CLIENT CARE-SEEKING BEHAVIOURS IN A
COMMUNITY SETTING AND THEIR
SOURCES OF SATISFACTION WITH
NURSING CARE

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This project was carried out as a research practicum under the direction of Dr. Moyra Allen while the author was a visiting student at the School of Nursing, McGill University.

INTRODUCTION

Only a few studies have focused on the client’s responses to nursing care and those have tended to examine selected aspects of an interaction. Factors that influenced patient behaviour in the hospital were studied by Tagliocozzo (1965). Two other studies by Becker (1978) and Christiansen (1978) have examined client compliance and non-compliance with prescribed care. Factors in hospitalization and illness which increased anxiety levels were the focus of a study by Wilson-Barnett (1978). A search of the literature failed to reveal any studies on the characteristics and processes inherent in a client-nurse interaction. Why do clients seek care? What do they expect when they seek care? What are the outcomes from their point of view? In examining some data collected as part of a larger study of nurses and clients, the answer to some of these questions appeared to be present in interviews that had been conducted with the clients. The availability of the data thus provided the impetus for this study.

PURPOSES OF THE STUDY

The purposes of the study were (1) to identify the characteristics and processes inherent in client care-seeking behaviour in a community health setting; and (2) to identify the sources of client satisfaction and dissatisfaction with the process of receiving nursing care.
**DEFINITIONS**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Category</td>
<td>A class or dimension in a scheme of classification.</td>
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<tr>
<td>Characteristic</td>
<td>A distinguishing trait or property.</td>
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<tr>
<td>Phase</td>
<td>A sequence in a series of related events.</td>
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<tr>
<td>Stage</td>
<td>Related segments that together make up a phase.</td>
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<tr>
<td>Dimension</td>
<td>The range or degree over which a particular characteristic extends.</td>
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<tr>
<td>Interaction</td>
<td>Mutual or reciprocal action between at least two people.</td>
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<tr>
<td>Activity</td>
<td>A generalized behaviour utilized by the nurse as a response to client need (e.g., support).</td>
</tr>
<tr>
<td>Action</td>
<td>A specific act utilized by the nurse which constitutes one element of an activity (e.g. listening).</td>
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<td>Self-referred</td>
<td>Clients who made the initial contact with the workshop themselves.</td>
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<tr>
<td>Other-referred</td>
<td>Clients whose contact with the agency was made by other persons on their behalf.</td>
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**DESIGN AND PROCEDURES**

The study was exploratory in nature. It utilized precollected interviews and the transcripts of the interviews formed the unit of analysis. A grounded theory approach, using a constant comparative method of analysis, was used to generate categories. Utilizing the categories, a model of care-seeking was constructed.

**POPULATION AND DATA COLLECTION**

The population consisted of 35 clients who had been in contact with one or more nurses from a community agency, "The Health Workshop," a facility staffed entirely by nurses. The clients were interviewed by one or two interviewers, between the 2nd of May and the 25th of August, 1978. All clients interviewed were adult, and usually only one member of a family took part in the interview. The clients were seen by eight different nurses. One nurse saw only one client, one saw nine clients while the mode was five.
The number of visits that clients had made to nurses at the time of the recorded interview ranged from one to 100, with a mode of four. In 17 cases the identified problem centered on a female, in three on a male and in 15 cases more than one member of a family was involved. Fifteen clients had been visited in their own homes and 20 in the workshop. Twenty-seven clients were self-referred.

LIMITATIONS OF THE STUDY

1. Time constraints prevented construct validation of the characteristics.

2. Negative findings in some small sub-groups were only partially explained due to the small numbers of cases involved.

3. Data were pre-collected so weak areas could not be supplemented by the addition of more cases.

4. Problem dimensions were not mutually exclusive based on the results of the reliability check.

ANALYSIS OF THE DATA

The constant comparative method used to examine the data employs joint coding and analysis to generate theory. Such theory is integrated, consistent, plausible, close to the data and in a form clear enough to be readily, if only partially, operationalized for testing in quantitative research (Glaser, 1969).

In conducting the analysis, the first step was to read all the interviews to identify some broad categories in the data. Once tentative categories were identified, interviews were reanalysed and the categories examined for common characteristics. The interviews were examined in sets of five. After the second set of five interviews were analysed, they were compared with the first set of five and the categories and characteristics revised as necessary. Subsequently each batch of interviews were compared with the initial batch. Exceptions were noted and reasons for the differences examined. The data were then examined for processes related to the characteristics. The next stage was re-examination of the categories, characteristics and processes in an attempt to delimit the theory.
Validity

Validity of categories was established by a panel of three judges (all nurse educators). Each judge analysed one interview (selected by use of a random number table) using the provided categories. Following discussion there was a revision of the data initially assigned by the researcher to these categories and some readjustment of the original titles. The panel then evaluated one further interview using the revised categories and agreement was reached on their appropriateness for analysis. Validity of the types of problem and types of care was also established but the properties and relationships were not validated by the panel.

Reliability

One graduate student accepted the task of analysing three interviews utilising the revised coding scheme following the validation procedure. A reliability of .73 was established between the student (S) and researcher (R). The reliability index was constructed as follows:

\[ I = \frac{R - S}{R + S} \]

\[ R = \text{Researcher Frequency} \]
\[ S = \text{Student Frequency} \]

Validity and Reliability of the Interviews

The quality of the interviews with clients varied somewhat. There was consistency in the information obtained by the two interviewers involved but in later interviews less probing questions were asked and for the purpose of this analysis, the data were less rich than in the earlier interviews.

FINDINGS

Phases of Care-Seeking

Three definite phases of care-seeking were identified: a preactive, an interactive, and a postactive phase. These phases formed the framework for the analysis. The dimensions, the behaviours and the activities relating to each phase were examined and the processes of care-seeking were identified (Figure 1).

Preactive Phase

The preactive phase consisted of three stages: (1) a situation which precipitated care-seeking behaviour; (2) the identification of a problem by the client; and (3) the initiation of care-seeking behaviours.
Phase I. PREACTIVE PHASE

Stage
- Situations which precipitated care-seeking behaviours
- Problem Identification
  - Emergency
  - Cumulative Stress
  - Post Hospital Care
  - Health Directed Care

Dimension
- Life Style
- Self-Esteem

Stage
- Initiation of Care-Seeking Behaviours
  - Choice of Agency
  - General Expectations of Care
    - Characteristics of Nurse
    - Activities of Nurse

Phase II. INTERACTIVE PHASE

Dimensions
- Characteristics of Nurse
- Activities of Nurse
  - Guidance
  - Support
  - Control
  - Physical Care

Phase III. POSTACTIVE PHASE

Consequences
- Satisfaction
- Ambivalence
- Dissatisfaction

Figure 1. The Model of Care-Seeking Utilised for Analysing the Client-Nurse Interaction.
Stage 1: Factors which Precipitated Care-Seeking Behaviours

Among self-referred clients, a preactive phase occurred before contact was made with the workshop and some common dimensions were identified related to the interaction of factors in the clients' lifestyles and the clients' self-esteem. Self-esteem was used to denote the ways in which the client viewed his own capabilities and body image. Lifestyle was a factor in the environment which affected the individual as he went about his daily activities.

Table 1
Preactive Phase: Situations Which Precipitated Care-Seeking Behaviours

<table>
<thead>
<tr>
<th>Situation</th>
<th>Threat to Lifestyle</th>
<th>Effect on Self-Esteem</th>
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<tbody>
<tr>
<td>Chronic pain</td>
<td>Malfunctioning support system</td>
<td>Psychological threat to self-image</td>
</tr>
<tr>
<td>Discharge after hospitalization</td>
<td>Unstable support system</td>
<td>Dependence/independence conflict. Threat to self as independend individual</td>
</tr>
<tr>
<td>Divorce, move to new area</td>
<td>No support system</td>
<td>Threat to psychological and social image</td>
</tr>
<tr>
<td>Chronic obesity</td>
<td>Social consequences</td>
<td>Threat to body-image</td>
</tr>
<tr>
<td>Negative experience with previous health care</td>
<td>Forced into dependence on health workers</td>
<td>Feeling of helplessness deprivation of independendence</td>
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Table I demonstrates some of the lifestyle and self-esteem factors that made the clients identify a need for care. Some clients already had stresses and strains in their life while others sought care because they wanted to prevent problems by improving their lifestyle; for example, a "good mother" produces a "healthy baby."
From the data, the following processes related to care-seeking emerged:

1) When factors in the individual's lifestyle exerted sufficient force on his self-esteem so that he perceived himself as helpless to resolve the problem unaided, care-seeking behaviour was initiated.

2) When an individual perceived that a change in lifestyle would be beneficial to his health but did not believe he had adequate resources to create this change, care-seeking behaviour was initiated.

Stage 2: Problem Identification

The dimensions of the problems presented by clients were limited to four major categories: emergencies, cumulative stress, post hospital (self-referred), and health promotion.

Emergencies were situations where the clients perceived that their problems required immediate input and when the purpose of seeking care was to get attention at that time only. Cumulative stress was identified when clients presented evidence of multiple problems or one problem that had built up over time. Post hospital care was the term used to identify those clients who referred themselves following discharge from hospital. Generally these clients found they had difficulty accepting independence and responsibility following a period of dependence. Health promotion was the term used to identify clients who came to the workshop seeking health measures that would change their lifestyle. They could be seeking to decrease the effect of chronic disease (diabetes, asthma) or might be looking toward a new direction in their life (pregnancy, family planning). The client might also be seeking measures to decrease illness potential (weight reduction).

Processes involved in problem identification (and presentation) were:

1) Having perceived a need for help, the individual identified a problem or goal with which to approach a health care agent or agency.

2) A dominant problem was selected but the presenting problem might be only one symptom of a more complex situation.

3) Clients who went through an inter-agency or inter-agent referral process might not have an identified problem or goal.

Stage 3: Initiation of Care-Seeking Behaviours

After a client had identified a problem, care-seeking behaviour began. Care-seeking behaviour involved both identification of an agency or agent able to provide help in the solution of an identified
problem or goal and the development of an expectation of care. For some clients, expediency was an important dimension of care-seeking. They looked for a facility which was close to home and where they would receive prompt service. All clients classified as emergencies were concerned with expediency. Similar behaviour was identified by Ingram (1978) who found that in an emergency, clients utilized the nearest service whether or not the facility was appropriate.

The role of a stimulus in directing a client's attention to a service once a problem had been identified, appeared to be another important dimension of care-seeking. Friends and neighbours provided information, as did nurses who spoke to groups. Friends' information was sometimes gained from attendance at an "Open House" at the Workshop. Verbal stimuli appeared to be most important; however clients frequently gained additional information from brochures and advertisements after their attention had been focused on the Workshop as an available service.

A third dimension of care-seeking was the client's previous experience with health care agencies. Several clients who came to the Workshop were looking for an alternative service because they felt that they were not receiving adequate help from health care agents and/or agencies with whom they were already involved. These clients expressed negative feelings about previous contacts with the health care system.

General Expectations of Care

Interactions were apparent between problem identification, selection of an agency and the development of an expectation of care. In reality, these are interdependent activities rather than separated in time. It was also apparent that clients did approach the agency with an expectation of the care they would receive, and the personality and characteristics they expected of the individual who would give that care.

Clients frequently made contact with the Workshop because they sought increased knowledge of a self identified problem or condition. However, clients saw themselves as able to manage their own problems but needed information and support from a nurse. The nurse was expected to be sympathetic to their problems. The expected prototype of this nurse for most clients appeared to be a knowledgeable individual, skilled in giving care, who would be reliable and respect confidentiality.
Three major activities clients expected the nurse to perform were physical care, support and guidance. Clients who identified their own primary problem as a need for help with physical care also expected support and guidance if they were self-referred. However, clients who were referred by hospital personnel either were unable to define expectations or did not identify support and guidance as nursing activities. The nursing actions identified by clients as providing support included listening and reassurance. Reassurance included reinforcement of the client's own observations and decisions. The most important nursing action in relation to guidance was provision of information. Expected nursing actions relating to physical care were weighing, blood pressure, taking a pulse, bathing and wound dressing.

A small group of clients (seven) showed a lack of external control in their own lifestyle and expected the nurse to impose controls within which they would have to function. This group showed a parallel between their lack of self control in lifestyle behaviour and their expectation that the nurse would set limits for them.

The Interactive Phase

The second phase, designated as the interactive phase in this study, consisted of the clients' perceptions of their visit with a nurse. In the interview, clients described their perception of the characteristics and behaviour of the nurse during the interaction. In most instances, clients described nursing activities that were related to guidance and support, which were also the behaviours most commonly expected by the clients when they sought help. Clients described the nurse as knowledgeable, caring, gentle, skilled, reliable, concerned and easy to talk to, putting one at ease.

Supportive activities were those that sustained clients in endeavours so they were more likely to succeed in solving their problem or reaching their perceived goal. Guidance activities were those activities which provided direction so individuals could select their own course of action. The activities described included sharing information, acting as sounding board for the client’s ideas and providing alternative resources when the client lacked information. The nurse was perceived as helping clients make their own decisions and not making decisions for them.

Among the clients referred by other agencies or agents, there were a small group who did not identify a need for guidance and support. While they described actions related to such activities, they did not see
them as relevant to their needs. When physical care was given by the nurses, the activities involved were congruent with the expectations of the clients. The clients who were referred from hospital and who had no clear expectations of care suffered role-confusion when physical care was not provided by the nurse.

Processes involved in the client-nurse interaction were:

1) Provision of supportive activities resulted in reduction of tension enabling clients to resume some or all of their normal coping behaviours;
2) Provision of guidance allowed the clients to select a course of action and to move toward the solution of problems or the establishment of new goals;
3) The provision of guidance and support to families whose problems were of a long-term nature resulted in a sense of security which appeared related to the perception that they had acquired a functional support system; and,
4) Clients who did not have a clearly defined goal or purpose did not see nursing activities as relevant even when they were addressed to the problem identified by the referring agency.

The Postactive Phase: Consequences of Care-Seeking

In the postactive phase, clients looked back on the interaction with a nurse and assessed that feeling of satisfaction, dissatisfaction or ambivalence with the process.

Clients who were satisfied either (1) saw a resolution of the problems; or (2) had identified new goals; or (3) perceived their tension to be reduced so they could independently resume problem solving; or, (4) perceived they were making progress toward their goals.

Ambivalence or dissatisfaction were present: (1) if the client’s expectation of care did not coincide with his perception of the care given; and, (2) if the client did not perceive the care as necessary, that is if he had no identified problem and generally no expectations of the care that he needed from a nurse.

Client Satisfaction with Nursing Care

Clients who expressed satisfaction with their care identified some common elements in describing the reasons for their response. These included reduction of tension (reassurance and relief were terms used by clients); finding someone who would listen to them; and finding someone who could provide them with information, enabling them to understand or solve their own problems.
While some clients identified progress in resolving their presenting problems, others expressed satisfaction if they perceived the nursing interaction to provide support even if progress toward solving their problems was not achieved. For example, one client whose husband had suffered a stroke realised that he would not recover, and that her goal for him was not feasible, but did show a positive response to the nurse’s visit, as she felt someone was sharing her responsibilities with her.

Even when the nurse did not identify a client’s covert problem (her fear of battering her child); when the nurse behaved in a way congruent with the client’s expectations, the outcome was satisfactory from the client’s viewpoint. In this instance, the nurse had listened to the concern about her son’s temper tantrums and given advice on child behaviour. This client had perceived her need as having someone to listen to her and give advice, and felt that the nurse had met this need.

Ambivalence or Dissatisfaction with Nursing Care

Out of 35 clients, 7 were ambivalent or dissatisfied with nursing care. These clients came from two groups: (1) those whose primary goal was weight reduction; (2) those who were referred from other agencies. The mechanism which created a lack of satisfaction appeared to differ in the two groups.

Seven clients contacted the clinic with a primary goal of weight reduction. Of these, four were satisfied with their care, two were ambivalent and one clearly dissatisfied. The nurse’s action in each case was clearly related to the goal. However, in looking at the client’s expectation of nursing action and the perceived action of the nurse in the situation, there was a lack of congruence between expected and perceived actions in the case of the three who were not satisfied with their care.

There were eight clients referred from other agencies. Of these, four did not understand the reason for their referral; they did not have a clearly identified purpose in seeing the nurse or a clear expectation of her role. These four were all ambivalent about the care given.

Processes involved in consequences of care-seeking were:
1) When the client perceived progress toward solution of a problem, or achievement of a goal, satisfaction with the interaction ensued;
2) When expectations were not congruent with the perceived interaction, ambivalence or dissatisfaction with care resulted; and,
3) When a client had not defined a problem and/or if he had no expectation of care, the result was ambivalence or dissatisfaction with the intervention.

PROPOSITIONS

Based on the findings of this study, five tentative propositions relating to nursing intervention were formulated and can be tested in future studies. Validation in a variety of settings, both hospital and community, would support or rule out their generalisability.

The propositions formulated were as follows:
1) Clients who perceived themselves as having inner control over their daily activities will expect guidance and support from the nurse in response to their initiation of an interaction.
2) Clients who lack inner control over their daily activities will expect the nurse to act as an authoritarian figure who exerts external control.
3) Clients who received nursing care congruent with their expectations will feel satisfied with the nursing intervention, whether or not their problem has been solved.
4) Clients who receive nursing care that is perceived as divergent from their general expectations will be ambivalent or dissatisfied with their care even when progress toward their goal has been achieved.
5) Clients who cannot identify their problems or who have no definite expectations of the care they will receive from the nurse will be ambivalent or dissatisfied with the care given.

DISCUSSION

The majority in this study decided on their own initiative to seek health care at the Workshop. For some clients, the effect of cumulative problems had created a level of stress with which they could no longer cope. Generally clients saw themselves as independent and able to solve their own problems on a day-to-day basis, but at the time they contacted the Workshop, they felt they had lost control over the situation. This supports LeFeourt’s (1966) contention that:

If the locus of control is external, unrelated to one’s own behaviours in certain situations and beyond personal control, he will perceive the situation to be more stressful (p. 207).

When these clients believed they had obtained information that allowed them to resume control of the situation, their stress level was reduced and they felt able to cope with the situation again. This suggest that it is important for the nurse to identify the areas perceived by
the client to be strengths and to work with these. At the same time, the nurse must avoid behaviour which indicates to the client that external control of the situation is being imposed by the nurse.

There was an atypical group of clients who requested external control of the situation by the nurse. These individuals exhibited lifestyle behaviours demonstrating a generalised lack of control over their own affairs; they did not perceive themselves as able to solve their own problems and sought an authoritarian approach from the nurse. When this was not given, they expressed themselves as less than satisfied with the client-nurse interaction. This suggests that, at least at the initial encounter, nurses must be alert to the type of expectations that a client has of the health professional.

The way in which a client’s expectations of the role and function of the nurse were met was of more importance in this study than was progress toward a stated goal. If a client recently discharged from hospital holds the expectation that the nurse will take his pulse and check his blood pressure, it may be important that she accepts these functions at the initial visit, even when the stated purpose is to support the client in an attempt to decrease an observed high anxiety level.

One critical function of the nurse was to listen to the client’s feelings, fears and ideas. The nurse was an informed listener and it was this knowledge base that differentiated her role from that of a neighbour. Clients could view the nurse as a friend but this did not detract from their image of her as a “professional” person. While the nurse was expected to be knowledgeable, she was not expected to have an immediate answer to a problem. The important thing was that she was able to identify the resources she would utilise before the next contact with the client.

It is important for nurses to be alert to those clients who have had previous negative experiences with the health care system. While the number in this study was small, it would appear that one of their major concerns was that they felt that in previous encounters with health care personnel, they had lost their control over the situation. They did not understand the doctor’s orders, or the explanation given related to their illness, so frequently the stress they experienced was severe. For these clients, the establishment of a trusting relationship was critical, particularly when the client was afraid that no-one would give him information. This is where the use of books and reference materials may be useful as the client can read the information for himself and then discuss areas not understood with the nurse.
Some clients who were referred by other agencies seemed to have difficulty in understanding the purpose of the nurse’s visit. The nurse must be alert to the expectations of clients who have been referred by others. If the client has no clear expectations of the care the nurse will give, it is necessary to explore mutual goals and identify the nurse’s role before nursing intervention commences.

This study demonstrated the need for the nurse and client to establish congruent goals. It also showed that for nursing care to be effective, the nurse must be sensitive to the client’s expectations of the nurse’s role and activities in the nurse-client interaction.

REFERENCES


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RÉSUMÉ

Comportements des clients cherchant à se faire soigner dans une localité et satisfaction que leur procurent les soins infirmiers

Le objectifs de cette étude étaient de déterminer les caractéristiques et les méthodes inhérentes au comportement des clients cherchant à se faire soigner ainsi qu’à déterminer les sources de satisfaction des clients bénéficiant de soins infirmiers. Cette étude était de nature exploratoire, et l’on a utilisé une méthode d’analyse comparative constante pour aboutir à certains résultats. La population étudiée comprenait 35 clients qui ont assisté à l’atelier à votre santé. On a déterminé trois phases définitives dans la quête des soins. Il s’agit de la phase pré-active, de la phase inter-active et de la phase post-active. Dans la première, les clients déterminaient un problème, choisisaient un organisme et fondançaient certains espoirs. Dans la seconde, le client interagissait avec l’infirmier ou l’infirmière. Dans la phase post-active, le client examinait ses interactions et évaluait ses sentiments de satisfaction ou d’insatisfaction face aux soins reçus. On a noté une certaine ambivalence ou insatisfaction chaque fois que les espoirs du client ne coïncidaient pas avec sa perception des soins donnés ou chaque fois que le client ne percevait pas les soins comme indispensables.