Health Nurses Twilight Seminar, Adelaide South Australia.

September 2004 'Considering culture, communication and child health: why we need research' Parenting Imperatives, A National Parenting Conference, Adelaide South Australia.

August 2004 'Consulting about communication and culture in child and family health' Flinders University research seminar series, Flinders University, South Australia.

Forthcoming

April 2009. Invited keynote speaker 3rd biennial Conference of the Australian Association of Maternal, Child and Family Health Nurses. Adelaide Convention Centre, South Australia.

November 2008 'Putting the 'multi' back into 'culture' in child and family health nursing'. Queen Elizabeth Centre, Fifth Biennial Conference. Reaching Out to Vulnerable Families: Achieving Better Outcomes for Children. Melbourne, Victoria, Australia.

October 2008 'Communicating culture in child and family health'. Invited presentation to Inaugural Colloquium for Child Health, Education and Research in Nursing, Flinders University. Adelaide, Australia.

September 2008 'Putting the 'multi' back into 'culture' in child and family health nursing'. New South Wales Child Health networks conference. Sydney New South Wales, Australia.

~~~~~

### **Publications arising from this study**

Grant, J, Luxford, Y, & Darbyshire, P 2005, 'Culture, communication and child health', *Contemporary Nurse*, vol. 20, pp. 134-142.

### **Forthcoming**

Grant, J, Luxford, Y 'Intercultural communication in child and family health: Insights from postcolonial feminist scholarship and three body analysis', *Nursing Inquiry*.

## REFERENCES

- Abercrombie, N, Hill, S & Turner, BS (eds) 2006, *The Penguin Dictionary of Sociology*, 5th edn, Penguin Books, London.
- Adorno, TW & Horkheimer, M 1979, *Dialectic of Enlightenment*, Verso, London.
- Agger, B 1991, 'Critical theory, post structuralism, postmodernism: Their sociological relevance', *Annual Review of Sociology*, vol. 17, pp. 105-31.
- 1992, *Cultural Studies as Critical Theory*, Falmer Press, London.
- Alperstein, G & Nossar, V 2002, 'Can the Families First initiative contribute to reducing health inequalities?', *NSW Public Health Bulletin*, vol. 13, no. 3, pp. 38-41.
- Andersen, C & Adamsen, L 2001, 'Continuous video recording: A new clinical research tool for studying the nursing care of cancer patients', *Journal of Advanced Nursing*, vol. 35, no. 2, pp. 257-67.
- Andersen, ML & Collins, PH 1998, *Race, Class, and Gender: An Anthology*, 3rd edn, Wadsworth Publishing, Belmont.
- Anderson, J 2002, 'Toward a post-colonial feminist methodology in nursing research: Exploring the convergence of post-colonial and black feminist scholarship', *Nurse Researcher*, vol. 9, no. 3, pp. 7-27.
- 2004, 'Lessons from a postcolonial-feminist perspective: suffering and a path to healing', *Nursing Inquiry*, vol. 11, pp. 238-46.
- Anderson, J, Perry, J, Blue, C, Browne, AJ, Henderson, A, Basu Khan, K, Reimer Kirkham, S, Lynam, J, Semeniuk, P & Syme, V 2003, "'Rewriting" cultural safety within the postcolonial and postnational feminist project: Towards new epistemologies of healing', *Advances in Nursing Science*, vol. 26, no. 3, pp. 196-214.
- Ang, I & Stratton, J 1996, 'Asianising Australia: Notes toward a critical transnationalism in cultural studies', *Cultural Studies*, vol. 10, pp. 16-36.
- Aranda, K 2005, 'Community nurses' talk of equality and the discursive constitution of selves', *Journal of Advanced Nursing*, vol. 51, no. 2, pp. 131-9.
- Arnold, M 1979, *Culture and Anarchy*, Cambridge University Press, Cambridge.
- Atkinson, P & Hammersley, M 1998, 'Ethnography and participant observation', in NK Denzin & YS Lincoln (eds), *Strategies of Qualitative Inquiry*, SAGE Publications, Inc, Thousand Oaks.
- Attride-Stirling, J, Davis, H, Day, C & Sclare, I 2000, *An Assessment of the Psychosocial Needs of Children and Families in Lewisham: Final Report*, South London and Maudsley NHS Trust, London.
- Attride-Stirling, J, Davis, H, Karless, G, Sclare, I & Day, C 2001, "'Someone to talk to who'll listen": Addressing the psychosocial needs of children and families', *Journal of Community and Applied Social Psychology*, vol. 11, pp. 179-91.
- Attwood, B & Markus, A 2007, *The 1967 Referendum: Race, Power and the Australian Constitution*, Aboriginal Studies Press, Canberra.
- Australian Broadcasting Corporation 2004, *PM – Children overboard chronology*, ABC, viewed 04/06/07, <<http://www.abc.net.au/pm/content/2004/s1177925.htm>>.
- Australian Bureau of Statistics 1991, *Information Paper: 1991 Census: Socio-Economic Indexes for Areas*, cat.no.2912.0, ABS, Canberra.
- 2006, *Migration*, ABS, Canberra.
- Australian Confederation of Paediatric and Child Health Nurses 2000, *Competencies for the Specialist Paediatric and Child Health Nurse*, ACPCHN, Sydney.
- 2007, *About ACPCHN*, ACPCHN, viewed 18/01/08, <[http://www.acpchn.org.au/default.asp?V\\_DOC\\_ID=748](http://www.acpchn.org.au/default.asp?V_DOC_ID=748)>.

- Australian Government Department of Health and Ageing 2007, *Asthma*, Australian Government Department of Health and Ageing, viewed 24/02/07, <<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pq-asthma-index.htm>>.
- Australian Indigenous Doctors Association & The Royal Australasian College of Physicians 2004, *An Introduction to Cultural Competency*, RACP, Paper developed for the Aboriginal and Torres Strait Islander mentoring program of the AIDA and RACP.
- Australian Nursing and Midwifery Council 2002, *Code of Ethics for Nurses in Australia*, ANMC, Dickson.
- 2003, *Code of Professional Conduct for Nurses in Australia*, ANMC, Dickson.
- 2005, *National Competency Standards for the Registered Nurse*, ANMC, Dickson.
- 2006, *Australian Nursing and Midwifery Council Standards: National Competency Standards for the Registered Nurse, Enrolled Nurse, Registered Midwife, Nurse Practitioner*, ANMC, Dickson.
- 2007, *Inclusion of Aboriginal and Torres Strait Islander Peoples Health and Cultural Issues in Courses Leading to Registration or Enrolment*, ANMC, Canberra.
- Australian Nursing Federation 1997, *Competency Standards for the Advanced Nurse*, Australian Nursing Federation Publications, Melbourne.
- Bacchi, C 2005, 'Discourse, discourse everywhere: Subject "agency" in feminist discourse methodology', *Nordic Journal of Women's Studies*, vol. 13, no. 3, pp. 198-209.
- Banks, M 1995, *Visual Research Methods*, University of Surrey, viewed 01/02/08, <<http://sru.soc.surrey.ac.uk/SRU11/SRU11.html>>.
- Barker, C 2003, *Cultural Studies: Theory and Practice*, 2nd edn, Sage Publications, London.
- Barker, W 1984, *The Child Development Program: A Collaborative Program Linking Parents, Community and Health Visitors*, Early Childhood Development Unit, University of Bristol, Bristol.
- 1990, 'Practical and ethical doubts about screening for child abuse', *Health Visitor*, vol. 63, pp. 14-7.
- Barthes, R 1972, 'The Great Family of Man', in *Mythologies*, Jonathon Cape, London, pp. 100-2.
- Bateson, G 1973, *Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution and Epistemology*, Paladin, St. Albans.
- Baum, F & Sanders, D 1995, 'Can health promotion and primary health care achieve Health for All without a return to their more radical agenda?', *Health Promotion International*, vol. 10, no. 2, pp. 149-60.
- Baum, F 1990, 'The new public health: Force for change or reaction?', *Health Promotion International*, vol. 5, pp. 145-50.
- (ed.) 1998a, *The New Public Health: An Australian Perspective*, Oxford University Press, Oxford.
- 1998b, 'Understanding health: Definitions and perspectives', in F Baum (ed.), *The New Public Health: An Australian Perspective*, Oxford University Press, Oxford.
- Bayly, C 2000, 'Culture and Care: Medical Strivings, Struggles and Satisfactions', Masters of Public Health thesis, Monash University.
- Belenky, MF, Clinchy, BM, Goldberger, NR & Tarule, JM 1986, *Women's Ways of Knowing: The Development of Self, Voice and Mind*, Basic Books, Inc., Publishers, New York.
- Belsky, J 1984, 'The determinants of parenting: A process model', *Child Development*, vol. 55, pp. 83-96.

- Benner, P 2001, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, commemorative edn, Prentice Hall, Inc, Upper Saddle River.
- Bennett, T 1992, 'Putting policy into cultural studies', in L Grossberg, C Nelson & P Treichler (eds), *Cultural Studies*, Routledge, New York.
- Best, S & Kellner, D 1991, *Postmodern Theory: Critical Interrogations*, The New Guilford Press, New York.
- Bhabha, H (ed.) 1990, *Nation and Narration*, Routledge, London.
- 1994, *The Location of Culture*, Routledge, London.
- Bidmead, C & Cowley, S 2005a, 'A concept analysis of partnership with clients', *Community Practitioner*, vol. 78, no. 6, pp. 203-8.
- 2005b, 'Evaluating family partnership training in health visitor practice', *Community Practitioner*, vol. 78, no. 7, pp. 239-45.
- Bird, C (ed.) 1998, *The Stolen Children: Their Stories*, Random House Australia Pty Ltd, Sydney.
- Blackford, J & Street, A 2002, 'Cultural conflict: the impact of western feminism(s) on nurses caring for women of non-English speaking background', *Journal of Clinical Nursing*, vol. 11, pp. 664-71.
- Blackford, J 2003, 'Cultural frameworks in nursing practice: exposing an exclusionary healthcare culture', *Nursing Inquiry*, vol. 10, no. 4, pp. 236-44.
- Bolton R. 1986, *People Skills: How to Assert Yourself, Listen to Others, and Resolve Conflicts*, Simon and Schuster, Australia.
- Borofsky, R, Barth, F, Shweder, R, Rodseth, L & Stolzenberg, N 2001, 'When: A conversation about culture', *American Anthropologist*, vol. 103, no. 2, pp. 432-46.
- Bourdieu, P & Wacquant, L 1999, 'On the cunning of imperialist reason', *Theory, Culture and Society*, vol. 16, no. 1, pp. 41-58.
- 2001, 'New liberal speak: Notes on the new planetary vulgate', *Radical Philosophy*, vol. 105, pp. 2-5.
- Braveman, P 2006, 'Health disparities and health equity: Concepts and measurement', *Annual Review of Public Health*, vol. 27, pp. 167-94.
- Braverman, H 1974, *Labour and Monopoly Capital*, Monthly Review Press, New York.
- Browne, AJ & Fiske, J 2001, 'First Nations womens' encounters with mainstream health care services', *Western Journal of Nursing Research*, vol. 23, no. 2, pp. 126-47.
- Browne, AJ 2001, 'The influence of liberal political ideology on nursing science', *Nursing Inquiry*, vol. 8, no. 2, pp. 118-29.
- 2003, 'First Nations Women and Health Care Services: The Sociopolitical Context of Encounters with Nurses', PhD thesis, The University of British Columbia.
- Browne, AJ, Smye, VL & Varcoe, C 2005, 'The relevance of postcolonial theoretical perspectives to research in Aboriginal health', *Canadian Journal of Nursing Research*, vol. 37, no. 4, pp. 16-37.
- Browne, K 1989, 'The health visitor's role in screening for child abuse', *Health Visitor*, vol. 62, no. 9, pp. 275-7.
- Bruni, N 1988, 'A critical analysis of transcultural theory', *Australian Journal of Advanced Nursing*, vol. 5, no. 3, pp. 26-32.
- Bryans, A & McIntosh, J 2000, 'The use of simulation and post-simulation interview to examine the knowledge involved in community nursing assessment practice', *Journal of Advanced Nursing*, vol. 31, no. 5, pp. 1244-51.
- Campina-Bacote, J 2003, 'Many faces: Addressing diversity in health care', *Online Journal of Issues in Nursing*, vol. 8, no. 1, viewed 23/11/04, <[http://nursingworld.org/ojin/topic20/tpc20\\_2.htm](http://nursingworld.org/ojin/topic20/tpc20_2.htm)>.



- Cancer Council Australia 2007, *The Cancer Council Australia*, The Cancer Council Australia, viewed 19/02/07,  
<<http://www.cancer.org.au/content.cfm?randid=906824>>.
- Cass, B 2002, 'The intersection of public and private worlds in the distribution of well-being of Australian children: Research and social policy implications', in M Prior (ed.), *Investing in Our Children: Developing a Research Agenda*, Academy of Social Sciences Australia, Canberra.
- Child Accident Prevention Foundation of Australia Kidsafe 2007, *Child Accident Prevention Foundation of Australia Kidsafe*, viewed 19/02/07,  
<<http://www.kidsafe.org.au/>>.
- Child and Family Health Nurses Association 2000, *National Competency Standards for the Child and Family Health Nurse*, CFHNA (NSW) Inc, NSW.
- Child and Youth Health 2007, *Health Checks*, Government of South Australia, viewed 04/01/07,  
<<http://www.cyh.com/HealthTopics/healthTopicDetails.aspx?p=114&np=304&id=1480>>.
- Children, Youth and Women's Health Service 2004, *Personal Health Record*, CYWHS, Adelaide.
- 2005a, Children, Youth and Women's Health Service, Strategic Plan 2005-2010, CYWHS, North Adelaide.
- 2005b, Children, Youth and Women's Health Service, Annual Report 2004-2005, CYWHS, North Adelaide.
- 2006a, Clinical Competencies for Child and Family Health Nurses, Government of South Australia, Adelaide.
- 2006b, *Home Visiting Manual*, Government of South Australia, Adelaide.
- 2007, Health Topics: Sleeping With Your Baby, CYWHS, viewed 04/12/07,  
<<http://www.cyh.com/HealthTopics/HealthTopicDetails.aspx?p=114&np=305&id=1911>>.
- Clear, M 1999, 'Caring culture and the politics of parent/professional relations', *Australian Journal of Social Issues*, vol. 34, no. 2, p. 119.
- Cohen, S 1980, *Fold Devels and Moral Panicks: The Creation of Mods and Rockers*, St Martin's Press, New York.
- Collier, JC & Collier, M 1986, *Visual Anthropology: Photography as a Research Method*, University of New Mexico Press, Albuquerque.
- Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care 2002, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine of the National Academies, Washington, DC.
- Congress of Aboriginal and Torres Strait Islander Nurses 2007, *Recommendations: Cultural Heritage and Identity*, CATSIN, viewed 10/01/08,  
<<http://www.indignet.com.au/catsin/recommendations.html>>.
- Cooney, C 1994, 'A comparative analysis of transcultural nursing and cultural safety', *Nursing Praxis in New Zealand*, vol. 9, pp. 6-12.
- Cornall, R 2003, 'Australia's approach to national security', paper presented to National Security Conference Sydney Convention and Exhibition centre, viewed 28/04/03,  
<[http://www.nadrac.gov.au/agd/WWW/rwpattach.nsf/viewasattachmentpersonal/\(CFD7369FCAE9B8F32F341DBE097801FF\)~SEC++National+Security+Conference.pdf/\\$file/SEC++National+Security+Conference.pdf](http://www.nadrac.gov.au/agd/WWW/rwpattach.nsf/viewasattachmentpersonal/(CFD7369FCAE9B8F32F341DBE097801FF)~SEC++National+Security+Conference.pdf/$file/SEC++National+Security+Conference.pdf)>.
- Coup, A 1996, 'Cultural safety and culturally congruent care: A comparative analysis of Irihapeti Ramsden's and Madeline Leininger's educational projects for practice', *Nursing Praxis in New Zealand*, vol. 11, pp. 4-11.
- Courtney, M 2005, *Evidence for Nursing Practice*, Churchill Livingstone, Marrickville.
- Cowley, S 1995, 'In health visiting, a routine visit is one that is passed', *Journal of Advanced Nursing*, vol. 22, pp. 276-84.

- Cowley, S, Bergen, A, Young, K & Kavanagh, A 2000, 'A taxonomy of needs assessment, elicited from a multiple case study of community nursing education and practice', *Journal of Advanced Nursing*, vol. 31, no. 1, pp. 126-34.
- Cowley, S, Mitcheson, J & Houston, AM 2004, 'Structuring health needs assessments: The medicalisation of health visiting', *Sociology of Health and Illness*, vol. 26, no. 5, pp. 503-26.
- Cox, AD, Pound, A, Mills, M, Puckering, C & Owen, AL 1991, 'Evaluation of a home visiting and befriending scheme for young mothers: Newpin', *Journal of the Royal Society of Medicine*, vol. 84, pp. 217-20.
- Cross, TL, Bazron, BJ, Dennis, KW & Isaacs, MR 1989, *Towards a Culturally Competent System of Care: Vol 1*, National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, Washington DC.
- Culley, L 1996, 'A critique of multiculturalism in health care: The challenge for nurse education', *Journal of Advanced Nursing*, vol. 23, no. 3, pp. 564-70.
- Cunneen, C & Stubbs, J 1997, *Gender, "Race" and International Relations*, Institute of Criminology Monographs, Sydney.
- Cunningham, C & Davis, H 1985, *Working with Parents: Frameworks for Collaboration*, Open University Press, Milton Keynes.
- Dagg, D 1997, *A Program Operation Perspective: Evaluating School Community Linked Services: Politics, Problems and Possibilities*, Australian Centre for Equity Through Education, Sydney.
- Danaher, G, Schirato, T & Webb, J 2000, *Understanding Foucault*, Allen and Unwin, St Leonards.
- Darian-Smith, E 1996, 'Postcolonialism: A brief introduction', *Social and Legal Studies*, vol. 5, no. 3, pp. 291-9.
- Davies, B & Harre, R 1990, 'Positioning: The discursive production of selves', *Journal for the Theory of Social Behaviour*, vol. 20, no. 1, pp. 43-63.
- Davies, B 1990, 'The problems of desire', *Social Problems*, vol. 37, pp. 801-16.
- 1991, 'The concept of agency: A feminist poststructural analysis', *Social Analysis*, vol. 30, no. Postmodern Critical Theorising, pp. 42-53.
- 1992, 'Women's subjectivities and feminist stories', in C Ellis & MG Flaherty (eds), *Investigating Subjectivity: Research on Lived Experience*, Sage, Newbury Park.
- 1993a, 'Beyond dualism and towards multiple subjectivities', in L Christian-Smith (ed.), *Texts of Desire: Essays on Fiction, Femininity and Schooling*, Falmer Press, London.
- 1993b, *Shards of Glass*, Allen & Unwin Pty Ltd, St Leonards.
- Davis H, Day C, and Bidmead C 2002, *Working in Partnership with Parents: The Parent Advisor Model*, The Psychological Corporation Limited, London.
- Davis, H & Spurr, P 1998, 'Parent counselling: An evaluation of a community child mental health service', *Journal of Child Psychology and Psychiatry*, vol. 39, pp. 365-76.
- Davis, H, Day, C, Cox, A & Cutler, L 2000, 'Child and adolescent mental health needs assessment and service implications in an inner city area', *Clinical Child Psychology and Psychiatry*, vol. 5, pp. 169-88.
- de Mello, D, Figueiredo, G & Nascimento, L 2003, 'Use of video recording technique in nursing research on children's health', *Revista Brasileira de Enfermagem*, vol. 56, no. 2, pp. 175-7.
- de Vries, G 1963, 'The Conditions of Childbirth in Adelaide', PhD thesis, Adelaide University.
- Deave, T 2003, 'Mothers' views on the First Parent Health Visitor Scheme', *Community Practitioner*, vol. 76, no. 7, pp. 251-6.

- Denzin, NK & Lincoln, YS 1998, 'Introduction: Entering the field of qualitative research', in NK Denzin & YS Lincoln (eds), *The Landscape of Qualitative Research: Theories and Issues*, SAGE Publications, Inc, Thousand Oaks.
- Department for Families and Communities 2007, *Families SA*, Government of South Australia, viewed 15/01/07, <<http://www.familiesandcommunities.sa.gov.au/default.aspx?tabid=676>>.
- Department of Families, Community Services and Indigenous Affairs 2007a, *Communities for Children: Early Childhood Intervention*, DFCSIA, viewed 19/02/07, <[http://www.facsia.gov.au/internet/facsinternet.nsf/vIA/cfc/\\$File/cfc\\_early\\_childhood\\_intervention.pdf](http://www.facsia.gov.au/internet/facsinternet.nsf/vIA/cfc/$File/cfc_early_childhood_intervention.pdf)>.
- 2007b, *Stronger Families and Communities Strategy*, DFCSIA, viewed 24/02/07, <[http://www.facsia.gov.au/internet/facsinternet.nsf/aboutfacs/programs/sfsc-early\\_childhood\\_invest\\_to\\_grow.htm](http://www.facsia.gov.au/internet/facsinternet.nsf/aboutfacs/programs/sfsc-early_childhood_invest_to_grow.htm)>.
- Department of Education and Children's Services & Wright, B 2005, *The Virtual Village: Raising a Child in the New Millennium: Report of the Inquiry into Early Childhood Services*, DECS, Adelaide.
- Department of Health 2004, New 'Family Friendly' Early Childhood Centres: Ministerial Release, DOH, viewed 05/02/07, <[www.health.sa.gov.au/](http://www.health.sa.gov.au/)>.
- Department of Health and Ageing 2007a, *Health Priorities*, DHA, viewed 24/02/07, <<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/Health+Priorities-1>>.
- 2007b, *Primary Health Care Services*, DHA, viewed 24/02/07, <<http://www.health.gov.au/internet/wcms/publishing.nsf/content/primary%20health%20care%20services-3>>.
- 2007c, *Search Gov Australia*, DHA, viewed 24/02/07, <[http://agencysearch.australia.gov.au/search/search.cgi?collection=agencies&sco=&cool0=41&cool1=15&cool2=5&cool3=0&num\\_ranks=20&client=445556fb&query=early+childhood&scope\\_disable=off&submit=Search](http://agencysearch.australia.gov.au/search/search.cgi?collection=agencies&sco=&cool0=41&cool1=15&cool2=5&cool3=0&num_ranks=20&client=445556fb&query=early+childhood&scope_disable=off&submit=Search)>.
- Department of Human Services & Layton, R 2003, *Our Best Investment: A State Plan to Protect and Advance the Interests of Children*, DHS, Adelaide.
- Department of Human Services & Menadue, JL 2003, *Better Choices Better Health: Final Report of the South Australian Generational Health Review: Summary*, DHS, Adelaide.
- Department of Human Services 2003a, *Every Chance for Every Child: Making the Early Years Count: A Framework for Early Childhood Services in South Australia*, DHS, Adelaide.
- 2003b, *First Steps Forward: South Australian Health Reform*, DHS, Adelaide.
- 2003c, *Sustained Home Visiting Program Model*, DHS, Adelaide.
- Department of Immigration and Citizenship 2006, *Visa and Immigration*, DIC, viewed 26/11/07, <<http://www.immi.gov.au/skilled/index.htm>>.
- Department of Immigration and Multicultural and Indigenous Affairs 2003, *Multicultural Australia: United in Diversity, Updating the 1999 New Agenda for Multicultural Australia: Strategic Directions for 2003-2006*, DIMIA, Canberra.
- 2004, *DIMIA*, DIMIA, viewed 20/09/04, <<http://www.immi.gov.au/facts/06evolution.htm>>.
- Derrida, J 1976, *Of Grammatology*, John Hopkins University Press, Baltimore.
- During, S 1987, 'Post-modernism or post-colonialism today', *Textual Practice*, vol. 1, pp. 32-47.
- Dyck, I 1998, 'Methodology on the line: Constructing meaning about 'cultural difference'', in V Strong-Boag, S Grace, A Eisenberg & J Anderson (eds), *Painting the Maple: Essays on Race, Gender and the Construction of Canada*, UBC Press, Vancouver.
- Dyer, R 1997, *White*, Routledge, New York.

- Egan, G 1990, *The Skilled Helper: A Systematic Approach to Effective Helping*, Brookes/Cole, Pacific Grove, CA.
- Eisenbruch, M 2003, Cultural Competence in Medical Education: Workshop, 29 October 2003: Report on proceedings, University of New South Wales, Sydney.
- Eisenbruch, M, Rotem, A, Waters, D, Snodgrass, R & Creegan, R 2002, 'Nursing in a Multicultural Context', in *National Review of Nursing Education 2002: Nurse Education and Training, Vol 1*, Commonwealth of Australia, Canberra.
- Elkan, R, Robinson, J, Williams, D & Blair, M 2001, 'Universal vs. selective services: The case of British health visiting', *Journal of Advanced Nursing*, vol. 33, no. 1, pp. 113-9.
- Epstein, RM, Morse, DS, Frankel, RM, Frarey, L, Anderson, K & Beckman, HB 1998, 'Awkward moments in patient-physician communication about HIV risk', *Annals of Internal Medicine*, vol. 128, no. 6, pp. 435-42.
- Erickson MF & Kurz-Reimer, K 1999, *Infants, Toddlers, and Families: A Framework for Support and Intervention*, Guilford Press, New York.
- Erickson, F 1992, 'The interface between ethnography and microanalysis', in DE LeCompte, WL Millroy & J Preissle (eds), *The Handbook of Qualitative Research in Education*, Academic Press, San Diego.
- Fairfax Digital 2002, *Credibility Overboard*, Sydney Morning Herald, viewed 04/06/07, <<http://www.smh.com.au/articles/2002/05/10/1020914043918.html>>.
- Fanon, F 1967, *The Wretched of the Earth*, Penguin, Harmondsworth.
- 1968, *Black Skin, White Masks*, MacGibbon & Kee, London.
- Fast, B & Chapin, R 2000, *Strengths-Based Care Management for Older Adults*, Health Professions Press, Baltimore.
- Fay, B 1987, *Critical Social Science: Liberation and its Limits*, Cornell University Press, New York.
- Fine, M 1998, 'Working the hyphens: Reinventing self and other in qualitative research', in NK Denzin & YS Lincoln (eds), *The Landscape of Qualitative Research: Theories and Issues*, Sage Publications, Thousand Oaks.
- Fiske, J 1994, *Media Matters: Everyday Culture and Political Change*, Routledge, London.
- Fitzgerald, MH 2004, 'A dialogue on occupational therapy', *American Journal of Occupational Therapy*, vol. 58, no. 5, pp. 489-98.
- Fitzgerald, MH, Williamson, P & Mullavey-O'Byrne 1998, 'Analysis of therapist definitions of culture', *Physical and Occupational Therapy in Geriatrics*, vol. 15, no. 4, pp. 41-65.
- Forsyth, S & McKenzie, H 2005, 'A comparative analysis of contemporary nurses' discontents', *Journal of Advanced Nursing*, vol. 56, no. 2, pp. 209-16.
- Foss, GF 1996, 'A conceptual model for studying parenting in immigrant populations', *Advances in Nursing Science*, vol. 19, no. 2, pp. 74-87.
- Foucault, M 1980a, 'The history of sexuality: An interview', *Oxford Literary Review*, vol. 4, no. 2.
- 1980b, 'Power/knowledge: Selected interviews and other writings', in C Gordon (ed.), *Harvester Wheatsheaf*, New York.
- 1981, *The History of Sexuality, Volume One: An Introduction*, Pelican, Harmondsworth.
- 1995, *Discipline and Punish: The Birth of the Prison*, Vintage, New York.
- Foucher, LA & Howard, MA 1981, 'Nursing and the "managerial demiurge"', *Social Science and Medicine*, vol. 15, pp. 299-306.
- Frankenberg, R & Mani, L 1993, 'Crosscurrents, crosstalk: Race, 'postcoloniality' and the politics of location', *Cultural Studies*, vol. 7, pp. 292-310.
- Frankenberg, R 1993, *White Women, Race Matters: The Social Construction of Whiteness*, University of Minnesota Press, Minneapolis.

- Fukuyama, F 1990, *The Great Disruption: Human Nature and the Reconstitution of Social Order*, Profile Books, London.
- Furniss, E 1999, *The Burden of History: Colonialism and the Frontier Myth in a Rural Canadian Community*, University of British Columbia Press, Vancouver.
- Gandhi, L 1998, *Postcolonial Theory: A Critical Introduction*, Allen and Unwin, St Leonards.
- Geertz, C 1973, *The Interpretation of Cultures: Selected Essays by Clifford Geertz*, Basic Books, Inc, New York.
- General Assembly of the United Nations 1948, *Universal Declaration of Human Rights*, UN, viewed 15/07/07, <<http://www.un.org/Overview/rights.html>>.
- Gerrish, K 2000, 'Individualized care: Its conceptualization and practice within a multiethnic society', *Journal of Advanced Nursing*, vol. 32, no. 1, pp. 91-9.
- Goldberger, NR 1996, 'Introduction: Looking backward, looking forward', in NR Goldberger, JM Tarule, BM Clinchy & MF Belenky (eds), *Knowledge, Difference, and Power: Essays Inspired by Women's Ways of Knowing*, Basic Books, New York.
- Good, G 2005, 'Presentism: postmodernism, poststructuralism, postcolonialism', in D Patai & WH Corral (eds), *Theory's Empire: An Anthology of Dissent*, Columbia University Press, New York.
- Gordon, M 2005, 'Making sense of a black day', *The Age*, 13/12/05, pp. 1-6.
- Gordon, S 2005, *Nursing Against the Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care*, Cornell University Press, New York.
- Government of South Australia 2006, *Immigration SA: Make a Change for the Better*, Immigration SA, viewed 01/08/07, <[http://www.immigration.sa.gov.au/site/why\\_sa\\_health.php](http://www.immigration.sa.gov.au/site/why_sa_health.php)>.
- 2007, *Children's Centres for Early Childhood Development and Parenting*, GSA, viewed 17/12/07, <<http://www.childrenscentres.sa.gov.au/pages/HOME/25447/>>.
- Grant, J & Luxford, Y forthcoming, 'Intercultural communication in child and family health: Insights from postcolonial feminist scholarship and three body analysis', *Nursing Inquiry*.
- Gray, A 1997, 'Learning from experience: Cultural studies and feminism', in McGuigan (ed.), *Cultural Methodologies*, Sage, London.
- Grewal, I 1996, *Home and Harem: Nation, Gender, Empire, and the Cultures of Travel*, Duke University Press, Durham.
- Guba, E & Lincoln, YS 1998, 'Competing paradigms in qualitative research', in NK Denzin & YS Lincoln (eds), *The Landscape of Qualitative Research*, Sage Publications, Thousand Oaks.
- Gubrium, JF & Holstein, JA 2003, 'From the individual interview to the interview society', in JF Gubrium & JA Holstein (eds), *Postmodern Interviewing*, Sage Publications, Thousand Oaks, pp. 21-49.
- Gustafson, DL 2005, 'Transcultural nursing theory from a critical cultural perspective', *Advances in Nursing Science*, vol. 28, no. 1, pp. 2-16.
- Habermas, J 1981, 'Modernity versus postmodernity', *New German Critique*, vol. 22, pp. 3-14.
- Hage, G 2000, *White Nation: Fantasies of White Supremacy in a Multicultural Society*, Routledge, New York.
- Haggis, J 2004, 'Thoughts on a politics of whiteness in a (never quite post) colonial country: Abolitionism, essentialism and incommensurability', in A Moreton-Robinson (ed.), *Whitening Race: Essays in Social and Cultural Criticism*, Aboriginal Studies Press, Canberra.
- Hall, DMB & Elliman, D (eds) 2003, *Health for All Children*, Oxford University Press, Oxford.

- Hall, S 1986, 'Gramsci's relevance for the study of race and ethnicity', *Journal of Communication Inquiry*, vol. 10, pp. 5-27.
- 1991, 'Ethnicity identity and difference', *Radical America*, vol. 3, pp. 9-22.
- 1992, 'New ethnicities', in J Donald & A Rattansi (eds), *'Race' Culture and Difference*, Sage Publications, London.
- 1996, 'When was the post colonial? Thinking at the limit', in I Chambers & L Curti (eds), *The Post-Colonial Question: Common Skies, Divided Horizons*, Routledge, London.
- 1997a, 'The work of representation', in S Hall (ed.), *Representation: Cultural Representations and Signifying Practices*, Sage Publications, London.
- (ed.) 1997b, *Representation: Cultural Representations and Signifying Practices*, Sage Publications, London.
- Harcourt Assessment Inc 2007, *Harcourt Assessment Parent Advisor Training Kit*, Harcourt Assessment Inc, viewed 26/10/07, <<http://www.harcourt-uk.com/product.aspx?n=1316&s=1320&cat=1434&sk=y=2802>>.
- Harding, S 1987, 'Introduction: Is there a feminist method?', in S Harding (ed.), *Feminism and Methodology*, Indiana University Press and Open University Press, Bloomington.
- 1991, *Whose Science? Whose Knowledge? Thinking from Women's Lives*, Cornell University Press, New York.
- Health Canada Population and Public Health Branch 2001, *The Population Health Template: Key Elements and Actions that Define a Population Health Approach*, Population and Public Health Branch.
- Health Targets and Implementation Health For All Committee 1988, *Health For All Australians: Report to the Australian Health Ministers' Advisory Council and the Health Ministers Conference*, AGPS, Canberra.
- Heaman, M, Chalmers, K, Woodgate, R & Brown, J 2006, 'Early childhood home visiting program: Factors contributing to success', *Journal of Advanced Nursing*, vol. 55, no. 3, pp. 291-300.
- Heath, P, Department of Education Science and Training & Department of Health and Aging 2002, *National Review of Nursing Education 2002: Our Duty of Care*, Department of Education Science and Training, Canberra.
- Henry, F & Tator, C 2006, *The Colour of Democracy: Racism in Canadian Society*, 3rd edn, Thomson Nelson, Toronto.
- Heywood, A 1992, *Political Ideologies: An Introduction*, St Martin's Press, New York.
- Hodge, B & O'Carroll, J 2006, *Borderwork in Multicultural Australia*, Allen & Unwin, Crows Nest.
- Hodge, B 2005, 'Ute culture and what's left of theory: An Australian academic visits Mexico', *Continuum*, vol. 19, no. 1, pp. 121-29.
- Holmes, D, Hughes, K & Julian, R 2003, *Australian Sociology: A Changing Society*, Pearson Longman, Frenchs Forest.
- Hooks, B 1984, *Feminist Theory from Margin to Center*, South End Press, Boston.
- Houston, AM & Cowley, S 2003, 'Health needs assessment in the health visiting service and the impact on the ethnic community', *International Journal of Nursing Studies*, vol. 40, pp. 85-94.
- Hudson, WJ 1988, *Australian Independence*, Melbourne University Press, Carlton.
- Hugman, R 1991, *Power in the Caring Professions*, Macmillan Press Ltd, London.
- Human Rights and Equal Opportunity Commission 1997, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, HREOC, Sydney.
- 2007, *Aboriginal and Torres Strait Islander Social Justice*, HREOC, viewed 11/12/07, <[http://www.humanrights.gov.au/social\\_justice/index.html](http://www.humanrights.gov.au/social_justice/index.html)>.
- Hunt, S & Symonds, A 1995, *The Social Meaning of Midwifery*, Macmillan Press Ltd, Houndmills.

- Hunt, S 2004, *Pregnancy, Poverty and Health Care*, Books for Midwives, Edinburgh.
- International Council of Nurses 2005, *Regulation Terminology: International Council of Nurses*, ICN, Geneva.
- Iyer 2000, *The Global Soul: Jet Lag, Shopping Malls, and the Search for Home*, Alfred A Knopf, New York.
- Jacobs, J 1993, "'Shake 'im this country": the mapping of the Aboriginal sacred in Australia – the case of Coronation Hill', in P Jackson & J Penrose (eds), *Constructions of Race, Place and Nation*, UCL Press, London.
- JanMohammed, AR 1985, 'The economy of Manichean allegory: The function of racial difference in colonialist literature', *Critical Inquiry*, vol. 12, no. 1, pp. 61-2.
- Jansson, A, Pertersson, K & Uden, G 2001, 'Nurses' first encounters with parents of new-born children: Public health nurses' views of a good meeting', *Journal of Clinical Nursing*, vol. 10, pp. 140-51.
- Jordan, G & Weedon, C 1995, *Cultural Politics: Class, Gender, Race and the Postmodern World*, Blackwell Publishers, Oxford.
- Karoly, LA, Greenwood, PW, Sohler Everingham, SM, Hoube, J, Kilburn, J, Rydell, CP, Sanders, MR & Chiesa, JR 1998, *Investing in Our Children: What We Know and What We Don't Know about the Costs and Benefits of Early Childhood Interventions*, Rand Corporation, Santa Moica.
- Keating, D & Hertzman, C (eds) 1999, *Developmental Health and the Wealth of Nations: Social Biological and Educational Dynamics*, Guilford Press, New York.
- Keleher, H 2000, 'Repeating history? Public and community health nursing in Australia', *Nursing Inquiry*, vol. 7, no. 4, pp. 258-65.
- Kellehear, A 1996, *Social Self, Global Culture: An Introduction to Sociological Ideas*, Oxford University Press, Melbourne.
- Kelly, G 1955, *The Psychology of Personal Constructs: Volume 1: A Theory of Personality*, W.W. Norton & Company Inc, New York.
- Kincheloe, JL & McLaren, PL 1998, 'Rethinking critical theory and qualitative research', in NK Denzin & YS Lincoln (eds), *The Landscape of Qualitative Research: Theories and Issues*, Sage Publications, Thousand Oaks.
- 2005, 'Rethinking critical theory and qualitative research', in NK Denzin & YS Lincoln (eds), *The Sage Handbook of Qualitative Research Third Edition*, 3rd edn, Sage, Thousand Oaks.
- Kirsch, GE 1999, *Ethical Dilemmas in Feminist Research: The Politics of Location, Interpretation, and Publication*, State University of New York Press, New York.
- Koch, T & Harrington, A 1998, 'Reconceptualising rigour: The case for reflexivity', *Journal of Advanced Nursing*, vol. 28, no. 4, pp. 882-90.
- Kristeva, J 1977, *About Chinese Women*, Marion Boyers, London.
- Labonte, R, Polanyi, M, Muhajarine, N, McIntosh, T & Williams, A 2005, 'Beyond the divides: Towards critical population health research', *Critical Public Health*, vol. 15, no. 1, pp. 5-17.
- Labonte, R 1992, *Community Health Empowerment: Notes on the New Health Promotion Practice*, Health Promotion Centre University of Toronto, Toronto.
- 2001, 'Health promotion in the 21st century: Celebrating the ordinary', *Health Promotion Journal of Australia*, vol. 12, no. 2, pp. 104-9.
- Lake, M 1993, 'A revolution in the family: The challenge and contradictions of maternal citizenship in Australia', in S Koven & S Michel (eds), *Mothers of a New World: Maternalist Politics and the Origins of Welfare States*, Routledge, New York, pp. 378-95.
- Lather, P 1986, 'Research as praxis', *Harvard Educational Review*, vol. 56, no. 3, pp. 257-76.

- Layton, R 2003, *Our Best Investment: A State Plan to Protect and Advance the Interests of Children*, Government of South Australia, Adelaide.
- Leeson, R 1990, *Settling Your Baby: A Survival Guide for Parents*, Magary Institute, Adelaide.
- Leininger, M & McFarland, MR 2006, *Culture Care Diversity and Universality: A Worldwide Nursing Theory*, Jones and Bartlett Publishers, Boston.
- Leininger, M 1997, 'Transcultural nursing research to transform nursing education and practice: 40 years', *Image: The Journal of Nursing Scholarship*, vol. 29, no. 4, pp. 341-7.
- Lewis, G & Slade, C 1994, *Critical Communication*, Prentice Hall, Sydney.
- 2000, *Critical Communication*, Prentice Hall, Sydney.
- Lewis, J 2002, *Cultural Studies: The Basics*, Sage Publications, London.
- Lincoln, YS & Guba, E 1985, *Naturalistic Inquiry*, Sage, Newbury Park.
- Ling Liem, I 1999, 'The challenges of migrant motherhood: The childrearing practices of Chinese first-time mothers in Australia', in PL Rice (ed.), *Asian Mothers, Western Birth: Pregnancy, Childbirth and Childrearing: The Asian Experience in an English Speaking Country*, 2nd edn, Ausmed Publications, Melbourne.
- Locke, RG 1986, 'Introduction', paper presented to Body, Self and Society: Human Sciences Perspectives on Health and Wellbeing in Australia, Perth, W.A.
- Long, H, Pirkis, J, Minhalopoulos, LN, Summers, M & Dunt, D 1999, *Evaluating Mental Health Service Frameworks for Non-English Speaking Background Communities*, Australian Transcultural Mental Health Network, Melbourne.
- Loomba, A 1998, *Colonialism/Postcolonialism*, The New Critical Idiom, Routledge, London.
- Love, NS 1998, *Dogmas and Dreams: A Reader in Modern Political Ideologies*, 2nd edn, Chatham House Publishers, Chatham.
- Lupton, D 2003, *Medicine as Culture: Illness, Disease and the Body in Western Societies*, 2nd edn, Sage Publications, London.
- Lynam, J, Browne, AJ, Reimer Kirkham, S & Anderson, J 2007, 'Re-thinking the complexities of 'culture': What might we learn from Bourdieu?', *Nursing Inquiry*, vol. 14, no. 1, pp. 23-34.
- Macquarie Dictionary*, 2008, viewed 14/02/08, <<http://www.macquariedictionary.com.au/>>.
- Magnusson, E 2005, 'Gendering of equality in the lives of Nordic heterosexual couples with children: No well-paved avenues yet', *Nordic Journal of Women's Studies*, vol. 33, no. 13, pp. 153-63.
- Manojlovich, M 2007, 'Power and empowerment in nursing: Looking backward to inform the future', *Nursing World: The Online Journal of Issues in Nursing*, vol. 12, no. 1.
- Marcus, GE & Fischer, MMJ 1986, *Anthropology as Cultural Critique: An Experimental Moment in The Human Sciences*, The University of Chicago Press, Chicago.
- Marcus, GE 1998, 'What comes (just) after post? The case of ethnography', in NK Denzin & YS Lincoln (eds), *The Landscape of Qualitative Research: Theories and Issues*, vol. 1, Sage Publications, Thousand Oaks.
- Markovic, M (ed.) 2001, *Responding to Cultural Diversity in Women's Health*, Key Centre for Women's Health in Society, Melbourne.
- Markus, A 2001, *Race: John Howard and the Remaking of Australia*, Allen and Unwin, Crows Nest.
- Marmot, M 2001, 'Economic and social determinants of disease', *Bulletin of the World Health Organisation*, vol. 79, no. 10, pp. 988-989.
- Martin J 1997, *Riddles*, viewed 26/04/07, <<http://www.jodimartin.com/lyrics.php?song=15>>.



- Martin, J 1996, 'Signs of the time: Race, sex and media representation', in S Castles & E Vasta (eds), *The Teeth are Smiling: The Persistence of Racism in Multicultural Australia*, Allen and Unwin, Sydney.
- Marvin, R, Cooper, G, Hoffman, K & Powell, B 2002, 'The Circle of Security™ project: Attachment-based intervention with caregiver-pre-school child dyads', *Attachment & Human Development*, vol. 4, no. 1, pp. 107-24.
- Mayer, G & Villaire, M 2007, 'Interpreters and their role in the health care setting', in *Health Literacy in Primary Care: A Clinicians Guide*, Springer Publishing Company, New York.
- McCain, MN & Mustard, JF 2002, *The Early Years Study Three Years Later: From Early Child Development to Human Development: Enabling Communities*, The Founders' Network of the Canadian Institute for Advanced Research, Toronto.
- McConaghy, C 1997, 'What Constitutes Today's Colonialism? Reconsidering Cultural Relevance and Mainstreaming in Indigenous Social and Educational Policy', unpublished manuscript, Armidale Department of Educational Studies, NSW.
- 1998, 'Positioned leadership: Education and the politics of location in rural and remote postcolonial Australia', in L Ehrich & J Knight (eds), *Leadership in Crisis? Essays on Contemporary Educational Leadership*, Post Pressed, Brisbane.
- 2000, *Rethinking Indigenous Education: Culturalism, Colonialism and the Politics of Knowing*, Post Pressed, Flaxton, QLD.
- McCormick, DP, Rassin, GM, Stroup-Benham, CA, Baldwin, CD, Levine, HG, Persaud, DI & Wolf, WJ 1993, 'Use of videotaping to evaluate pediatric resident performance of health supervision examination of infants', *Pediatrics*, vol. 92, no. 1, pp. 116-20.
- McKenna, JJ, Mosko, S & Richard, C 1997, 'Bedsharing promotes best feeding', *Pediatrics*, vol. 100, pp. 214-9.
- McKenna, JJ 1995, 'The potential benefits of infant-parent co-sleeping in relation to SIDS prevention: Overview and critique of epidemiological bed sharing studies', in TO Rognum (ed.), *Sudden Infant Death Syndrome: New Trends in the Nineties*, Scandinavian University Press, Oslo.
- 1996, 'Sudden infant death syndrome in cross cultural perspective: Is infant-parent cosleeping proactive?', *Annual Review of Anthropology*, vol. 25, pp. 201-19.
- 2000, 'Cultural influences on infant and childhood sleep biology and the science that studies it: Toward a more inclusive paradigm', in GM Loughlin, JL Carroll & CL Marcus (eds), *Sleep and Breathing in Children: A Developmental Approach*, Marcel Dekker, Inc, New York.
- McMurray, A 2007, *Community Health and Wellness: A Socio-Ecological Approach*, Mosby Elsevier, Marrickville.
- McNay, L 1992, *Foucault and Feminism: Power, Gender and the Self*, Polity Press, Cambridge.
- Mehrabian, A 1972, *Nonverbal Communication*, Aldine Atherton, Inc, Chicago.
- Mein Smith, P 1997, *Mothers and King Baby*, Macmillan Press Ltd, Houndsmills.
- Migrant Resource Centre of South Australia 2004, *Migrant Resource Centre of South Australia*, Migrant Resource Centre of South Australia, viewed 31/07/07, <<http://www.users.bigpond.com/mrcsa/index.html>>.
- Minichiello, V, Aroni, R, Timewell, E & Alexander, L (eds) 2000, *Indepth Interviewing: Principles, Techniques, Analysis*, 2nd edn, Longman, Sydney.
- Mitcheson, J & Cowley, S 2003, 'Empowerment or control? An analysis of the extent to which client participation is enabled during health visitor/client interactions using a structured health needs assessment tool', *International Journal of Nursing Studies*, vol. 40, pp. 413-26.

- Miteff, S 2006, 'Family Home Visiting celebrates two years', Health Focus: The Official Newsletter of the Children, Youth and Women's Health Service, no. 6, June 2006.
- Moreton-Robinson, A 2000, *Talkin' Up to White Woman: Indigenous Women and Feminism*, University of Queensland Press, St Lucia.
- 2004, 'Whiteness, epistemology and Indigenous representation', in A Moreton-Robinson (ed.), *Whitening Race: Essays in Social and Cultural Criticism*, Aboriginal Studies Press, Canberra.
- Mothers' and Babies' Health Association 1959, *The First Fifty Years: An Epic of Struggle, Perseverance, Work, and Yet More Work*, Mothers' and Babies' Health Association, Adelaide.
- Mothers' and Babies' Health Association n.d., *School for Mothers Institute*, Adelaide.
- Mulholland, J 1995, 'Nursing, humanism and transcultural theory: The 'bracketing-out' of reality', *Journal of Advanced Nursing*, vol. 22, pp. 442-9.
- Multicultural SA 2001, *What is Multiculturalism*, Government of South Australia, viewed 26/11/07, <<http://www.multicultural.sa.gov.au/about/multiculturalism.htm>>.
- Nash, M, Munford, R & O'Donoghue, K (eds) 2005, *Social Work Theories in Action*, Jessica Kingsley Publishers, London.
- National Health and Medical Research Council 2003, *Dietary Guidelines for Children and Adolescents in Australia*, NHMRC, Canberra.
- 2005, *Cultural Competency in Health: A Guide for Policy, Partnerships and Participation*, NHMRC, Canberra.
- National SIDS Council of Australia 2007, *SIDS and Kids Safe Sleeping*, The National SIDS Council of Australia, viewed 02/12/07, <[http://www.sidsandkids.org/documents/FAQOctober2007\\_2\\_\\_000.pdf](http://www.sidsandkids.org/documents/FAQOctober2007_2__000.pdf)>.
- Neill, R 2002, *White Out: How Politics is Killing Black Australia*, Allen and Unwin, Crows Nest.
- New South Wales Department of Education and Training 2005, *Racism No Way*, Conference of Education Systems Chief Executive Officers 2000, viewed 18/06/07, <<http://www.racismnoway.com.au/library/legislation/index-Commonwe.html#Heading60>>.
- Nicholson, B, Skelton, R & Silkstone, D 2005, 'Riots fire debate on racism', *The Age*, 13/12/2005, p. 1.
- Nicolacopoulos, T & Vassilopoulos, G 2004, 'Racism, foreigner communities and the onto-pathology of white Australian subjectivity', in A Moreton-Robinson (ed.), *Whitening Race: Essays in Social and Cultural Criticism*, Aboriginal Studies Press, Canberra.
- Nursing Council of New Zealand 2005, *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice*, NCNZ, Wellington.
- Oakley, A 1995, 'Interviewing women', in H Roberts (ed.), *Doing Feminist Research*, Routledge and Keegan Paul, London.
- O'Brien, N & Kearney, S 2005, 'Hate at the beach', *The Australian*, 13/12/05, p. 11.
- Offord, D, Boyle, M, Szatmari, P, Rae-Grant, N, Links, P, Cadman, D, Byles, J, Crawford, J, Blum, H, Byrne, C, Thomas, H & Woodward, C 1987, 'Ontario Child Health Study II: Six month prevalence of disorder and rates of service utilization', *Archives of General Psychiatry*, vol. 44, pp. 832-6.
- Osborne, S & Gardner, G 2005, 'Developing a culture of inquiry to sustain evidence-based practice', in M Courtney (ed.), *Evidence for Nursing Practice*, Churchill Livingstone, Marrickville.
- Owen, DS 2007, 'Towards a critical theory of whiteness', *Philosophy and Social Criticism*, vol. 33, no. 2, pp. 203-22.

- Palombo, L 1998, 'Italian Women in Australia from the 1870s to 1930s: From Invisibility to Motherhood', Masters thesis, Flinders University.
- Papps, E 2002, *Nursing in New Zealand: Critical Issues, Different Perspectives*, Pearson Education, Auckland.
- Parekh, B 1986, 'The "New Right" and the Politics of Nationhood', in *The New Right: Image and Reality*, Runnymede Trust, London.
- Phipps, S 1999, *An International Comparison of Policies and Outcomes for Young Children (CPRN Study No. F/05)*, Renouf Publishing, Ottawa.
- Pink, S 2001, *Doing Visual Ethnography: Images, Media and Representation in Research*, Sage Publications, London.
- Pittman, PM 2006, 'Beyond the sound of one hand clapping: Experiences in six countries using health equity research in policy', *Journal of Health Politics, Policy & Law*, vol. 31, no. 1, pp. 33-49.
- Polaschek, NR 1998, 'Cultural safety: A new concept in nursing people of different ethnicities', *Journal of Advanced Nursing*, vol. 27, pp. 452-7.
- Poulin, JE 2000, *Collaborative Social Work: Strengths-Based Generalist Practice*, F.E. Peacock Publishers, Itasca.
- Poynting, S 2004, *Bin Laden in the Suburbs: Criminalising the Arab Other*, Institute of Criminology, Sydney.
- Premier and Cabinet of South Australia 2006, *News: Home Visits Helping Families*, Premier and Cabinet of South Australia, viewed 08/01/07, <<http://www.ministers.sa.gov.au/news.php?id=132&print=1>>.
- Puckering, C 2004, 'The Mellow Parenting Program: Its Methods and Outcome', paper presented to Parenting Imperatives: A National Parenting Conference, Adelaide.
- Ramsden, I & Spoonley, P 1994, 'The cultural safety debate in Aotearoa', *New Zealand Annual Review of Education*, pp. 161-74.
- Ramsden, I 1990, *Kawa Whakaruruhau: Cultural Safety in Nursing Education In Aotearoa*, Ministry of Education, Wellington.
- 1992, 'Teaching cultural safety', *New Zealand Nursing Journal*, June, pp. 21-3.
- 1995, 'Cultural Safety: Implementing the Concepts', paper presented to Social Force of Nursing and Midwifery Conference, James Cook Centra Hotel Wellington, 23 May 1995.
- 2002, *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*, PhD thesis, Doctor of Philosophy in Nursing, Victoria University of Wellington, Massey University, viewed 10/01/08, <<http://culturalsafety.massey.ac.nz/ChapterEight.htm>>.
- Ratcliff, D 2003, 'Video methods in qualitative research', in PM Camic, JE Rhodes & L Yardley (eds), *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*, American Psychological Association, Washington DC.
- Razack, SH 1998, *Looking White People in the Eye: Gender, Race and Culture in Courtrooms and Classrooms*, University of Toronto Press, Toronto.
- Rees, S 2004, 'East Timorese women asylum seekers in Australia: Extrapolating a case for resettlement services', *Australian Social Work*, vol. 57, no. 3, pp. 259-72.
- Reimer Kirkham, S & Anderson, J 2002, 'Postcolonial nursing scholarship: from epistemology to method', *Journal of Advanced Nursing Science*, vol. 25, no. 1, pp. 1-17.
- Rice, PL (ed.) 1999, *Asian Mothers, Western Birth: Pregnancy, Childbirth and Childrearing: The Asian Experience in an English Speaking Country*, 2nd edn, Ausmed Publications, Melbourne.
- Richardson, S 2003, 'Aotearoa/New Zealand nursing: From eugenics to cultural safety...', *Nursing Inquiry*, vol. 11, no. 1, pp. 35-42.
- Ritzer, G 1993, *The McDonaldization of Society*, Pine Forge Press, Thousand Oaks.

- Robinson, J 1982, *An Evaluation of Health Visiting*, Council for the Education and Training of Health Visitors, English National Board for Nursing Midwifery and Health Visiting, London.
- Roche, B, Cowley, S, Salt, N, Scammell, A, Malone, M, Savile, P, Aikens, D & Fitzpatrick, S 2005, 'Reassurance of judgement? Parents' views on the delivery of child health surveillance programs', *Family Practice*, vol. 22, no. 5, pp. 507-12.
- Rogers, C 1959, 'A theory of therapy, personality and interpersonal relationships as developed in the client centered framework', in S Koch (ed.), *Psychology: A Study of Science*, vol. 3, McGraw-Hill, New York.
- Roman, LG 1993, 'White is a colour! White defensiveness, postmodernism, and anti-racist pedagogy', in C McCarthy & W Crichlow (eds), *Race Identity and Representation in Education*, Routledge, New York.
- Rose, G 1992, *The Strategy of Preventive Medicine*, Oxford University Press Inc, New York.
- 2001, 'Sick individuals and sick populations', *Bulletin of the World Health Organisation*, vol. 79, no. 10, pp. 990-6.
- Rosenbaum, E & Rosenbaum, I 1987, 'Achieving open communication with cancer patients through audio and videotapes', *Journal of Psychosocial Oncology*, vol. 4, no. 4, pp. 91-105.
- Rosenberg, CE 1987, *The Care of Strangers: The Rise of America's Hospital System*, Basic Books, New York.
- Royal Australasian College of Physicians 2004, *An Introduction to Cultural Competency*, RACP, viewed 10/01/08, <<http://www.racp.edu.au/index.cfm?objectid=49F4E2A9-2A57-5487-D0597D1ED8218B61>>.
- Ruddick, S 1989, *Maternal Thinking: Toward a Politics of Peace*, Beacon Press, Boston.
- Sackett, DL, Straus, SE & Richardson, WS 2000, *Evidence Based Medicine: How to Practice and Teach EBM*, 2nd edn, Churchill Livingstone, London.
- Said, E 1978, *Orientalism*, Vintage, New York.
- Saleebey, D (ed.) 2005, *Strengths Perspective in Social Work Practice*, Pearson/Allyn & Bacon, Boston.
- Sarup, M 1996, *Identity, Culture and the Modern World*, Edinburgh University Press, Edinburgh.
- Sarvimaki, A 1988, 'Nursing as a moral, practical, communicative and creative activity', *Journal of Advanced Nursing*, vol. 13, pp. 462-7.
- Sawicki, J 1991, *Disciplining Foucault: Feminism, Power and the Body*, Routledge, New York.
- Schech, S & Haggis, J 1998, 'Postcolonialism, identity, and location: Being white Australian in Asia', *Environment and Planning D: Society and Space*, vol. 16, pp. 615-29.
- Schott, J & Henley, A 2004, *Culture, Religion and Childbearing in a Multiracial Society*, Butterworth-Heinemann, London.
- Shah, S 2004, 'The researcher/interviewer in intercultural context: A social intruder!', *British Educational Research Journal*, vol. 30, no. 4, pp. 549-75.
- Sharry, J 2004, *Counselling Children, Adolescents and Families: A Strengths-Based Approach*, Sage, London.
- Sheridan, S 2000, 'The "Australian Woman" and her migrant others in the postwar Australian Woman's Weekly', *Continuum: Journal of Media and Cultural Studies*, vol. 14, no. 2, pp. 121-32.
- Simpson, J 2007, '"Can't we focus on the good stuff?": the pedagogical distance between comfort and critique', in L Cooks & J Simpson (eds), *Whiteness, Pedagogy, Performance*, Lexington Books, Lanham, MD.

- Small, MF 1998, *Our Babies, Our Selves: How Biology and Culture Shape the Way We Parent*, Anchor Books, New York.
- Small, R, Rice, PL, Yelland, J & Lumley, J 1999, 'Mothers in a new country: How important are language and cultural issues in immigrant woman's experiences of maternity care?', in PL Rice (ed.), *Living in a New Country: Understanding Migrants' Health*, Ausmed, Melbourne.
- Small, R, Yelland, J, Lumley, J, Brown, S & Liamputtong, R 2002, 'Immigrant women's views about care during labour and birth: An Australian study of Vietnamese, Turkish and Filipino women', *Birth*, vol. 29, no. 4, pp. 266-77.
- Smith, D 1974, 'Women's perspectives as a radical critique of sociology', in E Fox Keller & HE Longin (eds), *Feminism and Science*, Oxford University Press, Oxford.
- Smith, KI 1978, 'A family affair: The School for Mothers Institute Adelaide 1909 to 1927', Honours Degree of Bachelor of Arts thesis, Flinders University.
- Smith, LS 1998, 'Concept analysis: Cultural competence', *Journal of Cultural Diversity*, vol. 5, no. 1, pp. 4-10.
- Spence, D 2004, 'Prejudice, paradox, and possibility: The experience of nursing people from cultures other than one's own', in KH Kavanagh & V Knowlden (eds), *Many Voices: Toward Caring Culture in Healthcare and Healing*, University of Wisconsin Press, Wisconsin.
- Spivak, GC 1987, *In Other Worlds: Essays in Cultural Politics*, Methuen, London.
- 1995, 'The Rani of Sirmur', in F Barker et al. (eds), *Europe and Its Others*, The University of Essex, Colchester.
- Spock, B 1946, *Common Sense Book of Baby and Child Care*, Duell Sloan, New York.
- Spradley, JP 1980, *Participant Observation*, Holt, Rinehart and Winston, New York.
- Stanley, F 2001, 'Developmental Health and Wellbeing: Australia's Future: Child Development Health and Wellbeing into the 21st Century', paper presented to Prime Minister's Science, Engineering and Innovation Council Seventh Meeting, June 2001.
- Stewart, C & Hodge, A 2005, 'Isolated and angry', *The Australian*, 14/12/05, p. 11.
- Street, A 1990, *Nursing Practice: High, Hard Ground, Messy Swamps and the Pathways in Between*, Deaking University Press, Geelong.
- Strong, PM 1979, *The Ceremonial Order of the Clinic: Parents, Doctors, and Medical Bureaucracies*, Routledge and Kegan Paul, London.
- STTARS 2005, *STTARS Supporting Survivors of Torture and Trauma*, STTARS, viewed 31/07/07, <<http://www.sttars.org.au/>>.
- Stynes, R 2000, 'Analysing the data and writing it up', in V Minichiello, R Aroni, E Timewell & L Alexander (eds), *In Depth Interviewing*, 2nd edn, Longman, Australia.
- Swendson, C & Windsor, C 1995, 'Rethinking cultural sensitivity', *Nursing Inquiry*, vol. 3, pp. 3-10.
- Symonds, A 1991, 'Angels and interfering busybodies: The social construction of two occupations', *Sociology of Health and Illness*, vol. 13, no. 2, pp. 249-64.
- Talpade Mohanti, C 1984, 'Under Western eyes: Feminist scholarship and colonial discourse', *Boundary 2*, vol. 12, no. 3, pp. 333-58.
- 1994, 'Under Western eyes: Feminist scholarship and colonial discourse', in P Williams & L Chrisman (eds), *Colonial Discourse and Postcolonial Theory: A Reader*, Columbia University Press, New York.
- Taylor, FW 1947, *Scientific Management*, Harper and Row, New York.
- Thayer-Bacon, BJ 2003, *Relational "(E)pistemologies"*, Counterpoints: Studies in Postmodern Theory of Education, Peter Lang, New York.
- Truby King, F 1921, *The Expectant Mother, and Baby's First Months*, New Zealand.
- Truby King, M 1934, *Mothercraft*, Whitcomb and Tombs, Melbourne.

- University of Minnesota Centre for Early Education and Development 2004, *Trainings*, Regents of the University of Minnesota, viewed 20/07/07, <<http://www.education.umn.edu/CEED/coursesandtrainings/trainings/steepsib.htm>>.
- Van Loon, J 2001, 'Ethnography: A critical turn in cultural studies', in P Atkinson, A Coffey, S Delamont, J Lofland & L Lofland (eds), *Handbook of Ethnography*, Sage Publications, London.
- Victoria, CG, Wagstaff, A, Armstrong Schellenberg, J, Gwatkin, D, Claeson, M & Habicht, J-P 2003, 'Applying an equity lens to child health and mortality: More of the same is not enough', *The Lancet*, vol. 362, no. 9379, pp. 233-41.
- Vidich, AJ & Lyman, SM 1998, 'Qualitative methods: Their history in sociology and anthropology', in NK Denzin & YS Lincoln (eds), *The Landscape of Qualitative Research: Theories and Issues*, Sage Publications, Thousand Oaks.
- Vimpani, G, Patton, G & Hayes, A 2002, *The Relevance Of Child and Adolescent Development for Outcomes in Education, Health and Life Success*, Australian Institute of Family Studies, Canberra.
- Vimpani, G 1998, 'Home visiting: An essential building block to support families', *New South Wales Public Health Bulletin*, vol. 9, no. 11, p. 130.
- 2000, 'Home visiting for vulnerable infants in Australia', *Journal of Paediatrics and Child Health*, vol. 36, pp. 537-9.
- Vose, C & Thurecht, K 1999, 'What is different when you have a baby in a new country?', in PL Rice (ed.), *Living in a New Country: Understanding Migrants' Health*, Ausmed Publications, Melbourne.
- Wass, A 2000, 'Health promotion in context: Primary health care and the new public health movement', in *Promoting Health: The Primary Health Care Approach*, Harcourt Australia, Marickville.
- Weedon, C 1987, *Feminist Practice and Poststructural Theory*, Basil Blackwell Ltd, Oxford.
- 1997, *Feminist Practice and Poststructural Theory*, 2nd edn, Blackwell Publishing, Oxford.
- Whalley, M 2001, *Involving Parents in Their Children's Learning*, Paul Chapman Publishing London.
- 2004, 'Parents and Early Childhood Practitioners: Partnerships for Children's Well Being', paper presented to Parenting Imperatives: A National Parenting Conference, Adelaide.
- Williams, A, Cooke, H & May, C 1998, *Sociology, Nursing and Health*, Butterworth-Heinemann, Oxford.
- Williams, R 1976, *Keywords: A Vocabulary of Culture and Society*, Croom Helm Ltd, London.
- 1981, *Culture*, Fontana New Sociology, Fontana Paperbacks, Glasgow.
- Willis, P 2000, *The Ethnographic Imagination*, Polity Press, Cambridge.
- Wiman, E & Wikblad, K 2004, 'Caring and uncaring encounters in nursing in an emergency department', *Journal of Clinical Nursing*, vol. 13, pp. 422-9.
- Winters, J, Hauck, B, Riggs, CJ, Clawson, J & Collins, J 2003, 'Use of videotaping to assess competencies and course outcomes', *Journal of Nursing Education*, vol. 42, no. 10, pp. 472-6.
- World Health Organisation 1978, 'Declaration of Alma-Ata', paper presented to International Conference on Primary Health Care, Alma-Ata, URRR, 6-12 September 1978, viewed 04/06/05, <[http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)>.
- 1986, 'Ottawa Charter for Health Promotion: Conference on Health Promotion', paper presented to Ottawa Charter for Health Promotion: Conference on Health Promotion, Copenhagen, 17-21 November 1986, viewed 04/06/05, <[http://www.who.int/hpr/NPH/docs/ottawa\\_charter\\_hp.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf)>.

- 1997, *The Jakarta Declaration on Leading Health into the 21st Century* World Health Organisation, viewed 22/10/07, <[http://www.who.int/hpr/NPH/docs/Jakarta\\_declaration\\_en.pdf](http://www.who.int/hpr/NPH/docs/Jakarta_declaration_en.pdf)>.
- 1998, *Health Promotion Glossary*, World Health Organisation, Geneva.
- 2005, *The Bangkok Charter for Health Promotion in a Globalised World*, World Health Organisation, cited 22/10/07, <[http://www.afro.who.int/healthpromotion/bangkok\\_charter\\_health\\_promotion.pdf](http://www.afro.who.int/healthpromotion/bangkok_charter_health_promotion.pdf)>.
- Wright Mills, C 1970, *The Sociological Imagination*, Penguin Books, Harmondsworth.
- Yelland, J, Small, R, Lumley, J, Rice, PL, Cotronei, V & Warren, R 1998, 'Support, sensitivity, satisfaction: Filipino, Turkish and Vietnamese women's experiences of postnatal hospital stay', *Midwifery*, vol. 14, pp. 144-54.
- Young, ME 2002, 'From Early Child Development to Human Development: Investing in Our Children's Future', paper presented to World Bank Conference on Investing in Our Children's Future, Washington DC, April 10 -11 2002.
- Young, RJC 1992, 'Colonialism and humanism', in J Donald & A Rattansi (eds), *'Race', Culture and Difference*, Sage Publications, London.
- 1995, *Colonial Desire: Hybridity in Theory, Culture and Race*, Routledge, London.