Fraying Connections of Caring Women: An Exemplar of Including Difference in the Development of Explanatory Frameworks

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La recherche qui s'intéresse à une diversité de groupes mène à une meilleure compréhension des expériences et des optiques de ces derniers, mais elle contribue également à en accentuer l'exclusion plutôt que de favoriser l'accès aux courants dominants et aux solutions en place. Une méthode fondée sur la théorie féministe peut davantage rendre compte des groupes marginalisés grâce à l'ouverture qu'elle prône; elle permet d'élargir le cadre d'analyse et l'échantillonnage. Le présent essai tente de démontrer comment une telle démarche aboutit, dans le cadre d'une étude sur les soins donnés par les femmes, à un schème explicatif qui tient compte des réalités diverses. Ainsi, des dissonances dans la vie des femmes dispensatrices de soins ont été identifiées comme étant une réaction initiale à la concurrence et au changement en matière de prestation des soins. Les modalités et les caractéristiques de ce phénomène ont pu être mises en lumière grâce à un procédé d'échantillonnage et à une orientation théorique qui tiennent pleinement compte de facteurs tels que le sexe, l'origine culturelle, la capacité, la classe sociale et l'orientation sexuelle.

While research exploring diverse groups enhances understanding of their unique perspectives and experiences, it also contributes to the exclusion of such groups from mainstream frameworks and solutions. The feminist grounded theory method allows for inclusion of marginalized groups through theoretical sensitivity to feminist theory and theoretical sampling. This paper demonstrates how this approach results in an explanatory framework that accounts for diverse realities in a study of women's caring. Fraying connections were identified as women's initial response to competing and changing caring demands. The range of dimensions and properties of fraying connections was identified through theoretical sampling guided by the emerging themes and theoretical sensitivity to issues of gender, culture, age, ability, class, and sexual orientation.

Much of the research that addresses the health of populations delineated by such characteristics as gender, culture, or socio-economic status focuses on detailed exploration of issues of difference. While the knowledge gained from this research contributes immeasurably to our understanding of the needs of such aggregates, inherent in this approach are the hazards of stereotyping, marginalizing, and victim blaming attendant in setting a group apart. Moreover, such research

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commonly assumes homogeneity within heterogeneous populations. A central concern, then, is how to address differences within and among groups without contributing to marginalization. I submit that the feminist grounded theory method allows for the inclusion of difference in the development of explanatory frameworks useful for nursing (Keddy, Sims, & Stern, 1996; Stern & Pyles, 1986; Wuest, 1995a). Theoretical sampling and theoretical sensitivity, particularly to issues of gender, culture, class, ability, age, and sexual orientation, allow for the uncovering of variation in the emerging concepts that contributes to the relevance of the resulting framework for a diverse society. Because this research process is consistent with feminist principles of being useful to participants, avoiding oppression, and reflecting on both intellectual traditions and the research process (Acker, Barry, & Essevald, 1991), groups who are frequently marginalized in research are more likely to be treated respectfully as partners and to have their perspectives and concerns reflected in the findings.

In this paper, I will discuss how the feminist grounded theory method was used in a study of New Brunswick women's caring. In the literature, caring is depicted as fundamentally good and enriching for both the provider and the recipient (Bevis, 1981/88; Mayeroff, 1971; Ray, 1981/88; Roach, 1992) and as fundamental to human existence and well-being (Leininger, 1993). Feminist analysis puts forward two contrasting views (Baines, Evans, & Neysmith, 1991). One is that women's caring is an outgrowth of an oppressive family structure that socializes women to assume caring roles despite their increased responsibilities outside the home. The other is that women have unique caring talents and take satisfaction in assuming nurturing roles. Two key dimensions of caring are labour and love (Graham, 1983). The literature on family caregiving conceptualizes problematic aspects as caregiver burden and strain, especially when caring for the elderly and demented (Given & Given, 1991; Montgomery, 1989), a conceptualization that denotes a negative experience in which there is little likelihood that the caregiver will find any meaning (Farran & Keane-Hagerty, 1991). A final critical issue is the influence on caring behaviour of social and structural factors (Leininger, 1991). This paradoxical picture of caring, combined with current health reform that is resulting in greater demands placed on women to take on caring roles, led me to undertake a grounded theory study of women's caring. The goal was to discover what is problematic for women about caring and to generate a theory that explains how the central problem was resolved or processed (Glaser & Strauss, 1967).

The Emergent Design

The research question in grounded theory research emerges through analysis of data collected via dialogue with participants, observation, and/or literature review; the researcher does not impose her or his notion of what is most significant (Glaser, 1978). Sampling is theoretical.

> Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. This process of data collection is controlled by the emerging theory... (Glaser & Strauss, 1967, p. 45)

This sampling may be incidents, events, activities, or populations (Strauss, 1987). Participants are selected, therefore, because they are good sources of information for a specific analytic goal, rather than because they will allow the researcher to generalize to others of similar age, sex, or race (Sandelowski, 1995).

Glaser (1978) indicates that analysts must possess theoretical sensitivity in order to "render theoretically their discovered substantive, grounded theories" (p. 1). Theoretical sensitivity is enhanced by "disciplinary or professional knowledge, as well as both research and professional experiences" (Strauss & Corbin, 1994, p. 280). My theoretical sensitivity, particularly to feminist thought and cultural diversity, guided my response to the emerging theoretical concepts and directed the theoretical sampling. Constant comparison of themes emerging from each interview led to new questions and hypotheses, and my decisions regarding data collection were guided by consideration of where the answers might be found. For example, initial interview subjects were white, middle-class women keenly interested in caring optimally for their children as evidenced by breastfeeding, prenatal preparation, and participation in playgroups. They spoke of feelings of frustration and conflict in their caring and in their communication with lay and professional helpers. These women had time, energy, and financial resources to invest in their caring. I wondered whether women with less to invest might also experience this dissonance. What might I learn about the variation in the dimensions of fraying connections from women experiencing more difficulty providing basic needs and possessing fewer resources to invest in their caring — perhaps working-class or poor women? How would communication with helpers be influenced by cultural differences or limited English-language skills? Theoretical sampling took several forms: choosing new participants on the basis of

what they could contribute, seeking comparisons in data already collected, returning to participants to ask new questions, participant observation, and examining the literature and other written data.

Data Collection

Twenty-one women participated in this study. They were a convenience sample recruited for what they could contributre to the emerging framework. Letters describing the study were given to potential participants by key community people. Those who wished to participate contacted me. Fifteen women participated in individual tape-recorded unstructured interviews lasting one to two hours. Thirteen of the 15 were interviewed twice.

Two groups, one of two women and one of four women, each participated in two tape-recorded interviews. Group interviews were used to gather diverse perspectives for theoretical variation and also to learn about shared perspectives (Frey & Fontana, 1993). In the group interviews, women's comments triggered further thoughts, resulting in rich data for comparison. Participants enjoyed the group discussion but demonstrated no interest in continuing beyond the two meetings. Participant observations occurred when the investigator attended community events of particular interest to women, such as the screening of a National Film Board release on home birth, or social and support group meetings such as those of breastfeeding women or immigrant women. Field notes were taken to reflect these observations and the nature of informal discussions.

Characteristics of Participants

The women ranged in age from 20 to 64, lived in rural, suburban, and urban areas, and ranged in level of education from elementary schooling to doctoral degree. They included the employed and the unemployed; lesbian and heterosexual women, presently with and without a partner; and physically able and disabled. The women were of diverse socio-economic circumstances: welfare recipients, working poor, middle class, and pensioned on fixed income; with and without children of various ages and abilities. The women who agreed to be interviewed were from the dominant Anglo-Canadian culture. Data collected in participant observation focused on immigrant women and specific groups such as young, working mothers or breastfeeding women. Data from previously conducted interviews with members of First Nations and

Caucasian families of children with middle-ear disease, caregivers of family members with Alzheimer's disease (AD), and women who had left abusive conjugal relationships were theoretically sampled for further variation in concepts and further development of conceptual links.

Findings

Competing and changing caring demands from partners, children, extended family, and self, within the existing environment, emerged as the greatest problem for caring women. *Precarious ordering* is a dynamic, recursive, two-stage process women use to manage this problem (Wuest, 1995b). In the first stage, women's connections with others become frayed in the process of reacting to competing and changing demands. *Fraying connections* are evident in *daily struggles* with caring work, relationships, and adversity with helping systems; in *altered prospects* for future employment, parenting, and relationships; and in *ambivalent feelings* engendered in the responses to caring demands. In the second stage of *precarious ordering*, women become proactive using the intuitively and consciously acquired strategies of *setting boundaries*, *negotiating*, and *repatterning care* to reduce demands, change the environmental conditions, or manage more effectively. In this discussion, I report the findings of the first stage of *precarious ordering* named *fraying connections*, demonstrating how attention to difference in theoretical sampling resulted in the identification of variation in the emerging concepts such that the emerging framework is relevant to a wide range of New Brunswick women.

Caring Demands

Faced with multiple caring demands, women took diverse actions inherent in which was a sense of dissonance or conflict, eventually named *fraying connections*. The source of *fraying connections* was women's inability to deal with each demand in a singular and linear fashion, and their inexperience with particular demands. Analysis of the properties of caring demands revealed that it was the *changing* and *competing* nature of demands that imbued the caring responses with struggles, conflicts, and mixed emotions that were frequently at odds with women's caring ideals, that is beliefs about how caring should be. Individually, the two properties of caring demands each contributes to the development of *fraying connections*; however, when demands are both competing *and* changing, the intensity of fraying connections is
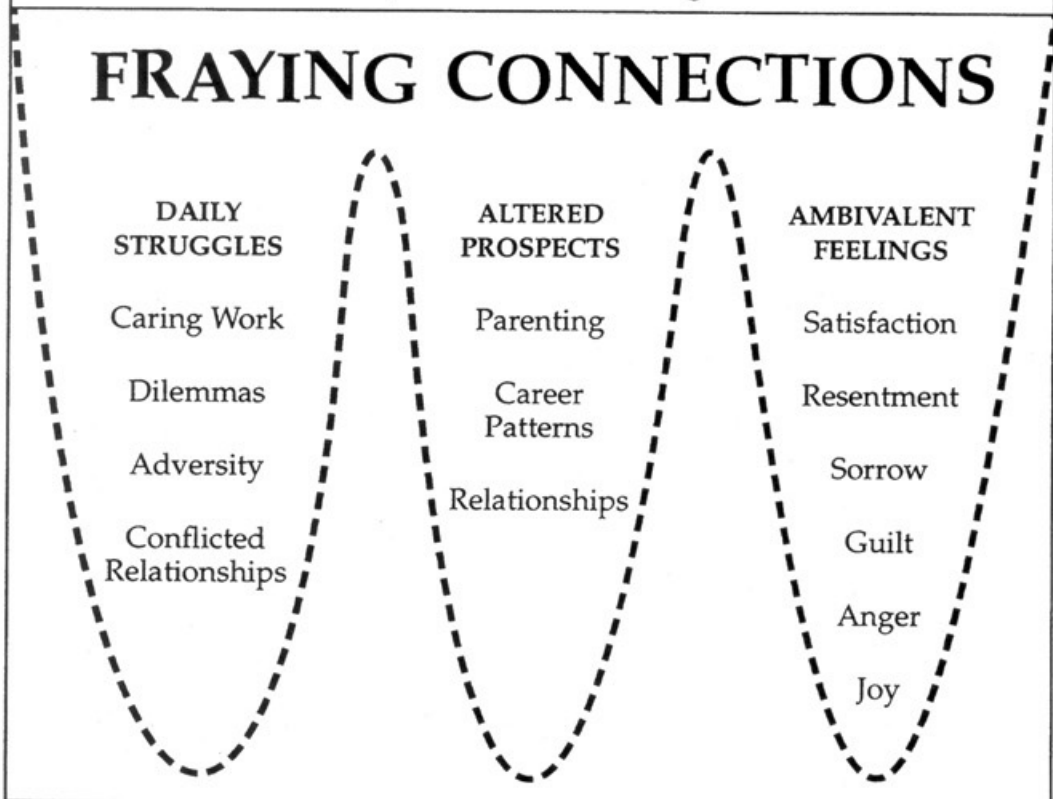
likely to increase. In addition, environmental conditions interact with caring demands to intensify or moderate *fraying connections* (Wuest, 1995b).

Fraying Connections

Fraying connections refers to the emotional, cognitive, relational, and material disorder and dissonance inherent in reactive responding to caring demands. Relationships between women and care recipients, helpers, and family members are vulnerable. *Fraying connections* fluctuate in intensity and manifest differently, according to the complexity, familiarity, quantity, and intensity of competing and changing demands and the intervening environmental conditions. *Fraying connections* can be transient or long-term. The three categories of fraying connections identified in this study are *daily struggles, altered prospects*, and *ambivalent feelings* (see Figure 1). The following discussion of the properties of fraying connections will delineate the ways in which theoretical sampling and sensitivity to feminist thought allowed for expansion of variation in emerging concepts.

Figure 1 *Fraying Connections: A Depiction of the First Stage in the Process of* **Precarious Ordering**

FRAYING CONNECTIONS

DAILY STRUGGLES	ALTERED PROSPECTS	AMBIVALENT FEELINGS
Caring Work	Parenting	Satisfaction
Dilemmas	Career Patterns	Resentment
Adversity	Relationships	Sorrow
Conflicted Relationships		Guilt
		Anger
		Joy

Daily Struggles

Struggles, the first category of *fraying connections*, are material, moral, and relational difficulties evident in caring work, dilemmas, adversity with systems, and conflicted relationships. *Fraying connections* exist both in the process of struggling and as an outcome of the struggle.

Caring work. The work of caring for health involves meeting such basic needs as nutrition, hygiene, sleep, comfort, transportation, and safety for self and others. Fraying connections are inherent in responding to the competing and changing demands that arise from these basic health needs, and they vary in intensity. Initially, in interviews with young, middle-class mothers the labour of caring for preschoolers and newborns and its resultant fatigue were evident. This led me to consider other groups who might find caring physically taxing. Theoretical sampling revealed that the most physically and mentally taxing form of caring work for women was with infants and young children, the mentally and physically disabled, the sick, and frail elders. All fraying connections rooted in caring work can be intensified or reduced by environmental conditions, particularly financial resources, substitute care, professional assistance, informal support, and transportation.

Caring work results in fatigue. Fatigue ranged from weariness to extreme exhaustion, according to the intensity and predictability of the demands and whether other demands had to be met as well. Physically demanding work, such as bathing and toileting elders or disabled adults, overcoming personal disabilities in activities of daily living, or caring daily for preschoolers, is extremely tiring. Daisy faced competing caring demands, with resultant discord, because her daughter had costly health needs that forced Daisy to work outside the home:

> Oh I hate that . . . every morning. Oh, I hate it, I hate it. Before going out the door, it is like, "This is packed, this is packed, this is packed." Packing and everything doesn't bother me too much, but when it is like minus 20 outside and the car is cold, and then I go over to my friends [the sitter] and they live on the top floor of the building. Lug everything up the steps, you know. It is like, "Why the hell do I do this?"

When caring work is unpredictable, fatigue can intensify. The data suggest that women's rest and sleep were regularly disturbed by children needing attention for feeding, or because of bad dreams, asthma attacks or ear infections, a teenager's late-night comings and goings, or a demented elder's wandering. Under these conditions, women are prone to exhaustion. I queried whether First Nations women, who had spoken of responding to their children's rhythms rather than to rigid

routines, would have similar experiences. Theoretical sampling of data previously collected revealed that the night-time demands of children were equally exhausting for First Nations women.

Fraying connections related to caring work are further evident in physical injury or stress-related illnesses such as hypertension. Physical health problems were found to be most common under conditions of intense caring demands of long duration, such as women caring for people with disabilities or dementia. Limited financial support and rigid criteria for access to services intensified the fraying connections for Gert, whose husband developed AD at 55 and was therefore too young to qualify for elderly support services. Gert, who had not been employed for 20 years, supported them with a minimum-wage cleaning job that did not pay enough for her to hire a caregiver. Gert left her husband alone, ran home at noon, phoned often, and got neighbours to keep watch. She worried constantly and eventually developed an ulcer. This variation in the data identified the disadvantaged position of caring women who have been outside the workforce.

Caring work also produces the "Empty Teapot Syndrome," described by Gina:

> I do find that I refer to myself as a teapot. And I think all women do. And I think what happens is that we pour out all the time, that we pour out and suddenly the heat under the griddle is boiling the pot dry and there is no water left. And that's when we get fried.

While fatigue and health problems may be a part of this phenomenon, the Empty Teapot Syndrome included a sense of physical and emotional bankruptcy that often accompanied having to deal with intense demands or with frequent, changing demands over a long period. The major consequence of fatigue, illness, and Empty Teapot Syndrome is that women are alerted to the toll of caring, and begin to think about *setting boundaries*.

Caring dilemmas. Caring dilemmas begin with competing demands to which women want, or feel they should, respond. Dilemmas occur when responding to one caring demand precludes responding to another or when there are several available courses of action, none of which is totally satisfactory. The outcome is that women perpetually "feel torn." A common dilemma was having to choose between caring for an ill or dying parent and caring for dependent young children; the dilemma intensified if the parents were far away or if the children were very young, and became complicated when women faced additional burdens such as job demands, financial concerns, or personal health problems. Dilemmas were harder to solve when one of the demands

was socially unacceptable, such as the woman's commitment to a lesbian partner or to an abusive partner.

A central dilemma was that of working outside the home versus caring for family. The decision to stay home and care for children, dependent others, or both, as opposed to using substitute care and taking a job outside the home, involves consideration of personal needs, financial needs, and the needs of the person(s) requiring care. Financial needs are a major consideration, and the decision is influenced by whether the woman has a partner, whether the partner has an adequate income, and cultural values about lifestyle and income. In single-parent families or in traditional families where both partners earn the minimum wage, a woman's income may be vital for subsistence living. Immigrant women face multiple dilemmas when a spouse who has been the traditional wage-earner cannot find employment and the woman can. Partner and family ideals about necessary lifestyles can push women to work outside the home even when personal ideals would dictate staying home. The level of dependency and complexity of the needs of the person requiring care, the financial drain of that person, and the likelihood of finding suitable substitute care are additional factors.

Adversity with Systems

Fraying connections were apparent in the conflict between women and the health, social, education, religious, and legal systems, which left them disillusioned. Women generally expect to find help from these systems. Erica had a hyperactive son.

> All I got from professionals was "You don't discipline him enough, you let him get away with too much." Like, "You're doing this wrong, do it that way." I had social workers knocking at my door saying, "Are you abusing your children"? for years and years . . . And I'm saying, "Sure I need help, but so does my son." Oh, no, no, no, I couldn't get anyone to step in and help my son.

Adversity is inherent in the process of seeking and obtaining help. Systems failed to help, provided inadequate help, or made things worse. These outcomes were associated with the availability and suitability of resources, and cultural gap between the professionals and the caring women.

Demeaning process. The process of accessing resources is demeaning for women when they feel devalued in their interactions with helpers — a situation that stems from both the behaviour of individual profes-

sionals and the structure of systems. Theoretical sensitivity to issues of respect, control, and power facilitated theoretical sampling to uncover dimensions of this process. The extent of disillusionment varied with the extent of the discrepancy between the behaviour of the professionals and the women's expectations of their relationships with them.

All women felt some degree of powerlessness in their interactions with professionals, associated with their vulnerability at the hands of the expert and the failure of professionals to demonstrate respect for the woman's potential contribution. Because most professionals tend to view themselves as better informed than caring women, they frequently failed to value women's observations, knowledge, and concerns. The use of medical or legal terminology was intimidating and hampered women's participation in decision-making. Physicians frequently used language suggesting that the processes of birth, menopause, and breastfeeding were risky ones requiring expert medical intervention. When professional attitudes conveyed the message that problems such as infant feeding difficulties were the woman's fault, she was discouraged from asking questions. Cultural variations in beliefs about such routine issues as nutrition, discipline, and communication between women and helpers served to intensify the difficulty. Women were intimidated by insinuations that issues were too complex for them to understand.

> He told me all the time, "You're putting on too much weight." I said, "How much am I supposed to put on with twins? I gained 40 pounds with my first baby and I'm kind of small to start with." He mumbled, "Well, I don't know how much is normal for twins, but you're putting on too much."

Professionals regularly deceived women, by misrepresenting policy, by giving them inadequate and wrong information, by behaving in an obstructive manner, and even by lying.

Women's accounts revealed that the attitudes of professionals varied according to how they viewed the woman seeking assistance. Women of difference frequently had their perspectives negated by professionals because they came from a different culture, failed to speak English, or were poor, lesbian, or developmentally or physically handicapped. The unspoken attributes attendant to labels, such as battered woman, disabled, single mother, and poor, intensified women's humiliation. Meeting criteria often required women to explain their particular circumstances repeatedly, a potentially mortifying experience. To obtain a peace bond, Astrid had to tell her story of physical and sexual abuse to the police, then to the crown prosecutor, and finally to the

judge. Her attempt to care for herself became self-abusive because of the system.

System structure contributes to women feeling demeaned. The lack of central coordination necessitates time-consuming phone calls to numerous agencies and departments to discover available resources. For women with poor language or social skills, or without access to a telephone, this presented a formidable task and further eroded their sense of competency. Gaps in the system were hazardous for women seeking help. In communities where access to a family physician required a referral, refugee and other immigrant women found it impossible to see a family practitioner.

Unsuitable help. Disillusionment can set in when the quality and nature of a service is unsatisfactory. Disrespect, the iatrogenic effects of medications, incorrect diagnosis, insufficient nursing care, inaccurate information about the legal system, and insufficient social-service support were examples of unsatisfactory assistance. A major concern for isolated women, such as rural women without access to transportation, was speed of response. Often as much as an hour elapsed before police responded to calls from abused women still in danger. The lack of knowledge among professional helpers of how to manage specific conditions, such as the aftermath of torture or war, left some refugee women with few resources for dealing with their own health or that of their children.

Conflicted Relationships

Conflict ranged from minor disagreements to physical battering, from occasional flare-ups to insidious persistence. Differences among women and recipients of care, family members, and employers about the extent and nature of caring, and about priorities and decisions, led to friction and strife. Caring relationships became tense when the woman failed to meet the recipient's expectations, or when her own expectations differed from those of the recipient. Men often failed to participate or even be aware of the complexity of caring demands of their children and neglected responsibilities to their aging parents, assuming that their partners would do it. Cultural incongruence between women and their partners or care recipients can increase such conflict.

Having to handle demands from more than one person forces women to prioritize responses — and disagreement can be the result. Partners sometimes resented women's attention to children or elders.

Jocelyn's lesbian partner resented her attention to her children, from whom Jocelyn was hiding her sexual orientation.

> ...her jealousies of what I was doing for my kids, and I just, you know, was in the middle — if my kids were around — trying to make sure that everybody was taken care of.

In abusive relationships, the demands of others often triggered a physical beating or a verbal assault.

Conflict frequently developed in the workplace when women needed flexibility to attend to their families' needs. Because Kate's coworkers thought she should have weaned her 14-month-old child, she received little support when she was running home to breastfeed at noon. Even when cultures and values are in accord, conflict arises if interference with employment is of long duration. Women facing long-term, high-demand needs, such as caring for demented elders or demanding special-needs children, often developed serious conflicts with both employers and coworkers that resulted in their being fired or quitting. Conflict is exacerbated by an unpleasant, resentful, or irritable nature in carers, care recipients, or other family members. Mothers of infants with persistent colic and daughters of elders resentful of their dependency had to deal with strained relationships over long periods. Conflict in relationships resulted in the loss of necessary supports for caring. Fraying connections increased because women had to deal with conflict as well as the original caring demand.

Altered Prospects

The second category of fraying connections, *altered prospects*, occurs when the direction of women's lives is unexpected and substantially changed because of competing and changing demands. The salient altered prospects that emerged in this study were parenting, relationships, and career patterns.

Parenting

Altered prospects related to parenting are associated with unanticipated caring demands. In the extreme, a child may be born with a physical or mental handicap or may develop health or social problems that require more care than had been anticipated. Caring demands associated with parenting undergo major alterations when a woman moves to a new environment and can no longer rely on old patterns. Nora moved to a low-cost housing area and found there was no safe place for her son to play. Ara, an immigrant woman, found that her disciplinary

methods were considered unacceptable in Canada and had to learn new ways of managing her children. Prospects are also altered when a woman changes attitudes about mothering after becoming a parent. Aline said, "I was Miss Career. Now I don't want to return to work. I want to be with my baby." This was an unexpected deviation from an expected life course requiring discovery of different ways to meet personal needs, those of the child, and those of the larger family unit.

Career Patterns

Career patterns often change or are relinquished in the face of caring demands from children, the disabled, the elderly or partner career demands. "I was brought up to believe I could have everything," said Hilary, who was coming to terms with the fact that she could not be both a mother and a career scientist.

> …there's no way I can have my father's career. One, I'm a female; two, I don't have a wife like he did. It's their career…and there's no way I would leave my kids for three months every year to go and do research.

Women who found alternative ways to progress along planned life paths continued to experience altered prospects: it took longer for them to complete their education, and job opportunities were often relinquished in favour of caring demands.

Relationships

Altered prospects are sometimes played out in the changing scope of women's lives when caring is very demanding. When caring is intense, there are few opportunities for personal activities and little time to cultivate relationships. The outcome can be isolation. Because people tend to avoid or withdraw from awkward or uncomfortable situations, isolation was intensified for some women, such as those caring for a demented parent. A significant altered prospect results when caring relationships do not meet a woman's expectations. Spousal relationships changed following the birth of a child. Abuse distorted images of caring relationships as women discovered that their expectations of reciprocal caring and commitment would never be realized: "I was just a piece of ass to him."

Significant reduction in caring demands also frays connections. Women who had responded to such demands all their lives suddenly faced completely altered prospects. When 80-year-old Marie placed her demented husband in a nursing home, she said, "I am no good for

nothing. Nobody needs me now." Women whose children had grown up and left home had periods of feeling similarly bereft. Altered prospects can create fraying connections that require minor adjustments or major transitions. Altered prospects result in challenges to women to modify or create new goals and to develop new skills.

Ambivalent Feelings

The final category of fraying connections is ambivalence stemming from competing and changing demands in the context of women's beliefs about how caring should be. Ambivalence is related to the contradictions between the realities of caring relationships and work, and beliefs about caring. Women identified caring as positive, connecting, and fundamental to their roles as mothers, daughters, and partners, and they experienced feelings of satisfaction and joy. However, the demands of caring also produced many discordant emotions such as guilt, resentment, anxiety, anger, fear, helplessness, and sorrow that were difficult to reconcile. The greater the imbalance between caring ideals and caring realities, the more ambivalent felt the women in the study.

Although this ambivalence was implicit in many of the feelings expressed by participants, the women began to talk openly about such feelings only after trust had been built with the interviewer. One woman, who had been very optimistic about her caring, asked toward the end of the second interview, "Did any of the other women you interviewed speak about resentment?" Brown and Smith (1993) found that women who express such ambivalent feelings about the arduousness of caring even when caring demands are patently unreasonable are generally made to feel they are going against the norm. This may account for women's difficulty articulating such feelings, and it supports the feminist process of involving women in analysis in the second interview.

Competing demands produced feelings of guilt when choices inevitably had negative consequences in the form of demands being unmet. Failure to measure up to personal caring ideals contributes to feelings of guilt: "I still go to bed most nights thinking that I didn't do enough that day." Guilt also arose from feelings of inadequacy when women compared themselves with other individuals in similar situations, or judged themselves against community norms and found themselves lacking. This guilt is associated with both quantity and quality of caring.

My parents are in their 70s and they live about 50 miles from here, and I get up there as much as I can but I am self-supporting and do not earn a great salary. My mother's an invalid. I guess it's just more like moral support for them that I can give at this point. My only sibling, my sister, lives up there… she's the one that's there all the time. I have gone through periods of feeling guilty about that, but it was her choice to move back there. I guess I kind of talked to myself, figured it out, because it is kind of hard. I don't think I could do it on a full-time, everyday basis.

Sometimes the anger and resentment were directed at the person being cared for, especially when demands were cumulative and exhausting. Anger also sprang from feelings of injustice. Lana anticipated a time when she would no longer be able to care for her mentally challenged daughter:

But she will have to be kept the way I want her to be. I will want her kept clean and I would want her just like she is here. I just make her look normal for a 25-year-old girl. Well, why shouldn't she have her legs shaved every time she takes a bath? And why shouldn't she have her underarms shaved? And why shouldn't she have a little bit of rouge on her face and her hair curled every morning? Why shouldn't she? I do it for myself.

Diane was angry about her mother's AD: "She doesn't deserve this." Often the anger is accompanied by sorrow and by resentment regarding the increasing demands. Women suffered when they felt their caring interventions had little effect. "It breaks my heart to see her this way. I can't do anything to help." This sense of helplessness was prevalent among women who were caring for those whose conditions could not improve.

Conclusion

The present findings make visible the complexity that originates from competing and changing demands of caring and from *fraying connections* at the emotional, relational, moral, and material level. Caring demands are not limited to women caring for family members with specific health problems. Caring is complex. Changing and competing demands are pervasive in the lives of all women as they care for themselves and others. The literature on caring pays scant attention to its competing and changing nature. Mayeroff (1971) tended to treat competing demands as an occasional problem to be overcome. In contrast, the present findings suggest that incompatibility of demands is pervasive in the lives of most women and that the changing nature of demands makes resolution exceedingly difficult. Noddings (1984) was

more realistic about sources of conflict in caring, but does treat such conflicts as singular problems and fails to identify the complex consequences of demands that are not only competing but changing. Such perspectives discount the complexity of competing and changing demands and can contribute to the marginalization of women for whom *fraying connections* are an everyday problem. Thus this study, by demonstrating the complexity of caring demands for women, highlights the need for nurses to carefully assess the competing and changing demands facing women carers and to consider how women might be supported in the process of *precarious ordering*.

Because the feminist grounded theory method permitted theoretical sampling guided by theoretical sensitivity, in order to uncover variance in emerging concepts, the discovered substantive theory reflects a central process that is common to the lives of diverse women. Rather than focus on a narrow view of caring for someone with a specific illness or disability, or caring by a specific group of women, this study illuminates the dimensions and properties of *fraying connections* as they have meaning for women in a wide variety of circumstances. Walters (1991) suggests that "It is only when women's concerns are documented that there is any possibility of taking them into account in policy making" (p. 33). These findings may be useful for policy-making because of their inclusiveness. They apply to women across the lifespan, from a wide range of cultural, educational, and socio-economic backgrounds, who care for the sick, the elderly, and the disabled and whose caring is directed at keeping families healthy. They draw attention to the importance of considering the ways in which women's response to caring demands is informed at a personal and community level, by culture, class, ability, age, and sexual orientation.

References

Acker, J., Barry, K., & Essevald, J. (1991). Objectivity and truth: Problems in doing feminist research. In M. Fonow & J. Cook (Eds.), *Beyond methodology: Feminist scholarship as lived research* (pp. 133-153). Bloomington: Indiana University Press.

Baines, C., Evans, P., & Neysmith, S. (1991). Caring: Its impact on the lives of women. In C. Baines, P. Evans, & S. Neysmith (Eds.), *Women's caring: Feminist perspectives on social welfare* (pp. 11-35). Toronto: McClelland & Stewart.

Bevis, E.O. (1981/88). Caring: A life force. In M. Leininger (Ed.), *Caring: An essential human need* (pp. 49-60). Detroit: Wayne State University Press.

Brown, H., & Smith, H. (1993). Women caring for people: The mismatch between rhetoric and women's reality? *Policy and Politics, 21*, 185-193.

Farran, C., & Keane-Hagerty, E. (1991). An interactive model for finding meaning through caregiving. In P. Chinn (Ed.), *Anthology of caring* (pp. 225-238). New York: NLN.

Frey, J., & Fontana, A. (1993). The group interview in social research. In D. Morgan (Ed.), *Successful focus groups: Advancing the state of the art* (pp. 20-34). Newbury Park, CA: Sage.

Given, B., & Given, C. (1991). Family caregiving for the elderly. In J. Fitzpatrick, R. Taunton, & A. Jacox (Eds.), *Annual Review of Nursing Research, 9* (pp. 77-99). New York: Springer.

Glaser, B. (1978). *Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory.* Chicago: Aldine.

Graham, H. (1983). Caring: A labour of love. In J. Finch & D. Groves (Eds.), *A labour of love: Women, work, and caring* (pp. 13-30). London: Routledge & Kegan Paul.

Keddy, B., Sims, L., & Stern, P.N. (1996). Grounded theory as a feminist research methodology. *Journal of Advanced Nursing, 23,* 448-453.

Leininger, M. (1991). The theory of culture care diversity and universality. In M. Leininger (Ed.), *Culture care diversity and universality: A theory of nursing* (pp. 5-72). New York: NLN.

Leininger, M. (1993). Culture care theory: The comparative global theory to advance human care nursing knowledge and practice. In D. Gaut (Ed.), *A global agenda for caring* (pp. 3-18). New York: NLN.

Mayeroff, M. (1971). *On caring.* New York: Harper & Row.

Montgomery, R. (1989). Investigating caregiver burden. In K. Markides & C. Cooper (Eds.), *Aging, stress, and health* (pp. 201-218). New York: Wiley.

Noddings, N. (1984). *Caring: A feminine approach to ethics and moral education.* Berkeley: University of California Press.

Ray, M. (1981/88). A philosophical analysis of caring within nursing. In M. Leininger (Ed.), *Caring: An essential human need* (pp. 25-36). Detroit: Wayne State University Press.

Roach, Sister S. (1992). *The human act of caring.* Ottawa: Canadian Hospital Association.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health, 18,* 179-183.

Stern, P.N., & Pyles, S. (1986). Using grounded theory methodology to study women's culturally based decisions about health. In P.N. Stern (Ed.), *Women, health, and culture* (pp. 1-24). Washington: Hemisphere.

Strauss, A. (1987). *Qualitative analysis for social scientists.* Cambridge and New York: Cambridge University Press.

Strauss, A., & Corbin, J. (1994). *Grounded theory methodology: An overview.* In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, CA: Sage.

Walters, V. (1991). Beyond medical and academic agendas: Lay perspectives and priorities. *Atlantis: A Women's Studies Journal, 17,* 28-35.

Wuest, J. (1995a). Feminist grounded theory: An exploration of the congruency and tensions between two traditions in knowledge discovery. *Qualitative Health Research, 5,* 125-137.

Wuest, J. (1995b). Precarious ordering: A theory of women's caring. Doctoral Dissertation, Wayne State University, Detroit.

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