

**TRANSGENERATIONAL VIEW OF THE MEANINGS AND
BEHAVIOUR STRUCTURES AROUND ASTHMA:
AN ECOSYSTEMIC APPROACH**

by

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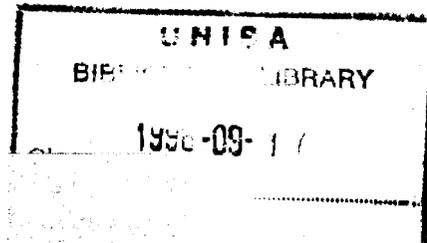
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SUMMARY

This study aims at giving a three-generational perspective on the meanings that a family attaches to asthma and on how these meanings recursively informed their behaviours. The wider social context was taken into consideration, as well as how this impacted on the family's meanings and beliefs around asthma. The researcher contrasted the biomedical and the ecosystemic epistemologies and showed that the differences between them can be seen as differences in logical typing.

Ecosystemic epistemology and social constructionism were used to guide the researcher in making distinctions and arriving at patterns and themes that fit the family under study.

The themes and patterns, all centered around the idea that asthma is an expression of a need for emotional closeness in the face of an impending threat to the family's established belief in closeness and enmeshment.



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OPSOMMING

Hierdie studie is gerig op 'n driegerasie-perspektief aangaande die betekenis wat 'n familie assosieer met asma en hoe hierdie betekenis hulle gedrag telkens beïnvloed. 'n Breër sosiale konteks is ook 'n aanmerking geneem, asook die impak hiervan op die familie se betekenis en oortuigings omtrent asma. Die navorser het die biomediese en ekosistemiese epistemologieë vergelyk en het aangetoon dat die verskille tussen hulle gesien kan word as verskille in logiese tipering.

Die navorser is gelei deur die ekosistemiese epistemologie en sosiale konstruksionisme om onderskeide te maak en om die gesin se patrone en temas te identifiseer.

Hierdie temas en patrone wat deur die navorser geskep is gedurende die interaksie met die familie, het alles gesentreer om die idee dat asma die uitdrukking is van 'n behoefte aan emosionele nabyheid, wanneer die gesin se vasgestelde geloof in nabyheid bedreig word.

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CHAPTER 1

THE CONTEXT OF THE NARRATIVE

Introduction

Psychosomatic medicine emphasises the unity of mind and body and the interaction between them. It therefore works on the premise that psychological factors play an important role in the development of all diseases. Whether that role is in the initiation, the progression, the aggravation or the exacerbation of a disease, or in the predisposition, or the reaction to a disease, is open to debate and varies from disorder to disorder (Kaplan, Saddock & Crebb, 1994).

As shall be detailed in the following chapter, stress and other psychological factors have been identified as having a causative function in the development of asthma. Kaplan et al. (1994) defines asthma as, "a chronic recurrent obstructive disease of the bronchial airways, which tend to respond to various stimuli, by bronchial constriction, edema and excessive secretion" (p. 759). This definition of asthma refers to an underlying somatic or physiological function which can be complicated by psychosocial factors that may act singly or in combination with other stimuli to precipitate an attack. As shall be detailed in the following chapter, all definitions of asthma include reference to a biomedical, physiological impairment, but few make direct reference to the underlying psychological processes.

Asthma is essentially a medical concept and has been extensively researched from a medical perspective. The approach adopted in this research, is to juxtapose views from both the biomedical and the psychological perspectives. Equal emphasis will be given to both perspectives, such that one refrains from prioritising the one model over the other. An approach that emphasises both sides in a nondualistic "both- and" manner, will thus be adopted. How this will be done, will be elaborated upon in chapter 3.

Previous Research

Previous research on asthma will be briefly described and expanded upon in the following chapter. However most research on asthma is based on the logical positivist paradigm which is lineal, reductionistic and believes in one objective reality (Engel, 1977).

Research in the field of asthma is generally based on the following positivistic assumptions:

Lineal Causality

In a positivistic epistemology the notion of lineal causality is concerned with “combinations of discrete elements” (Keeney, 1983, p. 14) that are viewed to be connected to one another through cause and effect. In this approach any one part of a system is seen as being able to influence other parts of that system in a unilateral manner.

As already mentioned, in a positivistic approach asthma is essentially seen as a disease of which expression in individual patients is a result of certain physiological changes and impairments. Thus the onset of asthma has been attributed to a number of both physiological and psychological functions. As will be detailed in the following chapter, asthma seems to be caused by respiratory infections, allergies to certain stimuli, exercise, and so on. Furthermore certain behavioural and parental relationships have been identified as possible causes of asthma. These will be elaborated upon in the following chapter.

The logical positivistic principle of lineal causality has been applied in studies of asthma in an attempt to get a better understanding of the disease. It is well-known that, for the biomedical model, the onset of the disease is due to known or unknown natural causes and it is therefore assumed that the elimination of these causes will often result in cure or improvement in individual patients (Engel, 1977).

Reductionism

According to the positivistic epistemology "in order to understand an object or phenomenon, it needs to be reduced into its most basic elements or building blocks, which are simpler, more easily understandable and often measurable" (Harre, 1981).

The very idea of having certain physiological impairments, that are observable and measurable, assumes a reductionistic conceptual base. Thus, in the case of asthma, the measurement of airflow in the diagnosis of the severity of asthma in sufferers and the identification of certain intra-psychic elements in both sufferers and their parents are seen as support of this conceptual base.

Neutral Objectivity

In a positivistic epistemology this notion implies that it is entirely possible, and indeed necessary, to seek the "Truth" about phenomena. Punctuated streams of events are verified and subjected to "objective" criteria in order that they may be quantified (Keeney, 1983) and the position and orientation of the researcher or observer is seen as having no bearing on the research process or results. The reification of asthma leads to generalisations being made about it across diverse contexts.

Previous researchers working within a positivist approach have tended to apportion blame to individual patients for being the site of pathology, and generalisations were made with regard to the experiences of these patients. Furthermore, applying the principle of lineal causality, certain behavioural and parental attributes were identified as possible causes of the disease.

A shift in focus was provided by systemic researches that rests on assumptions differing from the logical positivistic model. Minuchin, Bosman and Baker (1978), in considering the inclusion of the whole family towards an understanding of asthma, moved the focus away from considering it as a disease of the individual to considering it as a disease that lies within the whole family's interactional patterns. Goldberg (1979) and Rees (1990) also agree that the whole family should be included in the research domain to enable us to understand what interactional patterns could either initiate or

maintain the disease. Indeed for Towns (1994) the unit of treatment should not be predefined according to social parameters, but should be defined to include all those who talk about asthma as a distress. This connects to notions of social constructionism and cybernetic epistemology.

The Present Research

The present research is based on an ecosystemic/cybernetic epistemology, and social constructionist theory.

Ecosystemic epistemology focuses on patterns of relationships rather than dividing the world into dualisms of mutually excluding opposites. It prescribes seeing events as organised by recursive feedback processes and a way of seeing and describing patterns that organise events (Keeney, 1983).

Ecosystemic epistemology facilitates a move away from defining a system according to social parameters. It recognizes as a system the inclusion of all those who talk about a particular issue being a problem (Anderson & Goolishian, 1988).

Ecosystemic epistemology also points to "the observer's inclusion in that which is observed, thus emphasizing the self-referential nature of any and all descriptions" (Keeney, 1983). In this epistemology it is assumed that therapists and researchers interact so closely with the system they are observing that any description of it by them reveals as much of their own properties, as those of the system they are observing. This implies that researchers and therapists working within the ecosystemic epistemology cannot assume an expert position during the research nor have unilateral control over the system they are observing (Keeney, 1983).

Social constructionism, like ecosystemic epistemology, focuses on context, complexity and interrelationships. It challenges the positivistic view of knowledge being a map or direct representation of the world. It views knowledge as residing in the patterns of social interaction rather than in the individual mind (Hoffman, 1990). Social constructionism critically questions the concept of truth. What may be "true" for a particular point in time or context, may not be at another. What constitutes truth is

therefore heavily laden in the socio-cultural processes of a particular time in the history of society (Gergen, 1985).

Ecosystemic epistemology and social constructionist theory will be further detailed in chapter 3.

Aims and Focus of the Study

This study gives a description of the meanings that people within a particular family attribute to asthma, and how these meanings inform their behaviour around asthma.

The researcher chooses, for the first time in research on this topic, to explore the recursive connection between meanings attributed to asthma and how these inform the family members' behaviour. This is based on the premise that people's behaviour is informed by the meanings that they ascribe to situations and the relationship between these meanings and their behaviour is recursive and evolutionary. Also in accordance with Keeney and Ross (1992) there is a recursive connection between meanings and behaviour, such that "each is a frame for the other" (p. 9). This will facilitate looking beyond the "untreatable" nature of asthma as a disease to an understanding of what other relational factors contribute to the continuation of the physical symptoms.

The researcher opts to explore the meanings within a family over three generations, the reason for this being that, the third and all subsequent generations reflect on the family's evolutionary process of meaning-making. Furthermore these meanings are historical and interconnected and impact on the current myths and beliefs around illness and specifically around asthma (Lieberman, 1979). Furthermore the three-generational perspective will enable the researcher to produce enough data on the patterns, beliefs and meanings attributed to asthma. Thus a "thick description" (Lincoln & Guba, 1985) will be made possible.

Following Bateson (1979); "the presuppositions of the researcher are matters that should be brought into the open" (p. 33). Therefore, the researcher states the following as her presuppositions:

1. Asthma can be seen as a disease from a medical perspective and this

presupposes that there is an impairment in the normal physiological functioning of all or part of the organism. The physiological impairments that have been identified thus far are: A weak lung, narrowing of the airways, bronchospasm, oversecretion of mucus by the airways, and so on.

2. Asthma is a medical concept and has been researched extensively from the biomedical perspective. The researcher thus acknowledges the existence of this reality as one amongst many that exist in the world of creatura.

3. Even though asthma is taken to be a disease it is, however, embedded in a network of meanings attributed to this experience which could have an impact on the sufferer's compliance with treatment; maintenance of the symptoms (i.e., coughing, wheezing and tightening of the chest), etcetara, which are not only physiologically based, but also psychological.

These meanings will be co-constructed by the researcher together with the family members in the form of narratives. Narratives provide a natural way in which people language about and ascribe meaning to their experience. To talk in terms of stories rather than truth implies that objectivity is unattainable, as our reality is co-storied in interaction with others (Lax, 1992). Furthermore, to talk about the researcher as part of the research reflects an epistemology that is different from the one that has been discussed so far. It is also imperative to note that patterns of behaviour and meaning that connect family members from one generation to another will be described. These will be co-created by the researcher with the family. In co-creating these patterns, the researcher will acknowledge the recursive connection between these patterns and her own values and ideas around asthma. Research of this nature, on asthma, has never been explored in the field of biomedicine and ecosystemic epistemology.

On the Researchers' Self-Referentiality

In accordance with the epistemology that forms the basis of this research, the researcher comes to the field of observation with her mind full of ideas, which recursively influence her research practices (Steedman, 1991). It is in this regard that the epistemology espoused herein, acknowledges the inseparability of the observer

from the observed. We, as researchers, are part of those systems we study (Steier, 1991). It is therefore necessary for the researcher to research her own organisation as guiding what she does and as necessary in understanding the constructions she has made.

The researcher comes from a family in which significant people have asthma. Asthma has existed in the researchers' family for over three generations. Four of the researchers' aunts as well as her mother were diagnosed as asthmatic, and two of the researchers' uncles were also diagnosed as such. The researcher's maternal grandfather has asthma, and also the researcher's daughter. However, the researcher and most of her cousins were never diagnosed as asthmatic. Asthma has become so common in the researcher's family that it has become known as the "family disease"; and furthermore an ecology of ideas is shared that asthma is genetically transmitted. Whilst research on the genetic transmission of asthma is far from conclusive, it nevertheless remains a contentious issue in the field of medicine and an unsettling one for the researcher.

The researcher wishes not only to explore what seems to be the "inherited" or genetically transmitted aspects of asthma but to also consider what meanings and recursively behaviour, family members have around asthma that could contribute to the maintenance of the symptoms over three or more generations, such that we are able to talk about a pattern that connects. It is in this regard that the researcher finds Bogdan's (1984) idea that "the behaviours of each individual is cognitively consistent with the behaviour of every other individual in the system" (p. 375).

Overview of the Study

The following chapter, that is, the literature review, provides an overview of most of the research done on asthma so far. An attempt has been made to integrate a review of the literature on the biomedical aspects of asthma with the literature on the psychological aspects of asthma. Since asthma has been extensively studied from a biomedical perspective, there is obviously more literature on this perspective. However, in keeping with the epistemology that forms the basis of this research, the

medical research and/or perspective is useful and necessary within this particular context (Keeney, 1983).

The third chapter focuses on the theoretical narrative. This chapter sets out to describe the epistemology and theory that forms the basis of this research. Ecosystemic epistemology together with social constructionist theory are the two most basic epistemologies that will guide the researcher's distinctions and assumptions in conducting the research. Also included in this chapter, is a way of bringing the biomedical and the ecosystemic epistemologies together. This is done in such a way that the one model is not prioritised over the other. Furthermore in so doing, the researcher refrains from giving a dualistic either/or conceptualisation of both models. Both are useful and necessary within a particular context.

If ecosystemic epistemology and social constructionism provide guidelines for doing research, the researcher also has to choose a research epistemology that is consistent with these. This is discussed in Chapter 4. Qualitative research based on new paradigm research concepts (Lincoln & Guba, 1985) is suitable for use in this research. Its basic assumptions, will also be described. The researcher will also include an explanation of how this research will be legitimised, since it doesn't follow conventional ways of establishing legitimacy. The notion of conceptualising research as the co-construction of narratives is derived from the researchers' theoretical viewpoint, to be discussed in Chapters 2 and 3.

Chapter 5 focuses on a description of the family's language around asthma, its composition and the different narratives that each member has around asthma. Of note here is how each member's stories include all those of other members. A description of what constitutes our significant system is also forwarded.

Chapter 6 focuses on the researcher's narrative. This represents the researcher's interpretation of what for her constitutes the meanings and behaviour that the family members together with the researcher have co-constructed around asthma. A number of patterns and themes will be described. However these have nothing to do with what constitutes the "real" issues or patterns and themes of the family. They have been co-constructed by the researcher together with the family and refer to a specific context at a specific time. The researcher's experience of asthma in her own family together

with the epistemology that forms the basis of her training, were useful in the drawing of these distinctions.

Chapter 7 is the conclusion. This will include a description of the limitations of the research, together with recommendations for possible areas that still need to be researched. The researcher will also include in this chapter what was for her the usefulness of this way of drawing distinctions both for the academic community and the family under study.

CHAPTER 2

LITERATURE REVIEW

Introduction

The name of a disease usually identifies one or more of the characteristics of that disease. The Collins English Dictionary (1979) defines the disease as: "any impairment of normal physiological function affecting all or part of an organism" (p. 423). In chapter 1 the definition of asthma by Kaplan et al. (1994) was quoted in which asthma was labelled as a disease. In terms of the biomedical model a disease is the result of known or unknown natural causes and elimination of these causes will result in cure or improvement in individual patients. The biomedical model also demands that disease be explained on the basis of biomedical and neurophysiological processes. It thus follows that the biomedical model is reductionistic, deterministic and follows the mind-body duality (Engel, 1977).

What follows in this chapter is an overview of research done on asthma. It is important to note that in the literature review, equal emphasis will be given to both the biomedical and the psychological research. As stated previously, the biomedical perspective is necessary and useful within a particular context (Keeney, 1983). However, in keeping with the epistemology that forms the basis of this research, that is the *ecosystemic* epistemology, one should refrain from prioritising the one model over the other. If one has to indeed be holistic, one needs to acknowledge the existence of other realities. Furthermore, asthma is essentially a medical concept, and has been researched extensively from a medical perspective. At the same time, it is a human experience with meaning for the sufferer and his/her family. An attempt will therefore be made to integrate as much medical and psychological research as possible.

The Prevailing Definition of Asthma

Asthmatics are generally accepted to comprise patients "in whom episodes of wheezy breathlessness, with intervals of relative or complete freedom from symptoms, can be shown to be associated with variations in resistance to flow in intrapulmonary airways" (Scadding, 1983, p. 242). This categorisation involves a clinical description of function but makes no suggestions regarding etiology of the disease. This approach is further confirmed by the definition of asthma as a syndrome of multiple etiologies (Gershwin, 1981).

Asthma can further be characterised by increased responsiveness of the trachea, major bronchi and peripheral bronchioles to various stimuli, and is manifested by extensive narrowing of the airways which causes an impairment of air exchange primarily in expiration thus inducing wheezing (Purcell & Weiss, 1970). The airways may be narrowed because of edema (an excess of watery fluid in the tissues of the walls), increased mucous secretion, spasm of bronchial muscles or croup, which is a result of the collapse of the posterior walls of the trachea and bronchi during certain types of forced expiration (Purcell & Weiss, 1970).

Asthma sufferers tend to struggle to breathe. The difficulty in breathing may be so severe that the patient has difficulty walking or even talking. These patients take longer than the normal time to expire air, using accessory respiratory muscles in the process (Jariwalla, 1988). The difficulty in getting air in and out of the lungs feels like suffocation, increasing the patient's subjective feelings of panic and fear (Rees, 1990).

Clinical Manifestations of Asthma

As we have already described it, asthma is characterised by wheezy periods of breathlessness, with periods of relative or complete freedom from symptoms. The latter symptom-free phase is referred to as reversibility. Asthmatic patients could, however, also develop various degrees of irreversible obstruction in the respiratory system caused by structural damage of the bronchi as a result of asthma or other pulmonary diseases (Rawnsley, 1986).

Pathophysiology

According to Gross (1988) asthma is characterised by the following pathophysiological changes: airway constriction, mucosal edema, inflammatory infiltration of the airway walls, airway epithelial damage and desquamation, goblet cell hypertrophy, and mucous hypersecretion. These symptoms therefore imply that asthma may be precipitated by a multiplicity of stimuli. Patients who exhibit these variable symptoms are often arbitrarily subdivided into two groups. Extrinsic asthma, that is, those patients in whom immunological mechanisms appear to play an important role and intrinsic asthma, that is, those patients with "hyper-reactive airways" in whom immunological mechanisms may be difficult to document, but in whom a multitude of stimuli appear to be important in causing the asthmatic condition (Gross, 1988).

Immunopathological Consideration

Immunological considerations are especially notable in allergic bronchial asthma, which gets mediated via macrophage involved antigenic sensitisation of T-cell lymphocytes which results in B-cell lymphocyte stimulation to form Immunoglobulin-E (IgE). The antigen, specific IgE, is subsequently attached to specific receptors on airway mast cells and circulatory basophils. The aggregation of membrane antigen-specific IgE receptors triggers mast cell "activation" causing exocytosis of preformed mediator substances and the generation of other potential mediators of immune inflammatory reactions (Gross, 1988).

The mediators, being a diverse group of active biological and pharmacological agents, are capable of initiating both immediate and delayed local immunoinflammatory responses. The immediate phase causes bronchospasm oxidation of proteinaceous plasma into the bronchial walls, and airway mucus glycoprotein secretion, whereas delayed response is characterised by specific phagocytic infiltrations into the bronchial walls (Gross, 1988).

Persistent Airway Hyper-reactivity

A fundamental property of the airways in active asthma is the tendency to actively narrow, due to airway smooth muscle contraction. This characteristic has variously been labelled airway hyper-reactivity, bronchial excitability or bronchial hyper-irritability (Jariwalla, 1988).

Gross (1988) suggests that the tendency of the airway to narrow is the most pathogenic event in the acquisition of asthma. He further argues that, whereas immunogenic mechanisms account for 25% to 50% of asthmatic patients, airway hyper-reactivity is detectable in essentially all asthmatics, even during periods of clinical remission. Airway hyper-responsiveness may be induced by viral infections of the respiratory tract, antigen exposure in sensitised individuals, ozone, oxides of nitrogen and industrial sensitisers for example, isocyanates, epoxyresins and formaldehyde, wood dusts, etcetera (Jariwalla, 1988).

According to Jariwalla (1988) symptomatic airway hyper-responsiveness may also be caused by inflammatory airway disease, of which the description is based on the observation of redness, because of vasodilatation, edema, because of vascular permeability and pain, because of local stimulation of the nerve endings. When the inflammatory process involves a mucous membrane there is hypersecretion from the mucous glands and desquamation of epithelial cells. Inflammation may also include such complex reactions as the accumulation and activation of a variety of cell types, for example, neutrophils, macrophages and lymphocytes with the local production of a variety of mediators - some from cellular stores and others newly generated which cause the vascular and permeability changes, stimulate pain fibres and bring about a variable degree of local damage.

In summary, Gross (1988) proposes the following pathogenic mechanisms to account for airway hyper-reactivity:

1. Increased release of mediators (including metabolites of AA) acting directly upon various target cells.
2. Increased availability of mediators to various target cell receptor apparatuses, including airway afferent nerves.

3. Increased sensitivity of airway afferent nerve receptors to mediators that cause reflex bronchoconstriction and mucus hypersecretion.
4. Increased central nervous system sensitivity to afferent reflexes that could serve to amplify efferent outputs back to the airways.
5. "Imbalance" of the major efferent motor pathways.
6. Increased basal receptor "sensitivity" or intrinsic "tone" of airway smooth muscle cells.

Prevalence

Asthma prevalence has been reported to be slightly higher among males than females. Male predominance is most striking among children under whom male/female ratios of up to 2:1 have been found (Marais, 1972).

During most of adulthood, there appears to be little difference in prevalence between men and women (Marais, 1972).

Some of the highest occurrences in asthma have been reported in the Maldives (a prevalence rate of 20,2% amongst people younger than 20 years) (Woolcock, 1986). Other statistics for people younger than 20 years in developed countries include Birmingham (in the United Kingdom) 9,9%; Aberdeen (UK) 11,5%; Melbourne (Australia) 11,48% and Sydney (Australia) 12,7% (Cookson & Makoni, 1980; Woolcock, 1986). Marais (1972) found a prevalence rate of 2,8% for standard 6 white pupils in Namibia and South Africa.

Course and Severity

The course of asthma, according to Jariwalla (1988, p. 101), is quite variable. Some asthmatics remain subject to symptoms indefinitely, while others experience complete remission. Most childhood asthmatics have been reported to greatly improve over time until adulthood. Asthma during adulthood is less likely to remit than is childhood asthma (Jariwalla, 1988).

Childhood asthma associated with atopy is more severe than that without

associated atopy and yet, among childhood asthmatics earlier age of onset is associated with severity (Jariwalla, 1988).

Mortality

Death from asthma is difficult to assess with certainty since, as already mentioned, asthma is a symptom complex (i.e., exists alongside other kinds of symptoms) and doctors may list other causes of death, for example, respiratory failure, bronchitis, etcetera, when asthma is the true cause. It would seem, however, that there is a steady increase in the mortality rate of asthma (Boushley & Nichols, 1987; Warner, 1989). In the decade 1974 to 1984 in the United Kingdom death of patients of 5 to 34 years old increased by 4,7% per year. In the United States the number of asthma deaths per year in the 0 to 14 year age group doubled from 1977 to 1983 (Rees, 1990).

Death from asthma appears to be increasingly rare for those patients admitted in well-equipped hospitals with alert emergency departments. Boushley (1987) and Reinhardt (1985) find that inadequate maintenance therapy, underassessment by doctors, and patients whose severity of the attack results in failure to call for help and the inadequate response of medical services, repeatedly contribute towards asthma mortality. Retrospective studies suggest that, with better management of acute, severe asthma attacks, approximately 50% of deaths could be prevented (Pauwels & Snashall, 1986).

Etiology

Asthma can be triggered by the following conditions: allergy, respiratory infections, vigorous exercise, inhalation of some gasses and certain pharmacological drugs.

Allergens

Allergens that are known to cause asthma constitute both an atopy-a tendency to develop Immunoglobulin E antibodies which is usually genetically transmitted; and

inhaled allergens most of which can be divided into four groups viz. pollen, fungal spores, animal danders and house dust/mite. Pollen allergens which trigger asthma are predominantly from wind pollinated plants namely trees, grass and weeds (Cockcroft, 1988).

Ingested allergens such as foods and injected allergens (injections, insect bites, and stings) constitute uncommon triggering factors for bronchial asthma. Reaction to these kinds of allergens are generally manifested by one or more of the following symptoms; angioneurotic edema, anaphylactic shock, conjunctivitis, and bronchospasm (Cockcroft, 1988).

Respiratory Infections

Several important mechanisms have been identified by which respiratory infections taking the form of viral infections could provoke asthma. The relationship between viral respiratory illness and asthma remains very difficult to understand because it involves many organ systems, for example, airway epithelium, autonomic nervous systems control, and the immediate hypersensitivity system. However, it is worth noting that the ability of the respiratory viral infection to produce inflammation, leads to asthma (Busse, 1988).

Exercise

Vigorous exercise has been known to cause characteristic changes in lung function and to therefore lead to asthma in susceptible persons. However, it is the type and severity of the exercise that seem to provoke an asthma attack. According to Godfrey (1977) certain types of exercises can be tolerated by asthmatics, for example, swimming, riding, etcetera, whilst running can be detrimental to an asthmatic patient. Although the severity of the exercise-induced asthma depends upon the type of exercise, it also depends on the rate of output and duration of the exercise. Brief exercises, it has been observed, even if quite hard, would not cause much trouble (Godfrey, 1977).

Inhalation of Some Gases

Inhalation of noxious gases, for example, sulphur dioxide is for most patients, a well-recognised cause of the exacerbations of asthma. Sulphur dioxide which is usually used or generated in a wide variety of industries, leads to bronchoconstriction. Concentrations of sulphur dioxide in excess can be found in metal smelters, paper, pulp mills, petroleum refineries, vineries, and food processing plants (Sheppard, 1988).

Pharmacological Drugs

Asthmatic attacks can also be induced by the ingestion of certain pharmacological drugs, such as aspirin. Aspirin-induced asthma is usually characterised by the development of bronchoconstriction within minutes or several hours after the ingestion of aspirin (Thomson, 1988).

Genetic Factors

The extent to which genetic factors play a role in asthma is not as well documented as is the role played by the already discussed variables. Studies that have been done on twins suggest that there is a definite minor genetic element present in some cases of asthma (Jariwalla, 1988). However, the situation becomes compounded if there is atopy, which is definitely inherited, and asthma. It is therefore wise to concur with Jariwalla's (1988) proposal that "atopy and asthma are inherited separately. But atopy enhances a genetic susceptibility to asthma, increasing the chance that it will be expressed" (p. 120).

Psychological Factors

The extent to which psychological factors are involved in the aetiology of asthma, is still not clear. Rees (1990) identified two problems standing in the way of understanding the relationship between asthma and its psychological component.

Firstly the nature of the disease, for example, the fact that it is a multiplicity of symptoms (syndrome) of which the known aetiology is a variable, the age of onset. Secondly, important information such as subject selection procedures is often omitted by researchers from their manuscripts.

In a study of 388 asthmatic patients, conducted by Rees (1963), psychological factors were accounted for in only 37% of the cases which suggests that 63% of cases were unrelated to psychological factors. It has thus been accepted and argued that psychological factors could never be a complete explanation for asthma (Pauwells & Snashall, 1986).

Psychological processes may, however, be involved in the pathophysiology of asthma by means of several mechanisms.

Different Theoretical Explanations

Psychoanalytic View

The psychoanalytic view sees asthma as having its origins in the early life of the child and particularly the child's symbiotic relationship with the mother (Grossberg, 1979). The child's neurotic symptoms are seen as a way of coping with unconscious conflict and anxiety felt by the child. The fear of losing maternal love may arise from the threat of an actual separation from the mother or the patient's anxiety that the exposure of his aggressive and sexual fantasies would evoke the mother's rejection. A number of researchers (Coolidge, 1956; French & Alexander, 1941; Grossberg, 1979; Margolis, 1961) saw the asthmatic symptom as a wish to be "protected and encompassed" by the mother and they saw the asthmatic attack as being a suppressed cry for the mother's help in response to a threat of separation. Alcock (1960), on the other hand, saw the basic factor as a conflict between an unresolved dependence on the mother and a simultaneous urge to separate from her. He sees the attack as a repressed cry of anxiety and rage.

Asthma as a Learned Response

The role of learning through conditioning has long been considered important in the development of the symptoms of asthma. Experiments inducing asthma-like responses by conditioning in both animals and humans provided the theoretical framework for a theory of mother-child conditioning and stimulus generalisations (Ballard, 1973; Turnball, 1962).

Turnball (1962) said that if a neutral stimulus is followed by a painful stimulus such as a shock, the former becomes associated with the pain-arousing situation and after a number of trials the conditioned stimulus becomes a sign of the shock and is able to elicit a portion of the fear reaction, including variations in respiration prior to the occurrence of the shock itself. This emotional reaction to the sign will in turn motivate the organism to "try-out" various instrumental activities to avoid or escape shock.

Personality Factors, Mother-Child Relationships

Attempts have previously been made to find a relationship between asthma and personality patterns. Asthma has previously been associated with the cyclothymic or hysterical personality (Kaplan & Sadock, 1975). Current investigations have, however, shown that there is a wide variation in personality disturbances among asthmatic patients and that there is no single underlying personality type (Kaplan & Sadock, 1975).

French and Alexander (1941) were among the first to comment on the disturbed mother-child relationship as aetiological in the genesis of asthma. According to them it was unhealthy unconscious parental attitudes that were said to be causally related to the unhealthy emotional development of the child. In this context asthma is seen as a neurotic symptom, produced to cope with the conflict and anxiety in an unhealthy family situation. Mohr (1974) argues that mothers of asthmatic children had conflicting feelings both about their children and their role as mothers. Wittkower and White (1959) found that asthmatics characterised their mothers as rigid, insecure, domineering and frequently hostile towards their children or overprotective.

Emotional Factors

Emotions and the central nervous system may play a role in asthma attacks by means of direct effect on bronchiolar physiology independent of allergic or immune mechanisms (Kaplan & Sadock, 1975).

According to Chairi, Foschino-Barbaro, Nuzzo, Pecci and Rossi (1987), asthmatic children have a lower frequency and duration of expressed emotion and have specific difficulty in showing anger or hostility. These emotions are usually replaced with an abnormal respiratory pattern. Inability to express fear as well was cited in several other studies (Chairi et al., 1987).

Psychosomatic/Psychophysiological Medicine

Psychophysiological medicine, a term recently coined to replace the outdated term psychosomatic medicine (DMS IV, 1994) recognises the interplay between somatic and bodily processes. By definition, psychosomatic illness refers to bodily (somatic) changes which can be produced by a mental (psychic) attitude. Thus, emotional tension, chronic or acute, are often discharged in ways that upset the normal physiological equilibrium of an organ, hence the relationship of emotional tensions to organic and functional disorders (Grossberg, 1979; Selye, 1956).

How is it that certain people are more vulnerable to developing certain illnesses than others? According to Selye (1956), each newborn infant may have at least one vulnerable component of the autonomic nervous system. Thus the response to environmental stimulation may show a capacity for greater liability and thus for more intensive participation in later emotional response of abnormal or pathological degree. For instance, an infant born with a weak lung, could have more vulnerability to developing asthma than any other psychosomatic illness.

How does this mind/body relationship work in producing an illness? In the opinion of many psychoanalysts, according to Clark and Godfrey (1977), the underlying psychodynamic processes are essentially the same as in the contribution to a mental

illness. Prugh (1963) states that health and disease should be regarded as one of the different phases of life which are dependent on the homeostatic balance of the organism. In this framework, stress is experienced by the organism as the result of an internal-external interference with the satisfaction of basic needs, and this causes a disturbance of the adaptive equilibrium. Stress is relative, not absolute, and the organism has the capacity to deal with it successfully at any given moment (Selye, 1956). The outcome of stress could lead to a restriction of function, or a decompensation and adaptive breakdown of the organism, which is then physiologically believed to be a diseased state. Many of the symptoms, from ulcers, or cancer to asthma, may be the result of the organism's attempt to maintain psychological and physiological equilibrium, rather than being specific results of the stressful stimuli and their direct effects (Selye, 1956).

Mohr (1963) sees the formation of a psychosomatic disturbance as due to the timing and intensity of a hierarchy of factors:

1. During the first year of life, any noxious stimulus, psychological or physical tends to produce a generalised response.
2. Traumatic experiences of any sort during this early period can be responded to only at the physiological or somatic level.
3. A great variety of responses to traumatic stimuli are available to the infant or young child with the development of more mature adaptive and defensive patterns.
4. The maturation of the central nervous system and the capacity for voluntary muscular control widens the range of physical responses for the child.
5. On the physiological level, responses will become more differentiated with instruction and will be object directed.

The choice of psychosomatic illness will depend also in part upon the timing of the initial traumatic experience and reinforcement thereof and the repertoire of potential responses available (Grossberg, 1979).

In an attempt to add to a more holistic and systemic perspective of psychosomatic illnesses, Minuchin (in Minuchin, et al. 1978) based on his structural family therapy model, identifies factors that constitute a psychosomatic family. His view with regards to psychosomatic families is based on the following premises: (a) certain types of family

organisations are related to the development of psychosomatic symptoms in children; and (b) that children's psychosomatic symptoms play a major role in the feedback processes between the child and his family and the family's reactions to the child's symptoms are also cued and reinforced.

Minuchin (in Minuchin et al., 1978) further developed a model of the psychosomatic family. Following this model, three factors, in conjunction, initiate and maintain the development of psychosomatic illness in children:

- The child is physiologically susceptible to the condition.
- The family of the chronically ill child displays four transactions/characteristics: enmeshment, over-protectiveness, rigidity and lack of conflict resolution.
- The sick child plays a major role in the family's conflict avoidance mechanisms and this role is an important source of reinforcement for his symptoms (Minuchin et al., 1978).

Minuchin et al. (1978) define enmeshment as "an extreme form of proximity and intensity in family interactions" (p. 151). In a highly enmeshed, over-involved family changes in one family member leads to changes in all the other members. The problem experienced in such families is one of individual differentiation. The individual gets lost in the system. Rigid families are defined as those that strive to maintain the status quo. Change is unwelcome and poses a potential threat to the family. The over-protectiveness of psychosomatic families shows in the high degree of concern of family members for each other's welfare. The functioning and structure of these families is such that conflict is avoided (Minuchin et al., 1978).

Conflict in psychosomatic families can be avoided in one of three ways viz. triangulation, detouring and parent-child coalitions (Minuchin et al., 1978). Triangulation and parent-child coalitions share the same characteristic in that the spouse dyad is split in opposition or in conflict and the child ends up forming an alliance with the one parent against the other. In triangulation a child cannot express himself without siding with the one parent. Detouring, however, is seen when the spouse dyad is united through the symptoms. Parents either come across as protecting the sick child or blaming him, for he is then defined as the family problem (Minuchin et al., 1978).

Literature on family life and family therapy is replete with interactional patterns that either initiate or maintain psychosomatic illnesses. A study by Grossberg (1979) points to how a particular symptom is used unconsciously by families to maintain the families' homeostasis and myths. On the other hand, Gusstafson, Kjellman and Cederblad (1986) point to how the presence of asthma in the family could disrupt the family's functioning and further propose the use of family therapy as an adjunct to the conventional treatment of children with severe asthma. For these authors, dysfunctional patterns of interaction and relations are more common with severe asthma. However, these patterns are seen as a consequence of rather than a precipitator of the disease (Gusstafson, Björsten & Kjellman, 1994).

For Rees (1990), certain parental and behavioural responses towards the sick asthmatic child, maintain the illness and therefore contribute to undermining the efficacy of medical treatment. Indeed for Silverglade, Tosi, Wise and D'Costa (1994) there exists in many asthmatics a strong dependency on significant others, along with a sense of helplessness, anxiety, depression and hostility.

Therefore severe asthmatics react in specific ways that elicit parental over-protectiveness and behaviours that tend to undermine the development of confidence and self-control.

In an attempt to add to a more holistic approach to the understanding of asthma, Molinari, Taverna, Gasca and Constantino (1994) propose the inclusion of not only the nuclear family in the understanding of asthma, but also all the other professionals working with the child such as the psychiatrist, psychologist, allergist, etcetera. This follows from not only considering the biomedical aspects of the disease, but also considering the relational characteristics that could be contributing towards the continuation of the symptom.

Furthermore, these authors (Molinari et al., 1994) argue that psychosomatic families are often multiproblem families in which the psychosomatic symptom disguises other disturbances. Therefore, having a highly flexible system, which is able to adapt to the different demands within the family, is necessary.

For Towns (1994) the unit of treatment is not predefined according to the social parameters, but that the aggregate of all those who talk about asthma as a distress

should be included in the therapy. This connects to notions of social constructionism and second-order cybernetics (ecosystemic epistemology).

In summary, the above theoretical formulations (with the exception of Towns) overridingly adhere to a logical positivistic epistemology in underscoring the unilateral influence of certain psychological processes on the onset of asthma. Early mother-child interactions (psychoanalytical view) and certain bodily and emotional processes (psychosomatic view) are believed to cause asthma in the early life of the child (Coolidge, 1956). Indeed for learning theorists, certain reinforcement and punishment procedures can either maintain or initiate the development of asthma in children (Ballard, 1973).

Most of the above theoretical formulations are based on the logical positivists' principle of lineal causality. Indeed for the positivists, lineal causality is concerned with "combinations of discrete elements" (Keeney, 1983, p. 14) that are seen as connected to one another through cause and effect. Any one part of the system is seen as being able to influence other parts of that system in a unilateral manner. Furthermore, breaking down the experience of asthma into intrapsychic elements, leads to the reification of the disease, and further contributes to the logical positivists' principle of reductionism. According to the logical positivists, "in order to understand an object or phenomenon, it needs to be reduced into its most basic elements or building blocks, which are simpler, more easily understandable and often measurable" (Capra, 1983, p.1).

A shift in focus is provided by systemic literature (quoted above) that is based on assumptions that are radically different from those of the logical positivists' epistemology. Minuchin et al. (1978), in considering the inclusion of the whole family towards an understanding of asthma, move us away from considering it as an individual disease and towards seeing it as a disease that lies within the whole family's interactional patterns. Goldberg (1979) and Rees (1990) also accord with the inclusion of the whole family in understanding the interactional patterns that could either be initiating or maintaining the disease. Towns (1994) in defining the unit of treatment as the meaning system, moves us towards an epistemology that forms the basis of the present study. Whilst it may seem as if Town's (1994) study shares a lot of similarities

with the present study, it nevertheless focuses on different distinctions, as will be detailed later.

Treatment

The goals of treatment according to Canny and Levinson (1986) are:

- Maximum control of symptoms with minimum possible medication
- Decreased frequency and severity of attacks
- Maximal improvement in lung functions
- Education of patients about their disease and its management
- Minimising school/work absenteeism
- Participation in sports activities without restriction
- Normal growth.

It is interesting to note that cure is not included in the above as a goal of therapy. However, attempts are made to decrease mortality from asthma.

Available medical treatments of asthma include bronchodilators, anticholinergic agents, methyl xanthines, and prophylactic therapy.

Bronchodilators

Bronchodilators in the form of Terbutaline, Fenoterol, Pirbuterol, Repnoteral, etcetera, can either be administered orally, especially with nocturnal syrup forms or by use of a nebuliser solution, which delivers large doses directly into the lungs. Nebulisers are often indicated in the case of acute asthma. There is a general reliance on bronchodilators by medical practitioners in the treatment of asthma. However, certain side-effects have been reported such as fine tremors, feelings of anxiety, and occasional tachycardia. The latter refers to loss of effect of bronchodilator action with continued use. This can be corrected by a brief period without the drug or by corticosteroid therapy (Jariwalla, 1988).

Anticholinergic Drugs

These have long been known to be effective in relieving bronchoconstriction. Deadly nightshade extracts (*Atropa bella donna*) and thornapple (*Datnes stramonium*) have formed traditional remedies. They act by blocking bronchoconstricting activity and the effects of general vagal blockage limit their use to the inhaled route. The main compound available for many years was atropine. However, Ipratropium Bromide, was introduced in the mid 1970's and it is still in use. Previously the known side-effects of anticholinergic drugs were drying out of airway secretions, reduction of mucociliary clearance and its contribution to mucous plugging. However, with the introduction of Ipratropium Bromide these side-effects were no longer reported (Jariwalla, 1988).

Anticholinergic drugs are available for inhaling therapy only, in the form of a metered dose, inhaled and nebulised solution (Jariwalla, 1988).

Methylxanthines

These consist of a group of three naturally occurring substances, theophylline, theobromine, and caffeine. The most important of these is theophylline. These drugs can be administered orally, rectally, or parenterally, for example, subcutaneously, intramuscularly, or intravenously. The most common side effect for use of this is gastrointestinal irritations with nausea and vomiting (Jariwalla, 1988).

Prophylactic Treatment

Prophylactic treatment refers to the use of bronchodilator drugs as regulator long-term therapy to prevent the onset of many asthma attacks. It has been recognised that even patients whose asthma is well-controlled, may have pathological damage in the airways. Here the use of prophylactic drugs, which have an anti-inflammatory effect,

has been suggested (Jariwalla, 1988). Prophylactic drugs take the form of sodium cromoglycate, nedocromil sodium, antihistamines, kerohifen, calcium antagonists, and corticosteroids. All these can be administered either by an inhaled device or by the use of a nebuliser (Jariwalla, 1988).

Non-Pharmacological Treatment Procedures

Education

In the treatment of both childhood and adulthood asthma, education is much more important and should include both parents and teachers as well as the child. A number of teaching aids for children should be used such as comics, and visual aids (Gershwin, 1981).

Acupuncture, Hypnotherapy and Relaxation Therapies have also been Indicated in the Treatment of Asthma

Hypnosis has previously been used alongside a technique of suggestion. The two techniques are apparently indistinguishable from each other. Usually treatment follows four to eight sessions. The sessions consists of trance induction followed by either direct or indirect suggestion tailored to the particular asthma precipitate experienced by the patient. Usually the patient will be taught self-hypnosis, and instructed to hypnotise himself or herself several times a day (Gershwin, 1981).

Relaxation

In relaxation training, any suggestions are directed specifically towards the goal of achieving relaxation. The theoretical rationale for relaxation is that it will lessen autonomic arousal, thus decreasing direct autonomic effects on the bronchial smooth

muscle and indirectly altering immune responsiveness (Gershwin, 1981). Electromyographic techniques have also been used as an adjunct in relaxation (Gershwin, 1981).

Family Therapy, Group and Individual Therapies

There are cases in which group and or individual therapies report little progress being made following these modalities of treatment. Failure is accounted to poor experimental designs which preclude definite conclusions being drawn (Kaplan & Saddock, 1985).

Family therapy has been indicated in many studies as a treatment modality for asthma. In a study by Gusstafson et al. (1985) improvement was indicated in those children with severe asthma who received family therapy. Improvement was indicated in their general paediatric assessment which included such indices as the frequency and severity of the attack, the amount of medications necessary, school attendance, physical activity, etcetera. Therefore, it was concluded that children who received family therapy showed a marked improvement compared to those who had not (Gusstafson et al., 1985). Tal, Gil-Spielberg, Antonovsky, Tal, and Boaz (1990), further argue that, seeing that asthma as a chronic illness impacts on the day to day life of the asthmatic and his family, it is of utmost importance that treatment should include the whole family.

Molinari et al. (1994) have a much more holistic approach to the treatment of asthma which, according to them, includes not only the patient's family and their doctor, but also all the other professionals working with the child, for instance, the psychiatrist, psychologist, allergist, etcetera. They emphasise the need for collaboration among all people involved in the treatment of the disease. As mentioned earlier, this will allow flexibility in attending to the many problems associated with asthma.

Conclusion

In summary, the above description of the medical and psychological research on

asthma reveals a number of theoretical formulations similar to those of the logical positivistic epistemology. Emphasis has been put on aetiological factors which operate along the principle of a particular "thing" causing another in a unilineal way, that is, the principle of linear causality. Disease has been defined in terms of observable symptoms and/or syndromes. Behaviour is quantified, that is, airflow is measured and cure results in the adding or substitution of the problematic organ or functioning of an organ with something else, known as medications in the form of bronchodilators.

What follows in the next chapter, is a description of the epistemology that forms the basis of this research. An ecosystemic epistemology together with an additional lens of social constructionism will guide the researcher in drawing the distinctions around the meanings the family in this study attribute to asthma and how these inform their behaviour.

CHAPTER 3

THE THEORETICAL NARRATIVE

Introduction

As was noted in the previous chapter, the positivist perspective on the diagnosis and treatment of asthma, is one that is based on the premise that a sufficient deviation from normal, represents disease, that disease is due to known or unknown natural causes and that elimination of these causes will result in cure or improvement in individual patients (Engel, 1977). The biomedical model, which follows a traditional linear epistemology, is atomistic, reductionistic, anti-contextual and follows an analytical logic concerned with combinations of discrete elements. It requires that disease be dealt with as an entity independent of social behaviour or relational context. It also demands that behavioral aberrations be explained on the basis of disordered somatic (biomedical and neurophysiological) processes only (Engel, 1977).

Following this model, clinical diagnosis is tied to the process of ascribing a label to an individual in order to signify the particular pathology and class of symptoms exhibited. It sees the individual as the receptor of lineal causal effects and hence the site of pathology (Keeney, 1983).

In recent years there is evidence of an emerging trend to abandon this paradigm of knowledge in favour of the ecosystemic/cybernetic epistemology. What follows are the basic assumptions of the ecosystemic epistemology and how these informed the researcher's perceptions and distinctions in defining the focus and aims of this study; in designing an appropriate research process and in describing the family. The specific lens of social constructionism will be used to observe, understand and connect different narratives.

On Epistemology

Auerswald (1985) describes epistemology as "a set of imminent rules used in

thought by large groups of people to define reality" (p. 1). Indeed for Keeney (1979) one's epistemology leads to particular ways of knowing or arranging observed data. Furthermore, one's descriptions and maps of problematic situations contain an implicit epistemology. Epistemology is also used in this sense to signify how particular organisms think and know problematic situations (Bateson, 1979).

Keeney (1983) identifies the most basic acts or tools of epistemology. The first of these tools is the drawing of a distinction, that is distinguishing a thing from its background. In the process of distinguishing a thing from that which it is not, one creates a difference, and it is this difference that gives useful information about the nature of that which one seeks to describe.

Basic to understanding epistemology, is the idea that what one perceives and knows is shaped largely by the distinctions that one draws. These distinctions, therefore, reflect the basic assumptions of the observer/researcher drawing them. What follows then is an explanation of the distinctions and punctuations made in this study. They are based on the ecosystemic/cybernetic epistemology. Also following Keeney (1983) and Stroh, Becvar and Becvar's (1993) proposal, the two terms (ecosystemic and cybernetic) are seen as synonymous and can be used interchangeably. A further lens of social constructionism will be incorporated to contextualise these descriptions. It is also essential to note that the most basic distinction I have made, is to regard the difference between the new epistemology and its biomedical counterpart as a difference in logical typing.

The trend towards abandoning the biomedical Newtonian model in favour of the ecosystemic epistemology follows from seeing the ecosystemic perspective as distinct and therefore a better alternative to the Newtonian, biomedical model. However, the position adopted in this research is to see these approaches not as distinct, but rather as different sets of distinctions embodied in the more encompassing ecosystemic epistemology. Indeed for Keeney (1983) "any position, perspective, idea or frame of reference is merely a partial embodiment of a whole that can never be completely grasped" (p. 57). An approach that emphasises both sides of a distinction will be pursued, on the basis of doing justice to the ecosystemic assumptions of cybernetic complementarity. Assigning priority to the one model over the other will also be avoided

since doing so will lead us into yet another dualistic either/or logic distinction. An approach that emphasises holism while at the same time acknowledging the existence of other lineal, biomedical realities, will be useful in this context. It appears that while it is essential to be completely aware that any one paradigm is always and only a partial embodiment of the whole and should thus not be afforded privileged status, in any objective sense, it nevertheless becomes very difficult to escape prioritising particular paradigms. Indeed I contend that paradigm choice is a personal matter and this choice presupposes an assumption of what is more useful to the individual researcher in that particular context (Keeney, 1982; Mazabow, 1993).

It is also necessary to note that I have constructed what for me, and for the purpose of this study, would be a useful way of integrating the two systems of knowledge. Indeed this way of interpreting the two systems is based on my own ideas and presuppositions about both models, and could therefore be subject to many epistemological errors in terms of official theory yet remain true to my self-referential position in this research.

My own presuppositions with regard to seeing the lineal biomedical perspective as embodied in the ecosystemic epistemology are as follows:

- Ecosystemic epistemology, if it is indeed holistic, has to acknowledge the existence of the other reality, namely the biomedical reality.
- The emphasis should thus be on non-dualistic inclusive descriptions rather than on lineal, either/or descriptions.
- There can be no more or less valid ways of describing in the world of creatura (Bateson, 1979) given the self-referentiality of all descriptions.

Yet there may be more or less useful lenses for a particular question and context.

In reading this dissertation, it may appear that I tend to be biased towards the ecosystemic perspective. Indeed one's ways of describing follows from one's theories of how to make descriptions, that is, one's epistemology, and it is this epistemology that forms the basis of my training and beliefs as a psychologist.

The important question that now needs to be considered is: How will the two

systems of knowledge, that are based on radically different assumptions, be integrated? One way of looking at this is to regard the difference between the two systems of knowledge as a difference in logical typing. Indeed for Keeney (1987) distinctions at one logical level, that appear to be related through an either/or logic of negation may be seen at the next logical level as one side of a more encompassing whole, where both distinctions are recursively related and the dichotomies are bridged. Both descriptions will thus be embraced through Keeney's zig-zag ladder of the dialectic between form and process. By the process of double description we will be able to move from one description to the other, and thereby achieve a much more holistic view.

In terms of Keeney (1983) we can see the process of double description as a more holistic approach that is based on juxtaposing the different sides of a relationship. When applying this process to the interaction between two people we are able to observe how each punctuates the flow of this interaction. If an observer now combines the views of both persons of their interaction an understanding of the whole system will emerge.

Bateson (1979) uses the analogy of two eyes seeing in his explanation of double description. One eye perceives a monocular perspective. When the perception of the second eye is combined to that of the first, binocular vision takes place and this vision adds an extra dimension to what one eye can perceive.

This process of double description will be illustrated in the following chapter, in which each family member's story around asthma will be combined with those of the others to yield a thick and rich description that reflects on patterns and relationships.

In his book Bateson (1979) depicts his work as a "weaving of three levels of abstractions" (p. 281). He depicts the most concrete level to be the ethnographic data, a more abstract level as the arranging of the data to create "various pictures of the culture" and a still more abstract "self conscious" discussion of the procedures by which the various aspects of the data are put together (Bateson, 1979, p. 118).

Keeney (1983) has modified this method of analysing data by arranging it as a dialectic between form and process. Keeney has thus modified Bateson's ladder and added the orders of recursion to it. It is within this dialectic between form and process

that the two models will be integrated in a way that shows the one model at a higher level of logical typing than the other; although the two models will be recursively connected. Before we can proceed to describe Keeney's (1983) zig-zag ladder of dialectic between form and process, it is necessary to understand what is meant by levels of logical types.

The levels of logical types are "conceptual tools" according to Russell and Whitehead (1910, p. 29) that are used to specify that a paradox can be avoided by always pointing out the logical typing of statements (Keeney, 1983). A paradox is traditionally seen when a conclusion is reached, based on a number of generally accepted premises, but the conclusion is a contradiction or conflicts with generally accepted beliefs. The classic example of a paradox that Keeney (1983) gives is of the Cretan who stated "All Cretans lie" (p.29). The audience (which were Cretans) wondered whether he was lying by saying "All Cretans lie" and if he was lying, he was actually telling the truth - if he is telling the truth, he lies. This statement is paradoxical and serves as an illustration how a self-referential statement can, in one perspective, function as a statement and, in another perspective, function as a frame of reference about itself as a statement (Keeney, 1983). Russell and Whitehead (1919) therefore argued that, specifying the logical level of a term, concept or expression prevented it from being self-referential.

Von Foerster (1985) questioned the validity of Russell's "Theory of types" by arguing that an alternative view of the world could be constructed by using self-referential paradoxes as conceptual building blocks for such a view.

According to this view, since all statements are self-referential statements made by observers, they are heavily laden with self-referential paradoxes. According to Von Foerster (in Keeney, 1983), the observer always participates in what he observes.

While agreeing with Von Foerster, Bateson (in Keeney, 1983) adopted logical typing as a "descriptive tool for discerning the formal patterns of communication" (p. 30). In terms of this approach, logical typing could, therefore, be seen as one way of drawing distinctions. This view of logical typing therefore allows us to use it to disclose rather than conceal paradoxes (Keeney, 1983).

Following Keeney (1983) the use of logical types often suggests that our world is

hierarchically organised. However, he further alerts us to the fact that those levels are recursively organised. Recursion is used to denote "repetition, recurrence, circularity, cybernetics, redundancy, pattern and so on" (Keeney, 1983, p. 58). Logical typing therefore points to the reciprocity between people and events, ideas and behaviour.

Keeney's (1983) zig-zag ladder of form and process which follows from Bateson's dialectic between form and process, starts at the extreme left with orders of recursion. He begins, at the most basic (lower) level, with behaviour. Then, on a higher level, follows context with metacontext at the highest level. The middle column he called classification of form. This refers to the naming of the patterns that organise simple action, interaction and choreography. Keeney (1983) describes the classification of form as an abstraction that organises each order of description by connecting its elements together in a meaningful way. Bateson (1979) referred to this side as the analogue of what he called "tautology". Keeney (1983) calls this "skeletons of symbolic relations" (p. 46). He sees those skeletons as providing some understanding on how to link or relate diverse descriptions of process.

A diagrammatic presentation of the ladder of dialectic between form and process (Keeney, 1983, p. 41):

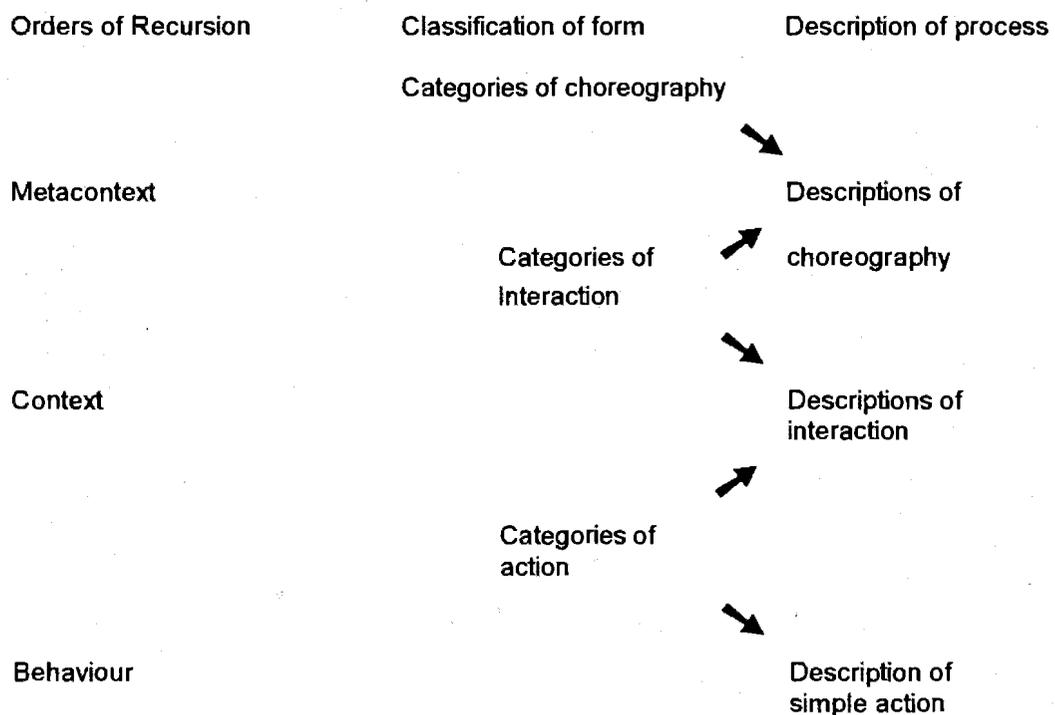


Figure 3.1 Keeney's (1983) zig-zag ladder of form and process

The right-hand column of the ladder Keeney (1983) called “descriptions of process” (p. 40). This refers to the unit (simple behaviour) observed. Descriptions of process refer to observations that can be called “sensory based experience” (p. 40). That is a form of description that is empty of all theoretical inputs. According to Keeney it is the closest one can get to encountering “raw-data”. This unit of observation follows from how an observer punctuates a stream of events (Keeney, 1983). An example of this punctuation could be how an observer sees the symptoms and behaviour of asthmatic attacks.

Bateson (1979) described this as an “analogue of the aggregate of phenomena to be explained” (p. 191). However, “descriptions of sensory based experience” (Keeney, 1983, p. 40) are always connected to some internalised symbolic systems such as the language one uses. Thus, the language one uses, prescribes a way of encountering the world through one’s senses. The fact that abstractions are recursively linked with sensory experience suggests that there is no such thing in reality as “pure sensory experience” or “raw data” (Keeney, 1983, p. 45).

Following Keeney (1983) descriptions of simple action mainly refer to observation of singular isolated units of simple actions. These include facial expressions, body positions, breathing patterns, voice tonality and volume, speech tempo, and so on. Extending this to asthma, this order of analysis may include coughing, wheezing, chest movements, and so on.

When an observer classifies simple actions as members of a specific category of action, the observer moves to the other side of the analysis by naming the category of action. One example of this could be naming simple actions such as wheezing, coughing, breathlessness, as asthma. This form of naming, that is, what the middle column calls “classification of form” (Keeney, 1983, p. 239) is a way of identifying and naming the patterns that organise the observed order of process.

When we move a level of logical typing higher than the level of behaviour we arrive at what Keeney (1983) calls descriptions of interaction. It is important to notice that this still falls under the description of process. Descriptions of interaction focuses on sequences or chains of action that are exhibited by interacting individuals or groups. It attends to how a number of simple actions are connected among participants, that is

any description of simple action must be followed by a description of the actions of another person that precede and follow it. For example, when a child gets an asthma attack, who is the first to notice, and who gets him medication? How does the child react when this happens? This example illustrates how the ordering of the streams of action becomes more important than the individual actions themselves (Keeney, 1983).

When one attempts to classify descriptions of interaction, this classification of form consists of naming patterns of relationship rather than patterns of action. Patterns of relationship can be categorised as either symmetrical or complementary. Bateson (1979) describes symmetrical relationships as "characterised by interchanges of behaviour such that the more A exhibited a given behaviour, the more B is likely to exhibit the same behaviour" (p. 193). Conversely, complementary relationships are those in which A's behaviour is different but complementary to that of B (Bateson, 1979; Keeney, 1983).

When one swings back to the description-of-process side of the ladder, the next order of analysis we encounter is "descriptions of choreography". These descriptions specify how the previously identified patterns (symmetric and complementary themes) are themselves patterned, that is, connected or sequenced. These higher order organisational patterns can consequently be named categories of choreography; under classification of form (Keeney, 1983). In the case of asthma the choreography of pattern could be organised by the patterned events and relationships associated with an attack of asthma.

Based on the above explication of Keeney's (1983) zig-zag ladder of the dialectic between form and process, we can conclude that the biomedical perspective only ends at the level of behaviour. It does not go beyond observable behaviour, to contextualise these behaviours. It ascribes a name asthma to the simple actions of wheezing, coughing, breathlessness, without considering how these descriptions are themselves organised or patterned. The ecosystemic perspective goes beyond observable behaviours to incorporate the context in which these behaviours take place, and also considers the metacontext which forms the choreography of these behaviours. It also considers the interactional patterns of these behaviours, as well as the fact that there is a recursive link between the ideas of these people about asthma and their

behaviours. It therefore follows that ecosystemic epistemology considers the meanings that people attribute to asthma. Furthermore, it considers different family members' reactions toward the sick asthmatic child; such that one is able to clearly discern the interactional patterns around asthma.

What follows are the basic assumptions of the ecosystemic epistemology.

Ecosystemic Epistemology

Overview

Ecosystemic epistemology involves seeing patterns of relationships in which parts are embedded within the whole rather than dividing the world into dualisms of mutually exclusive opposites. It prescribes a way of seeing events as organised by recursive feedback processes and is a way of seeing and describing the patterns that organise events (Keeney, 1983).

In contrast with linear epistemology, which defines a system as a particular social structure characterised by particular structural norms and roles, ecosystemic epistemology defines a system as a "cybernetic network that processes information" (Keeney, 1979, p. 119). To characterise this system, the cybernetic network refers to the context of complexly intertwined human relationships in which the relevant information processed includes both symptomatic and therapeutic communication. For Boscolo, Cecchin, Hoffman and Penn (1987) therapeutic communication within a system includes the network of meanings and interactive processes that are organised by the problem. Thus Boscolo et al. introduce the idea of a "significant system" (p. 23) which consists of all those who are involved in language with a particular issue. Instead of a system being defined and identified by a particular social structure such as "family", Boscolo et al. choose to define a system as "the network of meanings and relationships" (p.23). Anderson and Goolishian (1988) accord with this view by regarding a system in therapy as one that has coalesced around some problem. That means that a system is organised by all those languaging or having a conversation about a particular situation being a problem. In this research, the system in therapy will

comprise all those who talk about asthma being a problem. Over the generations this includes, the grandmother, mother and her two children, the researcher and the larger community and health professionals.

Ecosystemic epistemology points to the observer's inclusion in that which is observed, thus emphasising the self-referential nature of any and all descriptions. It thus follows that therapists/researchers are seen as part of the therapeutic/research system and not as outside observers. Therapists interact so closely with the system they are observing that whatever descriptions they make reveal as much of their own properties as of the properties of the system itself (Keeney, 1988). This interpretation implies that therapists can neither assume an expert position nor have unilateral control over the system they are observing. Boscolo et al. (1987) refer to this as the observing system rather than the observed system.

Following this framework, we realise a shift from considering the process of diagnosis as ascribing a label to an individual in order to signifying a particular illness, to considering diagnosing as a collaboration between the therapist and the other medical personnel connected to the problem. Through their conversation patients together with therapists are constantly evolving and changing the stories, narratives, and the meanings that come with every definition of the problem (Anderson & Goolishian, 1988). Indeed for Anderson and Goolishian a problem exists only if it is languaged and spoken about. In terms of their approach, if there is no concern or language about a problem, then there is no problem. In this instance, the physical symptoms of asthma may not be created in language, but, may very well be maintained in language. As stated previously, what happens relationally around the physical symptoms is important for this study. People's behaviours or reactions towards the physical symptoms of asthma are informed by the meanings they attribute to these physical symptoms.

Ecosystemic epistemology places enormous emphasis on patterns of behaviour rather than on the description of singular isolated events, such as, the diagnosis of asthma in this case. Ecosystemic epistemology also refers to the recursive links between behaviour within a system as well as between behaviour and meaning. Bateson (1979) defines a pattern as a "dance between interacting parts" (p. 21), which

are recursively linked, and feed back and forth not only information but also relational comments. In his definitions of a "pattern" he emphasises the similarities between the world of the living and the nonliving. He further argues that we should refrain from imposing physical limitations through the language we use and begin to appreciate the unity and the aesthetic aspect of the biosphere. He further inquires, "what patterns connect the crab to the lobster and the orchid to the primrose, and all four of them to me? And me to you?" (Bateson, 1979, p. 22). By this question Bateson points to the unity, the similarities in relations between all parts of the biosphere. It is important to note that in this approach patterns are not fixed, nor do they exist in an objective reality outside our descriptions of them. The patterns that we describe are those that we have co-created in language within the therapeutic system. It thus follows that the patterns that will be discerned are those that will be created and agreed upon by us (system). It is also important to emphasise the self-referential nature of the observers' descriptions of these patterns (Keeney, 1983).

Basic Theoretical Distinctions

The illusion of objectivity

In the following the work of Bateson (1979), Keeney (1979; 1983) Maturana (1975, 1978, 1991) Varela (1989) Von Glasersfeld (1984), Von Foerster (1985) will be discussed. The social constructionists' assumption that the objects we see are our own creation, and the errors we make in objectivity arise in and through language, will be presented.

Bateson (1979) argues that the brain contains no material objects other than its own channels and switchways and its own metabolic supplies - we can think of pigs or coconuts but there are no pigs or coconuts in the brain and therefore in the mind there are no neutrons, only ideas of pigs and coconuts. The process of coding or representation that substitutes the idea of pigs or coconuts for the thing itself is already a step in logical typing. "The name is not the thing named" (Bateson, 1979, p. 204). For Bateson, how we see the world cannot be reduced to the common sense of

representatively seeing what is there. Experience of the exterior is always mediated by particular sense organs and neural pathways. "To that extent, objects are my creation and my experience of them is subjective not objective" (Bateson, 1979, p. 39).

Thus for Bateson (1979), the images we "see" are manufactured by the brain or mind. To arrive at this perception, Bateson argues that the processes of perception are inaccessible, and only the products are conscious. Two general facts are stated: First, that we are unconscious of the process of making the images which we see and secondly, within these unconscious processes, we use a whole range of presuppositions which become built into the finished images.

Keeney (1983) concurs with Bateson's notion that what we perceive is largely due to the distinctions we draw. He further proposes that we should look beyond the gestalt of objectivity and subjectivity and consider the necessary connection of the observer and the observed, which leads to considering how the observer participates in the observed.

Like Bateson and Keeney, the "radical constructivist" school (Von Glasersfeld, 1984, p. 19) challenges the traditional separation of the knower from the known and emphasises the active role of the observer in constructing a reality. For Von Glasersfeld the relationship between knowledge and reality is one of fitting our ways of behaving and thinking to the flow of experience. He proposes that our constructions fit with reality in the same way that a key fits within a lock. Furthermore, just as several different keys may fit a lock, several different constructions may "fit" reality (Von Glasersfeld, 1984). To further argue the absurdity of objectivity, Von Foerster (1976) argues: "It is syntactically and semantically correct to say that subjective statements are made by subjects ... objective statements are made by objects" (p. 16).

The experimental and theoretical work of Maturana (1975, 1978, 1980) and Maturana and Varela (1987) provide a further contribution to the notion that objectivity is not possible. Their argument that the nervous system is an informationally closed neural network that responds to the environment in a manner determined by its own organisation and structure rather than in a way specified by external stimuli, presents a major challenge to the status of objective knowledge. Given this notion of closedness to information, it follows that we cannot perceive an objective reality but that, instead,

the objects that we believe we see are products of our own nervous system's activity. Thus we can only perceive what our structure determines and nothing outside of that (Penn, 1986). However, as humans who live and breath in dialogue and language (Efran & Clarfield, 1993), we bring forth the objects as if they were independent entities (Tomm, 1992).

A further major challenge to the objective base of knowledge which contrasts with that of the radical constructivist has emerged from the school of social constructionism, which views ideas and knowledge as social constructions arising in social interchange and as mediated through language (Fruggeri, 1992; Hoffman, 1992). Descriptions from this perspective are seen as social products emerging in the context of communal construction (Gergen, 1985; Gergen & Kaye, 1992) rather than as objective accounts or as "skull bound" individual constructions independent of the relational context of languaging. The researcher subscribes to the latter perspective because of her belief in the participation of the wider social context in the construction of meanings. The meanings that the family under study has around asthma, will be shaped by the socio-cultural values and beliefs of the wider society.

Recursion, Circular Causality and Self Reference

Bateson (1979) in *Mind and Nature* makes a distinction between the world of physical objects and the world of living forms. The physical world, he argues, assumes a billiard ball model in which causality is linear and forces act unidirectionally upon things. In the world of the living not just force, but information and relationship, become important. For Keeney (1983) the concept of recursion is used to denote "repetition; recurrence, circularity, cybernetics, redundancy, and pattern" (p. 58). Recursive descriptions define an item in terms of its relationship with other items. Implications of recursive processes are that the therapist can no longer be seen as unidirectionally "impacting" on the client or family through his techniques. The therapist becomes neither the agent of change nor is the client a subject. Both are part of a larger field in which therapist, family, and any number of other connected elements act and react upon each other.

Indeed, for Efran and Lukens (1990), the concepts of recursion and circularity imply that there is no instructive interaction. They give an example of teaching, to elaborate on this idea. The processes involved in teaching are such that the teacher would tell the students what they need to know and there would be absolute understanding of what the teacher teaches. However, because each student processes information differently each would arrive at more or less different scores on tests given to check their understanding.

In a circular process, instead of saying one thing affects another we notice an endlessly spiraling feedback loop without any clear beginnings or ends. Instead, we recognise circular processes in which, instead of A leading directly to B, A must first circle to C, then loop back to B and so on. Also, A's statement to B is fed back as information to A, which is then involved in A's next statement/action to B.

The concepts of recursion and circularity challenge us to consider how the observer participates in the observed. Also how health participates in illness, and change in stability. Throughout this dissertation reference will be made to how asthma participates in its construction as both an illness and also as not an illness but a solution to relational problems. Health and illness will thus be viewed as two parts of a coin that are recursively connected. It is in this regard that we talk about self-reference. Indeed for Bateson (1979) and Keeney (1983) what we perceive is largely due to the distinctions we draw. Furthermore, the descriptions of these distinctions reveal as much of our properties as those of the observed (Keeney, 1983). For Von Foerster (1976) there is an inextricable link between the observer and that which is observed. He further argues that it would be impossible to make any descriptions if the observer were not to have properties that allow him to generate such descriptions.

For the social constructionists, knowledge emerges as an ongoing self-referential construction between people. Individuals, in their processes of constructing the world, are bound by beliefs, maps and premises that they have about the world (Bateson, 1972).

The Primacy of Language

Following the work of Bateson (1979), Keeney (1983), Von Glasersfeld (1984), Von Foerster (1985), and the social constructionists, all problems exist in language. Until languaged about, no problem exists.

For Maturana (1982) language is not to be found in the brain but rather in the interactions through structural coupling with other structurally plastic beings in the environment. He defines a linguistic domain as a "domain of consensual behaviour ontogenically established between at least two structurally plastic organisms" (Maturana, 1975, p. 320).

Language arises simultaneously through (a) a complex structurally closed nervous system which allows for recursive interactions, (b) internal and external nervous system perturbations, and (c) a social or consensual domain which simultaneously perturbs the nervous system. It is through the relationship between the social domain and the nervous system that language emerges.

Maturana (1975) further argues that language as a biological phenomenon does not take place primarily in the head, but rather in the community. It requires the intimate communal contact that permits complex patterns of living to evolve and to be passed on from generation to generation. Language also creates the illusion that things really do exist without our inventing or making them. It creates the illusion that we can stand outside ourselves and observe. Thus language also creates the illusion of the observer (Efran, et. al, 1990, p. 167).

For the social constructionists as will be later explained, it is in languaging and between people that meanings are created. Without language life would have to be lived moment by moment, without narrative, evaluation and comparison. As Gergen and Kaye (1992, p. 5) argues "our constructions of the world and ourselves are limited by our languages ..."

Semantics and Politics

The question that now needs to be considered is: How do the "meanings" that

people attribute to lived experience inform their behaviours? It is in Bateson's (1979) idea that the behaviour of each individual is in some way consistent with the behaviour of every other individual in the system, that is, "the ideas of each family member lead him to behave in ways that confirm or support the ideas of every other family member" (Bogdan, 1984, p. 376). Thus, people's behaviours are consistent with the ideas or meanings they attribute to events. Following Keeney (in Keeney & Ross, 1992) all kinds of human communication address both the semantics and the political frame of reference. He defines a political frame of reference as a sequential pattern of behaviour whereas the semantic frame of reference refers to the meanings given to the sequential patterns of behaviours (Keeney & Ross, 1992). Therefore Keeney sees the relation between the semantic and the political frames of reference as recursive, that is, "each is a frame of the other" (p. 9). We cannot, therefore, address the semantic (meanings) without also looking at the patterns of behaviour (politics).

It is in this regard that both the family members and the researcher will co-construct the meanings attributed to asthma and furthermore the patterns of behaviour that are consistent with these meanings.

Having given a brief overview of ecosystemic epistemology, and the basic theoretical distinctions, what follows is an overview of social constructionist theory which also forms the basis of this research. Ecosystemic epistemology and social constructionism are similar in many respects and yet different in others. These will be compared and contrasted later in the chapter.

Social Constructionism

Overview

Like ecosystemic epistemology, social constructionism is concerned with explicating the process by which people come to describe, explain or account for the world in which they live. The significance of social constructionism is more fully appreciated against some backdrop of history. In explaining this, the researcher will rely heavily on the work of Gerken (1985). Gergen (1985) identifies two major and competing

intellectual traditions, towards the understanding of constructionism. The exogenic perspective which follows more along the lines of traditional linear positivistic epistemology and the endogenic perspective which holds that knowledge depends on innate processes of the organism, that is people's inherent tendencies to think, categorise or process information. The exogenic perspective sees knowledge as a mental representation of the events in the real world. It holds that proper knowledge "mirrors or maps" (Gergen, 1985, p. 269) the actualities of the real world. The endogenic perspective on the other hand, emphasises people's innate, intuitive tendencies in fashioning or shaping their knowledge of the world. This perspective has been closely associated with cognitivism. Following this theory, human action is critically dependent on the cognitive processing of information, that is, the world as understood by us rather than the world as it is. Following Gergen, the endogenic perspective has been unable to gain full understanding as a result of its inability to address some of the problems levelled against it such as its inability to give account of how cognitions influence behaviour and the origins of ideas. It is thus through people's discontent with both the exogenic and the endogenic perspectives that social constructionism emerged.

Social constructionism has also existed in the field of psychology for long, as represented by the work of researchers such as George Kelly with his personal construct theory, Kenneth Gergen and Clifford Geertz (in Hoffman, 1990) all of whom stress that knowledge is a social, as opposed to an objective construction.

What seems to be the most basic assumption of social constructionism is the idea that what we take to be our direct experience of the world does not in itself dictate the terms by which the world is understood. On this basic assumption, social constructionism challenges the positivist view of knowledge as being a map or direct representation of the world. It views knowledge as residing in the patterns of social interrelations rather than in the individual mind (Hoffman, 1990). Therefore, what are assumed to be knowable facts about the world, are actually the results of social interaction. Our ideas about the world are socially created in interaction with others. As we move through the world, we build up our own idea about it in conversation with others (Hoffman, 1990).

Social constructionism places heavy emphasis on the performative function of language. Language becomes an important medium through which all actions and ideas are understood. Following Gergen (1985, p. 270) "we generally count as knowledge that which is represented in linguistic propositions stored in books, journals and so on". It thus follows that the context within which these linguistic propositions take place, becomes equally important. Indeed, for Steedman (1991) it is the context that interacts with the objects we endow with meaning. Bateson (1979) accords with this view in saying that "without context, words and actions have no meaning" (p. 24). Therefore, nothing means anything on its own. Meaning comes not from seeing alone, it is co-constructed in interaction with others. Through acts of interpretations, humans are continuously engaged in processes of generating meanings. These meanings are not constant but evolve as the language describing objects of observation changes. Indeed for Hoffman (1990) these meanings become part of a constantly changing narrative. Hoffman further argues that "we organise our world in little packets of meaning that we call stories" (p. 3). Ideas do not, therefore reside inside people, but arise in dialogue and are always changing. Problems are thought of as stories that people have agreed to tell among themselves (Hoffman, 1990).

From a social constructionism point of view, the process of understanding is not driven by the forces of nature, but is the result of active interaction between people. These interactions are culturally bound. People's constructions of the world are influenced by their prevalent views at the time. As people's cultural practices and languages change at a particular time, so do their perceptions and view about the world. It is in this regard, that for Gergen (1985, p. 267), the "terms in which the world is understood are social artifacts, products of historically situated interchanges among people." Social constructionism critically questions the concept of "truth". What may seem to be "true" at a particular point in time, may not be at another time. As people's social relationships unfold, so do their interpretations of events change. What counts as truth is socially negotiated with others (Gergen, 1985, p. 268). According to this view, the cultural framework of a society dictates what it views as truth. What constitutes truth, therefore, is based on the socio-cultural processes of a particular point in the history of a society (Gergen, 1985).

Social constructionism also emphasises the process of negotiation in which society agrees to certain forms of understanding whilst prohibiting others. These forms of understanding that are socially arrived at through negotiation, recursively impact on people's behaviours. For instance, in this research the social understanding of asthma as being a chronic illness, actually impacts on the patients' behaviours. For instance, by playing the sick role asthma sufferers are prohibited from taking part in certain activities such as sports. Thus the descriptions and explanations of the social world constitute a form of social action, as these descriptions and explanations invite certain possibilities for directing behaviour, whilst constraining others (Gergen, 1985).

It is also worth noting that these descriptions and explanations of the world are not fixed, nor are they the unchangeable "truths" that the logical positivists make them to be. They are however, influenced by the changes in the cultural systems at a particular point in time. It is therefore imperative that the researcher participates in the prevailing cultural and social forms of understanding.

Having considered the basic assumptions of both the ecosystemic epistemology and social constructionism, what follows is a consideration of the interlink between both systems of knowledge.

The Interlink Between Ecosystemic Epistemology and Social Constructionism

Whilst it remains obvious that the two systems of knowledge are connected by some of their basic assumptions, it nevertheless remains important to note some of the differences that set the two systems of knowledge apart.

Both ecosystemic epistemology and social constructionist theory are connected by their belief in a constructed reality versus an objective one. Both systems of knowledge strongly object to the view that knowledge is a map or direct representation of the world out there. Both espouse a constructed reality in which both the observer and the observed participate. Social constructionism, like radical constructivism, acknowledges the presence of the observer in that which she seeks to observe. Social constructionism acknowledges the reflexivity between researcher/therapist and her object of study. Radical constructivism talks in this regard about observing systems.

Both systems of knowledge object to the idea of one single reality or truth, both espouse the idea of multiple constructed realities. Both acknowledge the importance of context in generating meanings, but social constructionism goes a step further by considering the wider socio-cultural context with its prevalent norms, beliefs and values and how these impact on behaviour. Whilst social constructionism focuses on the co-construction of socially negotiated meanings, radical constructivism is skull-bound, neurologically demarcated and limited (Hoffman, 1990).

Whilst radical constructivism views people as stuck in what Hoffman (1990) calls "biological isolation booths" (p. 3), social constructionism posits an evolving set of meaning which emerge as people interact with one another. Social constructionism holds that our beliefs about the world are social inventions, whilst constructivism holds that people's ideas about the world are formed in their informationally closed nervous system (Maturana, 1978). Social constructionism places far more emphasis on the social interpretation and intersubjective influence of language, family and culture. Radical constructivism, on the other hand, places far more emphasis on the autonomous nature of living systems (Maturana, 1978; Von Foerster, 1984).

Based on the above, it therefore follows that ecosystemic epistemology and social constructionism will be used as basic theoretical models guiding this research. Because of the researcher's belief in the importance of a recursive link between the wider social context and the beliefs and patterns of behaviour, the researcher felt it necessary to incorporate social constructionism in her research. Furthermore it is in the researcher's belief that people live through narratives, and it is these narratives that give meaning and understanding to their lives. Thus social constructionism proved the natural way to follow (Gergen, 1985).

Closely related to the social constructionist's emphasis on the primacy of language, is Anderson and Goolishian's (1988) emphasis on human systems as language-generating meaning-generating systems. What follows, is an explanation of their ideas in this regard:

Views of Anderson, and Goolishian, on Language Systems

Following these authors, human systems are seen as existing only in the domain of meaning or intersubjective reality. This is a domain in which human systems communicate and are in conversation with each other. This domain is referred to as the linguistic or conversational domain. The linguistic domain specifies all the language or communicative interactions that human systems are engaged in. By language, we are not referring to specific signs, or to symbols, but rather to specific meanings that are interactively generated through the medium of words and other communicative actions. Thus, these meanings are generated through a dynamic social process of dialogue and conversation.

Radical constructivism emphasises the importance of language as a process in which humans both create and deal with the realities they exist in. As humans we hear, write, and speak through language. Therefore humans are users of language (Anderson & Goolishian, 1988). It is through language that humans are able to maintain meaningful contact with each other, and through language people co-construct the meanings, for example, of shared experiences, such as disease, which form their intersubjective realities. Being in language, is therefore a social process engaged in interaction with others. Maturana and Varela (1987) also accord with this view that, every human action takes place in language and that every act in language brings forth a world created with others.

According to these authors, we create objects of our worlds with and through language. In a similar vein, Bateson (1979) also held that the mental characteristics of a system exist in the system as a whole. The mind is not in someone's head but rather in interaction with others. He further challenges us to keep in mind that, it is more familiar and comfortable to select that which confirms our already existing beliefs. He called this way of thinking an "ecology of ideas". By this he means that the behaviour of every member of the significant system is consistent with the behaviour of the others, such that the behaviour of all family members show order, pattern, and organisation. It is within this context that the behaviour of all the people who suffer from asthma will be seen as recursively linked to their ideas about the disease, in such a way that we

are able to discern the patterns that connect different family members from the one generation to the next.

It thus follows that Anderson and Goolishian (1988) conceive of reality as different sets of meanings created in dynamic social interaction. This view moves us away from concerns about issues of unique truths. It demands that we give up the view of humans as the "experts" but view humans in conversation with each other.

Whilst this view recognises the importance of the dynamic social process of meaning generating, it is also far from being complete. It fails to account for how these meanings impact on the behaviours of people in such a way that there is a recursive link between people's attribution of meanings to situations and their behaviours.

What follows is a consideration of how these meanings are communicated to others, in the process of social interaction and this is done by way of a narrative or story-telling.

Use of Narrative

From time immemorial, story-telling or narrative via parables, myths, legends, and allegories, have been used to teach morality, culture, values, norms, and customs. Story-telling has hence played a vital role in guiding tellers and listeners in their conduct and thought patterns, as well as providing a vehicle for entertainment (Sarbin, 1986).

According to Gergen and Gergen (in McNamee & Gergen, 1992) ways of understanding past events, present ones and those that may occur in the future, are connected in a linear manner to develop this account, which can be referred to as a story or "self-narrative" (p. 10). In the process of developing a self-narrative, the person strives to establish logical links among life events so that instead of viewing one's life as purely one unconnected sequence after another, the person tries to understand events as systematically related. This self-narrative is not a collection of facts, but rather a story that embodies one's conception of self, relationships, and life experiences so as to communicate to one's self as well as others about the meaning and purpose of one's life (Goldstein, 1990).

Thus narrative thinking means invoking a story form onto experiences or events. This may take place instantaneously or later in reflecting upon the experience or recounting it to self and others.

According to Steier (1991), just as people make sense and meaning of their lives through storying about them, so too do researchers create their research worlds through storying about them, and according to Wittgenstein (in Steier, 1991), they view these narratives as experiences that guide one in viewing some "streams of life" (p. 104) as worthy and of more importance than others.

The stories that we tell, are firmly situated within the political, social, and cultural contexts of the time, (as will be detailed in chapter 5). Due to their dependence upon cultural norms and language usage, they reflect the possibilities for experience within a particular cultural and historical era, relating to social constructionism's emphasis on the sociocultural creation of knowledge.

Indeed for Bateson (1979), a story, is "a little knot or complex of that species of connectedness which we call relevance" (p. 22). He argues that stories naturally establish connections between people. Firstly because some people have similar stories and secondly because all people think in terms of stories. He views stories as inextricably linked with context, as one's position within a specific context is recursively connected with what one is able to story about. Bateson further suggests that stories are linked with meaning, for without context, words, and actions have no meaning.

Based on the idea that reality is storied through interaction with others, our identity and relationship with self and others is defined by how we story about them. Both ecosystemic epistemology and social constructionism supports this idea. Crucial to the notion of narrative is that we give meaning to our experiences through co-constructed narratives.

Therefore, the researcher will be using the narratory principle to organise the streams of events within the family. This is so, because the narrative/ story is able to ascribe meaning and coherence to experiences. It is constructed through social interaction and is thus useful for this research.

Conclusion

In this chapter we have explored the basic epistemologies and theory that will guide the researcher's actions and construction of ideas around asthma. We have also explored how ecosystemic epistemology and social constructionism share some of their basic assumptions whilst also differing at some levels.

The idea that reality is socially constructed in interaction with others received special emphasis in this chapter. The influence of the wider socio-cultural context has also been taken into account, in shaping the ideas and meanings people have around asthma. The recursion between meanings and behaviour has also been acknowledged. This idea is also of the utmost importance in this research, since this research seeks to explicate how the ideas people have around asthma have informed their behaviours.

What follows in the next chapter, is an explication of research methodologies that are in keeping with the underpinnings of the ecosystemic and constructionist epistemologies. Research epistemologies and methodologies that recognise the subjectivity of experience and self-referential nature of any and all descriptions will be explored, such that our research methodologies are not in contrast with the most basic epistemology that guides our description and distinctions.

CHAPTER 4

THE RESEARCH NARRATIVE

It has been noted in the literature review that asthma has mainly been described and researched in terms of a positivistic world view. This view separates the researcher from the research, and attributes unilineal causality to the onset and maintenance of asthma. It searches to know with certainty the one true reality of asthma and views illness in a reified and a-contextual manner. The purpose of this chapter is to describe a research methodology that is consistent with the underpinnings of the new epistemology which forms the theoretical basis of this research. As noted by Steier (1991) qualitative research methods may be more effective in coming to grips with the full complexity of systems theory. Like systems theory and the new epistemology, qualitative research based on the tenets of the new paradigm of research, emphasises social context, complexity, holism and recursivity. In this research a naturalistic paradigm of research will provide a useful avenue for describing the trans-generational family experience of meaning creation. Indeed, for Bateson (1979) without context words and actions have no meaning.

As detailed previously, the choice of the naturalistic paradigm is in no way related to the fact that it alone is the correct way of doing research, because if this were so one would be contradicting the basic principles of the epistemology that forms the basis of this research. As we have stated previously, one has to look at which paradigm fits and is useful in which context (Moon, Dillon & Sprenkle, 1990). As noted also by other researchers (Keeney & Sprenkle, 1982), both qualitative and quantitative approaches offer valuable research perspectives, with qualitative methods being more responsive to approaches that emphasise holism (aesthetic) and quantitative methods being more responsive to approaches that emphasise practical matter of fact ways (pragmatic), of studying family therapy (Moon et al., 1990).

What follows are the basic assumptions of naturalistic qualitative research.

Basic Assumptions of the Naturalistic Research Paradigm

Naturalistic researchers conduct their explorations in natural contexts and focus on looking at events and actions in a holistic rather than a reductionistic manner. In this study research participants were interviewed in their homes and places of employment. This method will be discussed later in the chapter. In keeping with the naturalistic view, one cannot separate actions and behaviour from their context, therefore the research interactions should take place with all participants in their context to get their fullest understanding (Lincoln & Guba, 1985). Indeed, for Bateson (1979) words and actions gain their meaning from context. It therefore follows that context becomes an important medium through which people's words and actions can be understood.

Following this research paradigm, there is no dualistic separation between the subject and the object of inquiry. Subjects in this research paradigm are called 'participants' (Moon et al., 1990) because of the active and equalitarian roles they play in the research process. It therefore follows that research in this paradigm "acknowledges the self-referential nature of the research process and outcome" (p. 360). Furthermore, the factors inherent in this form of research need to be addressed and researchers can do this by examining the original distinctions and punctuations that they made to arrive at a particular research perspective, as well as describing how their use of a particular theoretical perspective led to the constructions and interpretations made (Keeney & Morris, 1985).

The naturalist also uses herself as the primary data gathering instrument. The most basic reason for this is that the human instrument is able to adapt to the multiple realities being constructed in the research process, and the human instrument is also capable of grasping and evaluating the meaning of each interaction since the researcher is the primary data gathering instrument (Lincoln & Guba, 1985). It is therefore imperative that her role is clear and that all her assumptions (ways of punctuating) and biases are made explicit when reporting her qualitative findings (Moon et al., 1990).

The naturalist acknowledges the existence of multiple constructed realities. For the nuances in these realities to be appreciated the researcher needs to draw upon his

or her intuitive, tacit knowledge. Lincoln and Guba (1985) describe tacit knowledge as “all that is remembered somehow, minus that which is remembered in the form of words, symbols or other rhetorical forms. It is that which permits us to recognise faces, to comprehend metaphors and to know ourselves” (p. 208). Tacit knowledge becomes therefore an indispensable part of the research process.

The naturalist uses qualitative methods rather than objective measuring devices that are appropriate to humanly implemented cues such as speaking, listening, observing, interviewing, observing non-verbal communications, and so on. Once in the field, the inquiry takes the form of successive and recursive repetition of four elements, namely, purposive sampling, inductive analysis of the data obtained from the sample, development of grounded theory and a projection of the next steps in a constantly emergent design (Lincoln & Guba, 1985).

In naturalistic investigations, the purpose of sampling is to include as much information as possible, with the focus being not on developing generalisations but on detailing the many aspects that give a context its unique characteristics (Lincoln & Guba, 1985). A second purpose of sampling would be to generate the information upon which the emergent design and grounded theory can be based and the research aim be addressed (Lincoln & Guba, 1985).

Grounded theory, that is, theory that follows from the contextualised findings, is a necessary consequence of the naturalistic paradigm. In addition, the naturalistic paradigm incorporates the idea of using theory that is applicable at a specific time for a specific research context. This viewpoint enables multiple realities to be posited. An a-priori theory would not be able to predict the many realities that the researcher will encounter when carrying out the research, or be able to take into account the various factors that impact at a local level (Lincoln & Guba, 1985).

From this perspective, it can be seen that the “design” of the research is an evolving one that emerges from the interactions between the researcher and participants within a particular context. These interactions are not predictable beforehand as the results of a mutual interaction cannot be predicted until they actually occur. All of these features taken together point to the indeterminacy of research in the naturalistic paradigm, such that research becomes an unfolding process, co-evolved

between researcher and participants (Lincoln & Guba, 1985).

The Link between the Naturalistic Research Paradigm and Social Constructionism

As detailed previously, taking a social constructionist stance means, as a starting point, challenging the traditional objectivist and rationalist view of inquiry, which keeps both the physical and social world at a distance as an independently existing universe and which holds knowledge as reflecting or even as corresponding to the "real" world. Social constructionism emphasises the performative function of language through which people generate meanings in interaction with each other (Hoffman, 1990). Thus the research process, from a constructionist point of view, is seen as socially constructing a world or worlds which include the researcher, rather than as being outside the body of their own research. Therefore included in this focus are issues of self-reference and reflexivity and how these can inform methodologies and the research process in general.

Reflexivity, or as Mead (in Steier, 1991) would define it "a turning back of one's experience upon oneself" (p. 3), acknowledges the presence of the knower in her own process of knowing. Indeed for Steedman (1991) knowing cannot be separated from the knower. The researcher comes to the field of observation with a mind full of ideas and values. It is these ideas that need to be openly acknowledged and exposed to scrutiny (Atkinson & Heath, 1987). Following Keeney and Morris (1985) "research becomes a task of re-examining (that is re-searching) what one did to construct a particular reality" (p. 548). It therefore follows that the original distinctions and punctuations made, need to be exposed so that the readers of the research can understand how they were constructed.

Reflexivity, following Steier (1991), can be construed in two ways. Firstly, to imply a reflex action, as in instinctively doing something or, secondly, to be contemplative. Indeed, both conceptions are necessary. The first allows the researcher to immerse herself in the situation and respond spontaneously without thinking. This also gives the researcher the ability to respond to difficult situations that require immediacy. The

second conception of the word allows the researcher to question the distinctions she has drawn, which are part of how she comes to know that which she is investigating.

The question that now needs to be answered is: how does one develop methodologies to do research and conduct inquiry from a social constructionist standpoint?

Firstly, it is necessary to agree with Steier (1991) in saying that our research tells a story also about ourselves; that we as researchers are reflexively part of those systems we study. Therefore, the researcher needs to research her own organisation, values, and assumptions, as guiding what she does and as necessary in understanding how she draws distinctions (Keeney & Morris, 1985). Indeed, for Steier (1991), research becomes a "way of unconcealing our own tacit world, including the constraints that we have self-imposed" (p. 7).

It therefore follows that the distinctions drawn by the researcher, are not a privileged view of what really takes place, but they are her own constructions, co-constructed in language with the participants (Steier, 1991).

My constructions of family in this study, which involves a three-generational perspective, are shaped by my experience of what "family" is and the questions that I will ask participants in this regard reflect my own presuppositions of what should be useful information to address my aim. We thus realise the reflexive connection between us as researchers and our research activities.

Following Hoffman (1990) constructing is a social process, "rooted in language not located inside one's head" (p. 3). This process of constructing is done in interaction with others, who are also in the process of constructing their own experiences. Research should thus become a reciprocal and recursive process in which we as researchers also examine our constructing processes and expose them to scrutiny by others (Steier, 1991).

In summary, a social constructionist stance to research emphasises our own role in research; this being defined as reflexivity. Steier (1991) argues that, if we want to hear our reciprocators "voices in our stories" (p. 80), we need to take the idea of ecology seriously, which is fitting together our ideas with those of our participants in the co-construction of a world. He proposes that we understand reflexivity as involving the

various “mirrors” of our activities of construction with those of our reciprocators (Steier, 1991).

Legitimation of Knowledge in Naturalistic Research

Serious contentions have been raised around procedures of establishing legitimacy in qualitative research. These contentions are usually voiced by those researchers who subscribe to the conventional notions of linear causality and a belief in one tangible reality and see the goal of research as the acquisition of knowledge to be generalised to the wider population a-contextually (Atkinson, Heath & Chenail, 1991). In an attempt to address issues of validity and reliability in qualitative research, Lincoln and Guba (1985) coined four new terms that they thought fitted in better with the naturalistic paradigm and could replace the positivist formulations of internal validity, external validity, reliability, and objectivity. These they named as credibility, transferability, dependability, and/or conformability.

Credibility

Lincoln and Guba (1985) chose the concept of credibility to replace the positivist's criterion of internal validity. It is important to note that positivists used the criterion of internal validity to describe the extent to which changes in an outcome (dependent variable) can be attributed to changes in an independent variable. A causal connection between dependent and independent variables is usually assumed. For the naturalist, the criterion of credibility is used to reflect an adequate representation of the constructions originally made by the participants in the reconstruction that have been arrived at, via the inquiry process. The implementation of this criterion is twofold: Firstly for the naturalists, an inquiry has to be carried out in such a way that the probability of findings being credible is enhanced and secondly, these findings will only be seen as credible after they have been approved by the constructors of the multiple realities being studied (in this instance the family) (Lincoln & Guba, 1985).

Five techniques or activities that make it likely that credible results are obtained,

have been suggested. The first of those is prolonged engagement (Lincoln & Guba, 1985). This activity refers to the investment of sufficient time in the participants' context, so as to learn the culture of those participants. Thus it is important for the researcher to understand the context within which the research is embedded. Indeed, for Bateson (1979) without context words and actions have no meaning. Therefore it becomes imperative that the naturalists spend enough time in becoming orientated to the situation.

Also tied to the technique of prolonged engagement, is that of persistent observation. Persistent observation enables the researcher "to identify those characteristics and elements in the situation that are most relevant to the problem being investigated and to focus on them" in depth. This kind of focusing demands of the researcher the ability to sort out the things that are relevant from those that are irrelevant to the situation (Lincoln & Guba, 1985).

The technique of triangulation has also been used to assess the credibility of findings. Triangulation "has its origins in the metaphor of radio triangulation, that is, determining the point of origin of a radio broadcast by using directional antennas set up at the two ends of a known baseline" (Lincoln & Guba, 1985, p. 305). For the naturalists, this method is used to confirm a proposition by referring to two or more sources of the inquiry. Thus, once a proposition is confirmed by two or more sources, the uncertainty of its interpretations is greatly reduced (Lincoln & Guba, 1985). Indeed, for Moon et al. (1990) triangulation and length of time in the field are two of the most important ways of enhancing the reliability and validity of research findings. In this research study exposing the research findings to the researcher's supervisor and subsequently to the academic community which form part of the researcher's training, is one such attempt at enhancing the credibility of the research findings through triangulation.

The techniques identified for the enhancement of the credibility of findings, are peer debriefing, that is, the process of exposing oneself to a disinterested peer who will then play devil's advocate in probing into your assumptions and biases, meaning and seeking to understand the basis of your interpretations (Lincoln & Guba, 1985).

Transferability

Lincoln and Guba (1985) replace the positivist criterion of external validity with the concept of transferability. Indeed, for naturalists the extent to which findings could be transferable from one context to the other depends on the similarities between the sending and the receiving contexts. Therefore, inferences about transferability cannot be made by an investigator who knows only the sending context. It thus follows that the naturalist cannot specify the external validity of an inquiry; she can only provide the thick description necessary to enable someone interested in making a transfer to her own context to reach a conclusion about whether or not transfer would be appropriate as a possibility (Lincoln & Guba, 1985).

Dependability

Dependability is a criterion chosen by Lincoln and Guba (1985) to replace the positivists' term of reliability. A technique that has been suggested to help enhance dependability of a finding is that of an inquiry audit, based metaphorically on the fiscal audit. Like the fiscal auditor, the inquiry auditor is expected to examine the process of inquiry, and in determining its acceptability attests to its dependability. The inquiry auditor also examines the product, the data, the findings, interpretations, and recommendations. The inquiry auditor can also serve the purpose of examining the confirmability of findings. The auditor uses such raw data as notes, recorded materials, video tapes, and so on, to confirm the inquirers' findings and clarify her interpretations. Through the use of the inquirer's reflexive journal, the auditor is able to probe into her assumptions and values that influenced the outcome of the research; to also assess the methodological decisions made by the inquirer, and the reasons for making them (Lincoln & Guba, 1985).

In summary, Lincoln and Guba's (1985) criteria for enhancing the trustworthiness of qualitative findings have been criticised from many angles. Indeed, for Atkinson, Heath and Chenail (1991) these criteria are still rooted within the positivistic assumptions about the nature of knowledge. For these researchers the use of

systematic methods of data collection and recording do not in any way make the insight of qualitative researchers more valid or trustworthy. However, an entire community of the readers of research have to decide on the legitimacy of the research findings (Atkinson et al., 1991).

Communal Legitimation

As stated above, it is actually the “consumers of research” (Atkinson et al., 1991, p. 163) who establish the trustworthiness of the study by deciding whether they understand the researcher's reasoning that led to her constructions and establishing whether these are feasible against their perceptions of “reality”. Lincoln and Guba (1985) accord with this view that the legitimisation of knowledge is the responsibility of the consumers of the research. Individual researchers, regardless of the methods they use, cannot establish the trustworthiness of their findings.

Following Walters (in Atkinson et al., 1991), there is no compelling evidence to support the idea that the quality of an insight is related to the process by which the insight was generated. Good ideas should be evaluated in terms of their “elegance, effectiveness and coherence” (p. 162) not in terms of the nature of the process by which they are generated.

Also in keeping with the naturalists' use of tacit knowledge, the quality of ideas generated in qualitative research have more to do with the imaginative and intuitive abilities of the researcher than the specific method the researcher was using when the idea came to her mind (Lincoln & Guba, 1985). It is thus likely, following Atkinson et al. (1991), that “the insights of a bright, imaginative researcher who followed no systematic procedures of data collection and observation could be of a higher quality, as evaluated by the readers of the research, than the insights of a task orientated researcher who carefully followed the systematic method of data gathering and recording” (p. 162). It is the responsibility of the researcher to be reasonable in her claims and to present all possible evidence in support of her insights, in order to illustrate these insights vividly enough so that her colleagues and community members can understand them, try them out, and evaluate them for themselves. Through dialogue between consumers who are

each evaluating the researcher's ideas for themselves, an agreement can be reached with regard to which ideas are more legitimate than others (Atkinson et al., 1991).

Ethics and Accountability

In presenting her research findings, the researcher needs to realise that she is accountable to the community to which the research will be presented. The researcher also has the responsibility of following certain procedures, which will make it likely that the readers will be able to assess whether her findings are legitimate. The researcher needs to state how her constructions were co-created (Keeney & Morris, 1985; Steier, 1991). This implies that researchers retrace the distinctions they created in co-constructing a "reality" so that the reader can understand how the researcher arrived at her conclusions (Atkinson & Heath, 1987). Keeney (1983) accords with this in stating "to understand any realm of phenomena, we should begin by noting how it was organised, what distinctions underlie its creation" (p.21). Furthermore the researcher bears equal responsibility to the respondents, who should be given back their co-created notions and not be treated like subjects.

Indeed, for Keeney and Morris (1985) "research becomes a task of "re-examining" that is, researching, what one did to construct a particular reality" (p. 548).

In presenting to readers the distinctions that underlie the researcher's co-construction, she is also subjecting her research to be "researchable" by others (Steier, 1991). She is therefore moved from her privileged position and lets readers decide on whether or not her findings are legitimate (Atkinson & Heath, 1987). Therefore, the principle of ethicality is maintained insofar as the researcher is able to show the readers how she arrived at her constructions, and gives them the liberty to decide whether these are feasible or not.

Research Methodologies Used

Interviewing

An interview, as Dexter (in Lincoln & Guba, 1985) describes it, is "a conversation with a purpose" (p. 268). The purpose of doing an interview includes, among others, obtaining here and now constructions of persons, events, activities, feelings, and concerns, reconstruction of such stories as they happened in the past, projections of these as they would happen in the future and verification of constructions developed by the inquirer. Interviews can be categorised by their degree of structure, their degree of overtness and the quality of the relationship between interviewer and respondent (Lincoln & Guba, 1985).

The mode of interviewing chosen in this study, is one of an unstructured interview. The unstructured interview is non-standardised and the interviewer does not seek normative responses. Rather the problem of interest is expected to arise from the respondent's reaction to the broad issue raised by the interviewer. Furthermore, it is still necessary for the interviewer to note that the broad issues she raises, reflect her own assumptions and are her own co-constructions. The interviewee is allowed to introduce, to a considerable extent, his or her own notions of what she regards as relevant, instead of relying upon the interviewer's notions of relevance. Together they should co-evolve a conversation that is mutually beneficial to both (Lincoln & Guba, 1985).

The degree of overtness or covertness ranges along a continuum, at one end of which the respondent is completely unaware that she is being interviewed (whether structured or unstructured) and at the other end of which the respondent is fully and completely informed not only of the fact that an interview is taking place, but of the purpose of that interview and how the resulting information will be used (Lincoln & Guba, 1985). If interviewees have to participate and be regarded as "peers" in the research process, they have to be informed that the interview is taking place. In this study, participants were informed of the nature of the interview: That it would be unstructured, and they were also allowed to ask questions pertaining to the aim or the

purpose of the study. In accordance with Massarik (1981) it is harmless for the researcher to respond and also reveal facts about herself.

Carrying out an interview involves certain steps that, while not necessarily being followed in linear fashion, must nevertheless be accounted for at some point in the process. For instance, the researcher needs to decide whom to interview, she also has to prepare herself for the interview, and must also terminate the interview at the end of it (Lincoln & Guba, 1985).

Data collected from an interview can be recorded in any of several ways. In this research study both audio- and videotape recordings were used. Informed consent was received from the participants by way of a signed consent form.

In summary, the interview, as utilised in a naturalistic inquiry, may serve a number of purposes, as detailed above. It is usually unstructured, although at later stages of the enquiry more structured forms may be used. It is almost always overt if it has to recognise the participants' equalitarian roles, and it is usually an in-depth interview in that the interviewer and respondent usually view each other as "peers" working towards the accomplishment of the same "goal" (Lincoln & Guba, 1985).

Use of the Genogram

A genogram is described by Kipling (in Lieberman, 1979) as, "a visual diagram of family relatedness, structure and history" (p. 68). The genogram also graphically represents the skeletal relationship structure of two or more generations of a family, upon which the coalitions, patterns, bonds, and the transgenerational passage of their culture may be superimposed. It also serves to depict important relationships, both in the past and in the present (Lieberman, 1979).

Whilst it is clear that the genogram is a relatively new instrument in the field of family research and therapy, it nevertheless remains a useful instrument in this type of research. It is consistent with the underpinnings of both constructionism and the new epistemology in that it acknowledges the primacy of context, in this instance different contexts over time. It also acknowledges the participative role of the family in exploring their own, history, culture, values and beliefs. Furthermore, meanings can be explored

relatively easily with the family's historical backgrounds already in place.

Following Roberto (1992), a genogram also stimulates the researcher/therapist and family members to think about extended family patterns over time, thus contributing to the formation of systemic hypotheses about behaviour, beliefs, values, and legacies.

In this study, the genogram was used to generate information about the following:

- The family tree network, with special focus on those that had asthma.
- A description of the relationship patterns between all the members of the family.
- An exploration of the patterns of behaviour and how these organise the behaviour of others across the generations.
- Through interpretation, a co-construction of the meanings that each person with asthma attaches to the disease, and how this is recursively connected to those of the others and their behaviours transgenerationally.

Steps Followed in this Research

The Context of the Research

The research took place at a leading hospital's child psychiatry department. The researcher met with Paula for the first time at the asthma outpatient's clinic. The researcher had previously informed the medical doctors of her research study and asked them if they could please identify all those patients in whose families asthma occurred in more than one generation.

Paula approached the researcher and informed her that she would be willing to join in the study and also mentioned that she was interested in becoming a clinical psychologist. Therefore, the initial contact was made by Paula. An interview was set up with Paula's mother and younger brother. Paula's mother is a nursing sister in the same hospital. She was contacted telephonically and agreed to meet with the researcher. The purpose and aims of the study were explained to her. Following her agreement to join in the study, she proceeded to contact her mother in Natal (Bella) and asked her to come through.

The initial interview was with Grandmother Bella at a leading hospital in Johannesburg's Child Psychiatry clinic. It involved a genogram construction. This was done together with Bella. The last interview was held at Thandi's house in a township in Soweto. Altogether five interviews were held. The interview with Thandi and her children, Paula and Siphon, was held at a leading hospital in Johannesburg because the researcher needed to use the one-way mirror. It is important to note that it was difficult for the researcher to get a family in which asthma occurred over three consecutive generations. Therefore, when Paula came forward, the researcher was delighted to have her join the study. Confidentiality was maintained by changing all the real names of the family members, their workplaces, and schools.

Choice of Methodology

As stated previously, the methodology chosen for this study, is one that is consistent with the underpinning of the new epistemology, which forms the basis of this research. Ecosystemic epistemology and social constructionism are best fitted to study social phenomena because of their emphasis on context, complexity, and relationships (Lincoln & Guba, 1985). Furthermore, both epistemologies acknowledge the existence of multiple realities of which the logical positivist epistemology is one. Indeed for Keeney and Morris (1985) the logical positivist epistemology is useful for studying certain phenomena (those in the physical world) and should therefore not be completely disregarded. Specifically, unstructured interviews were used, a home visit was made and a genogram was constructed.

Interview Procedures

As stated previously, the mode of interviewing chosen for this research, is one of an unstructured interview. The purpose and aim of the research was shared with participants before they could decide on whether or not they would like to join. Both audio and video tapes were used to give readers access to the actual research interviews (for example are presented in Appendix B). In so doing, the researcher is

able to include the readers as much as possible in the research process.

Legitimation Procedures

As stated previously, it is the “consumers of research” (Atkinson et al., 1991, p. 163) who establish the trustworthiness of the study.

In this study, the researcher gave readers access to transcriptions of all the video and audio tapes so that they could have access to the research process. Through this, readers will be able to see the distinctions that the researcher draws, and how these relate to the co-constructions she made with the family. In making these co-constructions, the researcher also acknowledged ecosystemic epistemology and social constructionism as her guide and basis for drawing distinctions whereby meanings were attributed to her discussions with the family. She also included her assumptions and biases as colouring her perceptions. She also provided a self-description and clarified her way of drawing distinctions.

Therefore, the legitimisation of this study will be the responsibility of the readers of the study, in this instance the academic community, and will also be dependent upon how comprehensive the researcher gave them access to the research process.

Meta-perspective on the Narratives

Through the use of narrative, that is, the different stories that family members tell about their experiences of asthma, the researcher will arrive at themes that connect these different narratives from the one generation to the next, such that she is able to generate a pattern that connects all narratives.

The researcher will also attempt to generate a meta-perspective of these narratives, which is an account of her experience of listening to the family members telling her stories about asthma, and the family also being cognisant of the fact that these are her co-constructions together with the family. This meta-perspective will be presented as the researcher’s narrative about the research process and findings.

Conclusion

In this chapter, we looked at the naturalistic research paradigm that is consistent with the underpinnings of the new epistemology. We also explored how the findings from this research paradigm could be legitimised. The different steps followed in this research were also outlined.

What follows in the next chapter, are the family members' narratives around asthma, together with the researcher's interpretations of these.

CHAPTER 5

FAMILY'S NARRATIVES AROUND ASTHMA

Introduction

What follows in this chapter is a description of what constitutes our "significant system"; that is, all those who are involved with a particular issue being a problem (Boscolo et al., 1987). This includes the family context, that is, the relationships between them in their physical and social environment, and the multiplicity of perspectives put forward by the different family members in interaction with the researcher.

The different stories that follow are shaped by the family members' interaction with each other and with the wider socio-cultural context. Indeed for Epston, White and Murray (1992) we each develop a story in interaction with others and stories play a vital role in organising our experience. It is in these stories that we give meaning to our experience.

Family Context

The family originates from a small village in one of the most remote parts of Natal. This village is defined by the storytellers as the most rural place in Natal. It is Zulu dominated and all cultural practices follow the Zulu tradition, such as a belief in the dominant position of males in the family, a belief in ancestry and the subservient position of women in the community.

The family was staying in a three-bedroom house that the father of the family (Bandi) had built. The family lived comfortably in that house. All male children slept together in the one bedroom and all the female children in the other. Bella and her husband would occupy the other bedroom. The family made a living out of selling crops that they had cultivated on their piece of land. The family also kept live-stock, in the form of cattle and sheep.

In keeping with their cultural practices, the mother, Bella, was a housewife, and her job was to raise the children. Bandi would work in their small plantation to make a living. This was how they lived until the family started experiencing financial problems, and Bella had to find a job in Thekwini (Durban). Thekwini was close to 60 km from where they were living. She had to live in Thekwini and could only go home on weekends.

Presently only Bella and her eldest son are staying in a small villiage in Natal. All the other children are married and have houses of their own. Thandi (Bella's daughter) was staying with them in Natal, after her divorce from her husband. She moved to Johannesburg due to her children's ill health. She attributed their poor health, that is, asthma attacks, to the weather conditions in Durban, and therefore she relocated.

She (Thandi) is presently renting a one-roomed shack in Soweto, a township that is notorious for gangsterism, hijacking, and jackrolling (kidnapping of young girls with the intention to rape them). Thandi and her children use the one-roomed shack as bedroom, bathroom, kitchen, and livingroom. Inside the one-roomed shack is a double bed, which fills basically all the space there is, a small table on top of which placed a hot-plate, pots, and some dishes. Underneath the table are books. There is also one wardrobe in which all three family members hang their clothes. As one enters the shack, one cannot help but notice the overcrowding. There is little space for free movement inside the shack. There is, however, one small window, through which is an electric cord runs from the main house into the shack. I suppose it is their connection for light in the home.

Family Composition

Bella and her husband Bandi were married in 1931. They had seven children altogether. The eldest son, John, died shortly after he was born; that was in 1933. He was followed by Zama-Zama who was born in 1935. Then Zandi who was born in 1938, and then followed Muzii (1940), Buhle (1942), Khosi (1945), and lastly Thandi who was born in 1947.

Those that had asthma in the family were Bella, Thandi (when she was young until age 4) and her children, Paula and Siphon. The rest were never diagnosed as having asthma, however, some of Bella's grandchildren have what she regards as a bad persistent cough (see genogram). The genogram constructed to present familial relationships is presented in Figure 5.1.

Family Narratives

The narrative view holds that, "it is the process of developing a story about one's life that becomes the basis of all identity and thus challenges any underlying concept of a unified or stable self" (Sarbin, 1986, p. 320). We develop narratives in conjunction with others. Therefore the process of developing a narrative is a social one, in which we each define who we are, in interaction with others (Gergen, 1985). As stated earlier, stories play a vital role in organising our experience and it is in these stories that we give meaning to our experiences. What follows then are the different narratives that family members have constructed around asthma. It is also important to note that, the researcher is a co-author of these narratives; she is in no way distinct from them. Therefore, what follows is a co-construction of the different stories that family members have around asthma (Epston, White & Murray, 1982).

Bella's Narrative

Bella is 84 years old and was married to Bandi in 1931. Her husband died in 1987. She had altogether seven children, as stated previously. Her mother died from bewitchment when she was three years old. Bella's mother was bewitched by a jealous neighbour. She had to be brought up by her maternal grandmother, who also died when she was eight years old. She does not remember what the cause of her grandmother's death was, but only remembers that she had shortness of breath (dyspnea) at the time of her death. In retrospect, Bella thinks her grandmother could have had asthma. Bella's father died in 1831 from natural causes.

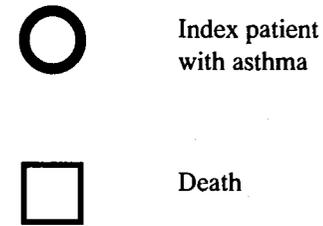
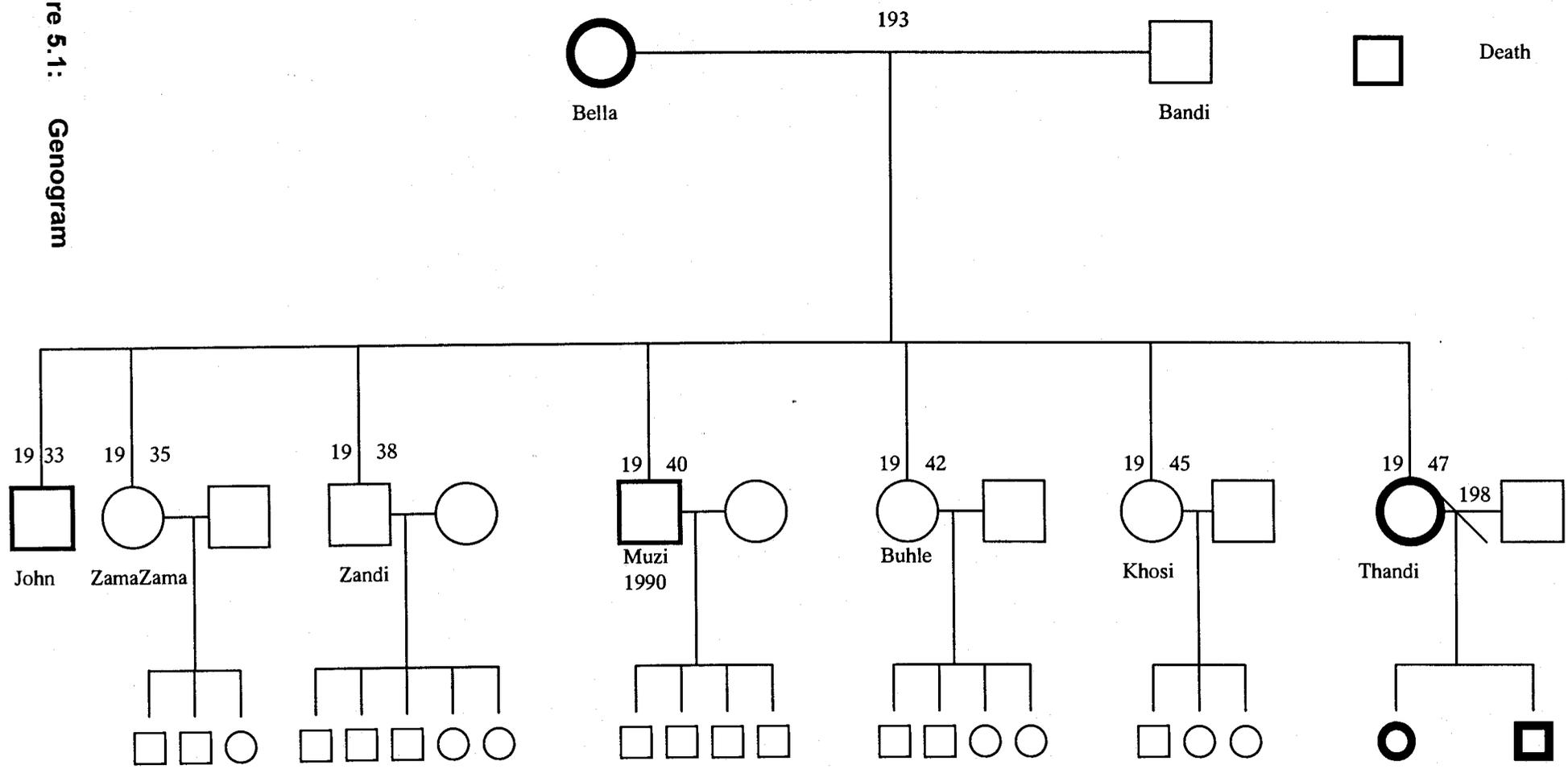


Figure 5.1: Genogram



Two years after she was married, that is in 1933, she started experiencing serious chest problems. She and her husband consulted an *inyanga*, who then told them that Bella was bewitched by their neighbour, who had wished for Bandi to have married her daughter. This was also the reason why Bella could not conceive, as was culturally expected of her before she got married. Upon this revelation by the *inyanga*, she was given "muti" to cure the bewitchment. Her chest problem became even more severe and persistent. It was at that time that she also contracted spinal TB. It was only then that Bella was to conceive her first child John whose Zulu name means "to try". Mzanywa (John) died shortly after he was born. Then the rest of the children followed (refer to family composition).

Bella describes her husband as a traditional Zulu man, very conservative and authoritative. He used to be the one that chose names for all the children. He was a reserved man, he preferred being alone. When he was upset, he would not talk to anyone. However, he would sometimes get drunk and be talkative. According to Bella, there was not much difference when her husband was sober to when he was drunk. The only difference would be on those days that he would want to beat her. She used to run away whenever her husband threatened to beat her.

Bella only knew that the diagnosis of her illness was asthma in 1987. All along they did not know that what she had was asthma. No changes occurred in her behaviour upon knowing her diagnosis in 1987. Before 1987 they used to call her disease "chest problems". Bella would first experience persistent coughs, mostly at night. She would try to cough out what felt like sputum in her chest. She describes the attacks as very painful. She would try to breathe, she said, but could feel her chest closing. Her initial reaction would be to sit up and try to breathe. At that time all the family members would be asleep, including her husband.

She would eventually get out of bed to drink a glass of water. For Bella just plain water would provide some relief. Should water fail to provide relief, she would take medication as a last resort. She dislikes medication, she added. She used to have mild attacks when her husband was around, which would be coughing and wheezing only. During those times that she had those attacks, her husband would give her money to go to hospital. She would usually go to hospital alone since the hospital was far from

where they lived and it would therefore have cost a lot of money if her husband had accompanied her. Whenever she was distressed her husband would give her money to go to hospital. This he would do since Bella would also get attacks when she was angry or upset with him. He would tend to withdraw, and go and sit outside. This he would do, not because he did not care, but because he did not know how to react. Bandi would sometimes apologise whenever Bella told him she was upset.

Bella describes herself as a close and secretive person. She would never share her problems with anyone besides her husband and children. Bella would sometimes also conceal from her children that she was upset. The reason for this, she says, was because she would not want to hurt them. No one in the village knew she had asthma. She describes her relationship with people outside her home as superficial. She describes herself as a strong active person before she had chest problems, which were later diagnosed as asthma attacks. She feels asthma weakened her, and changed her whole life. She used to work hard and enjoyed buying clothes and dressing elegantly.

There was a time in their house when things were financially bad and Bella had to find a job despite her husband's refusal that she do so. Bella worked in Thekwini (Durban) as a domestic worker, and would only go home on weekends. She had taken responsibility for everything in the house, including providing food for all and sending them to school. She described this as the most troubled time of her life, when she could not eat, nor fall asleep. She used to lie awake at night, trying to find alternatives for their poverty at home. Upon seeing her awake troubled her husband and he would get his blankets and go and sleep in the next room. Bella started experiencing severe asthma attacks after the death of her husband. Water could not help relieve these attacks; she therefore had to make frequent trips to the hospital, all by herself. Her husband had never seen the severe attacks.

Of all her seven children she thinks Khosi is most like her in terms of her being hard working and diligent. Of all her children only Thandi had asthma which she outgrew after age 4. Bella describes her life as one full of struggle. She had to struggle to conceive, then struggled for her health, and is presently struggling under the control of her eldest son, Zamazama. Zamazama is a bully, unruly, and ill-treats his mother. He treats all women like children, including his own mother. According to Bella, her

present concern is about her son. He is partly responsible for her ill health, she says. However, her son does not recognise this, and even if he did, he would not be bothered about whether he is making his mother unhappy or not.

If Bella could make three wishes, she would wish for "a house", good health, and for God to take her to His kingdom, she says.

Thandi's Narrative

Thandi comes from a family of seven children and she is the youngest of all the siblings. She was born in 1947, got married and got divorced again two years after her marriage. She has two children, Paula, 16 years old and Sipho, 9 years old.

She had asthma as a child until the age of 4 years old. She has no recollection of this time. What she does know is what she has been told by her mother. She describes herself as a person who is full of self-pity and self-sympathy. When something wrong happens to her she mopes and gets really depressed about it. "I would die if I still had asthma" she said. She cannot stand seeing her children having an attack. She really gets depressed and "it then looks as if she had the attack!" she said. She recalls staying awake one night when Paula had just had an attack.

Thandi usually notices it first when her child Paula is about to have an asthma attack. According to Thandi, Paula starts with a persistent cough. She then later starts wheezing; however, before she wheezes, Thandi would already have advised her to use the spray. According to Thandi, the spray usually manages to arrest the attack.

Thandi has had to relocate from Durban to Johannesburg because of the severity of her children's attacks in Durban. She described Durban as a very humid place which was not conducive to her children's health. Relocating to Johannesburg in 1991 was a very demanding and emotionally straining process; she recalls. First she had to find a job as a nursing sister at a leading hospital in Johannesburg. She is presently staying with her two children in a one room shack in Soweto.

Thandi could not recall what her life was like when she had asthma; neither could she account for the factors helping towards recovering from it. However, she has been told that her asthma was not severe and at times thought she could still be having the

attacks. Thandi also feels that she has experienced severe emotional strain which could have, if possible, re-activated the attacks. For Thandi, having asthma feels like being in a dark tunnel. She describes herself presently as being in the dark, and only hoping that things could be different. Thandi lost her ex-husband through a car accident some time ago. She describes herself as being very close to her children and really concerned about their well-being. Whenever Paula has an attack she gets desperate, and this showed in fact that she gets the spray for her, asking her to lie down straight and carrying her to make her lie down comfortably. Whenever the spray fails to arrest the attack, she usually takes her daughter to hospital. According to Thandi, both her children haven't had serious problems since they arrived in Johannesburg. Despite people's protestations about relocating to Johannesburg, she went ahead with her plans. She finds that her children are much better than what they were in Durban. However, Thandi wishes to move back to Durban due to financial problems, lack of family support, and the violence and gangsterism that she finds in Johannesburg.

Thandi described her mother as a strong and active person before she got weakened by the disease. She concurs with her mother on issues such as bewitchment. She believes that there is such a thing as bewitchment. She also argues that her mother is getting helped by a water "placebo" to relieve the attacks instead of medicine. She argues that all lies in a belief. She also feels that she could never disregard the Western medical perspective since she is also a nursing sister.

Thandi usually spends time with her children advising them on how to care for themselves when they have an attack. She also explains topics such as rape and hijacking with her daughter, Paula. According to Thandi, her mother's ideas about asthma are largely shaped by her background. Her mother grew up in an environment in which people believed in witchcraft, they believe that she has been bewitched. On the other hand Thandi argues that her children are growing up in a society that has little to do with *inyangas* and witchcraft, hence they do not believe in it. She argues that she entertains a little from both sides, that is, bewitchment and Western medicine. When asked about her three best wishes, she wished for four things: Good health, and success for her children, a comfortable house, and a car.

Paula's Narrative

Paula is a 16-year old, standard 8 student at a prominent English school. She is well-spoken and also does part-time modelling. She is the one that made the link between the researcher and the family. The researcher met Paula at the a leading hospital in Johannesburg's asthma outpatients' clinic. She approached the researcher, stating that she heard through the nursing sisters that the researcher wanted to do research with all those who come from families in which more than one person had asthma. She mentioned that in her family four people had asthma and that she would be interested on joining in the study. She was first diagnosed as having asthma when she was two years old; it was after her parents' divorce. Her attacks were very frequent then. She had severe attacks as a baby and her mother used to spend a lot of time at the hospital. She thinks that she, of all the grandchildren, has asthma because she is weak. She gets ill easily and does so frequently. She believes she inherited this weakness from her mothers' genes. Therefore Paula identifies a great deal with her mother.

An attack usually starts with a persistent cough. "It usually feels like there is something blocking my throat that I cannot cough out" she says. Her initial reaction towards this, is to get a spray. The spray usually arrests the asthma; however, if it fails to do this, she would start wheezing and be sent to hospital by her mother. According to Paula, if she had not had asthma, she would have been more active in sport. She also feels her asthma restricts her in many ways. She likens having asthma to being in jail. She cannot do what she wants or what is expected of her, she says. She feels there is a lack of liberty and movement with asthma. Paula also does not see herself recovering of asthma. Thandi overindulges her children whenever they are sick, especially of asthma. According to Paula, the reason she does this is that she gets scared that they might die from asthma. Paula, on the other hand, does not imagine herself dying from asthma now.

She tends to avoid talking about, or discussing things that are too painful or too scary for her. She tends to block out a lot of things; hence none of her friends know she has asthma.

According to Paula, her last severe attack was in Durban in 1991. It happened during examination time, around April or May. Paula feels that this happened because she had to focus her attention on too many things at the same time. She got into such a state of panic that she started running short of breath. The more she tried to breathe, the more she suffocated. She eventually got an attack that landed her in hospital. She cannot remember another time that this happened. However, she believes it usually happens when she has to focus on too many things at the same time. She does not like too much structure and prefers a flexible laissez-faire life style, doing things at her own pace.

Paula's beliefs about what causes her asthma, are different from those of her grandmother and her mother. She does not believe that she was bewitched to have asthma and could never consult a witchdoctor. Her reason for this is that she thinks that they neither know what they are doing, nor the chemical composition of the medications they use.

According to Paula, her asthma attacks have become fewer since she came to Johannesburg. This she attributes to the weather. Despite the air pollution in Soweto, Johannesburg is still a much more conducive place for Paula to stay. She realises that the attitudes that people harbour in Johannesburg are different from those of people in Durban. She feels patronised by people who insist that she is too young to have asthma. To this she firmly responds by saying it has nothing to do with age. She feels that those that manage to discover she has asthma tell her that it is unusual for a child of her age to have asthma. On the other hand, people in Johannesburg who manage to discover that she has asthma, think of it as something normal, and are quite relaxed about it. Those people who discover she has asthma are usually the ones she met at the asthma outpatients clinic.

Sipho's Narrative

Sipho is a 9-year old standard 1 pupil at a prominent English school. He was diagnosed as having asthma in 1988 when he was a year old. This was also two years after his maternal Grandfather died. He gives his reason for having asthma, as,

“because he enjoys playing with water and mud”.

Sipho does not see any possibility of recovering from asthma because he will never stop playing with water and mud. He says he likes his asthma because he does not go to school when he has asthma. He is allowed to play in the house, stay in bed and play in bed only when he is sick from asthma. Another disease that he usually gets is flu, which at times, if left untreated, complicates into asthma. According to Sipho, when he is sick, his mother spoils him, by holding him close to her, and letting him lie in a straight-up position on her so he can breathe properly.

Sipho often thinks of death whenever he gets an attack. This he does because it is scary being unable to breathe, and he often thinks he could die. Sipho thinks having asthma is bad and usually gets very angry when he thinks of the disease. Nobody in his class knows he has asthma, not even his class teacher. He thinks it would be boring if they had to know he has asthma. He also feels the other children will tease him by saying that he is weak and he would then get very angry.

Sipho does like asthma, since he feels he derives some benefit from being sick of asthma. He also admits to sometimes pretending he has an attack. This he usually does when he feels his mother is ignoring him. Mother usually ignores him when she talks to Paula.

Sipho has not had severe, life-threatening attacks since he came to Johannesburg. He has consequently been put off medication for the time being. However, he feels his asthma was much better in Durban than it is in Johannesburg. He prefers life in Durban since, they stayed in a proper house there. When it is cold he did not have to go and sit in the sun outside. There were heaters in Durban which they could use to make the house warm.

He likens asthma to Casper, the friendly ghost. However, Casper has friends who usually want him to get sick of asthma. Casper would usually come to his rescue and chase his friends away. For Sipho, Casper prevents the attacks that are usually brought about by Caspers' friend. Casper and his friends do not get along. When asked what he would do if Casper managed to get rid of his asthma, he said he would pretend to be sick. Thandi never notices it when Sipho pretends to be sick.

Sipho seems confused about the role that asthma plays in his life. Sometimes he

likens it to a friendly ghost and at other times to a nightmare. For instance, even calling his asthma a friendly ghost, implies two levels of meanings. For him a ghost is something that children are scared of and yet his ghost is friendly. He need not be scared of it. Siphso differs from his elder sister with regards to the role of bewitchment in disease. He does believe that there is such a thing as bewitchment. However, he feels no one would want to bewitch him since people like him a lot. He defines bewitchment as a bad wish or "spell" that people cast on others. It either happens or it does not. He does not believe he was bewitched into having asthma.

Siphso, like his sister, also feels that once people get to know he has asthma, they comment about just how young he is. He does not believe it has anything to do with age. His views in this regard are a bit coloured by his sister's. Siphso's position in the family seems to be on the periphery. He is not so much included in decisions made. His mother and sister treat him like a small child. He is usually left out in the conversation between his mother and sister.

Conclusion

We have seen how the different family members have co-constructed their stories around their experiences of asthma. We have also experienced how each in relating his or her story includes the others. We thus, agree with Steier (1991) in his assertion that we tell our stories through others.

What follows in the next chapter is the integration of the diverse narrations by the family members to create a meta-perspective, that is, the researcher's narrative. Indeed Bateson (1979), states that greater understanding is created when, in addition to combining diverse pieces of information, the researcher enriches this description with a "second language of description" (p. 884). The researcher will give an interpretation of what for her constitutes the meanings and behaviours that the family members and the researcher have co-constructed around asthma.

CHAPTER 6

THE RESEARCHER'S NARRATIVE

This chapter sets out to describe the distinctions that the researcher has drawn, using ecosystemic epistemology and social constructionist theory as her guide. These distinctions are intersubjective, reflecting a reality co-created by the researcher and research participants in interaction. For Keeney and Ross (1992) one's distinctions and perceptions are a consequence of how one participates in perceiving, which in turn is a consequence of one's social context, one's values, experience, time, and so on. In other words, listening to what therapists and researchers claim to perceive, tells us as much about them as about the families under observation. In the descriptions that follow, the researcher acknowledges that the analysis that she makes of the family's relationships cannot be considered to be an objective description. Thus all the descriptions will be self-referential, reflecting the researcher's epistemology (that is, ecosystemic epistemology), and the researcher's experience of asthma in her own family. For Varela (1976), once one is aware that what one sees is due to personal punctuations co-created with others, the focus should shift to the process of what one does to draw a distinction and thereby create a reality.

It is also important to note that the present family under study has also co-created a reality around asthma which is based on their epistemologies and experience of the disease, which too are incorporated in the description generated by this study. Thandi's training as a medical staff member also forms part of her epistemology. Furthermore, the positivist epistemology often adhered to in the medical world, attributes causality to the onset of a disease and posits that disease is a result of known and unknown "causes". Therefore, this family's epistemology follows the conventional way of thinking about disease which is at variance with, but also complimentary to the epistemology espoused in this study.

Through the distinctions drawn by the researcher, an attempt will also be made to address two broad research questions, that is, the family's co-constructed meanings around asthma, and how these have informed their behaviours. Attention will be given

to recurring and recursive patterns linking family members with society in general, as this recursively shapes the family's own constructions (Gergen, 1985).

What follows is a description of the themes and patterns that emerged through the therapist's interaction with the family and how these recursively informed their behaviours. It is important to note that the patterns and themes that the researcher will draw are not the "true" features of this family or of a person per se, but are the researcher's distinctions that emerged through her interaction with the family and are thus intersubjectively created. Fruggeri (1992) accords with this by arguing that "there are no descriptions that are more exact or more accurate, therapists' descriptions are linked to their ways and therapists will see what their viewpoints allow them to see" (p. 44).

Co-construction of Secrecy

The first theme that emerges through the transgenerational passage is the family's description of its members as closed, secretive and unable to share openly their emotional needs and issues pertaining to their health (semantic frame). This is seen on a political level by the Grandmother, that is Bella, keeping a number of issues regarding health and illness away from her neighbours. The subsequent generations are born into this realm of co-created meanings of secrecy which they then co-evolve. Indeed for Keeney and Ross (1992) any description of an interactional sequence (political) requires a shift to a semantic frame of reference. A description of how "meaning" is acted out requires a shift back to a political frame of reference. From the point of view of a cybernetic epistemology, this is so because the pattern that connects meaning and behaviour is a recursive one (Keeney, 1983). We therefore realise the recursive connection between the family's co-construction of itself as secretive, closed, and unable to share openly issues pertaining to health and illness; and their behaviour of keeping as many issues pertaining to their health and illness away from their neighbours.

One may ask how these semantic frames of being closed and secretive and the political frame of keeping away from others, are co-evolved from the one generation to

the next. It is in Bogdan's (1984) idea that "the behaviours of each individual is cognitively consistent with the behaviour of every other individual in the system" (p. 375) in such a way, that the behaviour of every member in a system shows order and complementarity. Furthermore, the meanings that family members attach to situations or illness, arise from their shared values and norms. According to Kluckhohn and Strodtbeck (in Geyer & Van der Zouwen, 1986) values can be defined as "shared standards or reference points which define the nature of reality, the desirable modes of conduct and the ends of social action" (p. 34). According to Langman (1986), in a family system, values are both historical, referring to the cultural traditions and prior experiences of family members, and contemporary, referring to present social realities and everyday experiences. Therefore once specific meanings are generated within a family, they tend to recur through generations because of the stability that these meanings have provided over the years, and the family's "fit" with these ideas.

Indeed for Bella, not divulging issues pertaining to health and illness, is based on the premise that she has superficial relationships with all those people outside her family (semantic frame). This semantic frame informs her behaviour in that, by defining her relationship with others as superficial, she learns not to trust them and therefore keeps as much distance from them as possible (political frame).

This interpretation illustrates the recursive complementarity between the meaning frame of having superficial relationships with people outside her family, and the interactional sequence of keeping as much distance from outsiders as possible (Keeney & Ross, 1992). Following Keeney and Ross, to illustrate the relational aspect of any distinction, one needs to understand that any one-sided distinction may be viewed as "half of a more encompassing pair" (p. 33). When applying this understanding to the family under consideration, it becomes clear that their definition of themselves as closed, secretive in relation to outsiders, complementarily draws them close and open to each other in such a way that the recursive complementarity (Keeney & Ross, 1992) between being closed and secretive to outsiders and being open and connected to family members, is realised.

Furthermore, this openness and connectedness between family members is recursively linked to the asthma attacks. As in the case of Paula and Siphon, an attack

brings them close to their mother, asthma becomes a need for emotional expression (semantics) which is recursively responded to by mother, by bringing them close to her. To quote Thandi "whenever my children have an attack, I hold them close to me, I let them lie down on top of me to help them breathe properly".

For Bella, whenever she had an attack, her husband gave her money to go to hospital. The meaning that Bella attached to this political frame, is that her husband does care, and shows it in the only way he knows how. Therefore, for Bella, sending her off to hospital by herself, is an indication of caring and love. And yet for the researcher, asthma in this regard could be punctuated as creating distance. This is so, because, for both of them, their descriptions are coloured by their experiences and the epistemologies that form the basis of their understanding. As stated previously, the researcher and the family members work from different epistemologies or ways of understanding reality. Following Varela (1976), whatever descriptions are elucidated are based on the act of categorising the world in certain ways according to one's governing epistemology.

Even though the behaviours following an asthma attack are different for Bella from those of Paula and Siphso, the semantic frame still remains the same, that asthma becomes an expression of emotional need, which is responded to in different ways, but still communicates the implicit message "I do care and I am with you".

It therefore follows that the family has co-constructed the idea of its members as being secretive and closed to outsiders (semantics), which recursively informs their behaviour by distancing them from society and complementarily becoming even more connected and open with each other. The asthma attack becomes an expression of an emotional need (semantic), which is responded to by drawing members closer to each other (politics) and therefore confirms the connectedness and closeness between family members.

Following the work of Keeney and Ross (1992) "any particular communication can be seen as half of a more encompassing pair, duality or distinction" (p. 33). It therefore follows that both sides of any distinction need to be embraced if one has to indeed be ecosystemic.

Also tied to the family theme of being closed and secretive to outsiders, but open

and connected to family members, is the theme of being enmeshed with each other and disengaging from society. This enmeshment is realised by the family's definition of themselves on the one hand as closed and over-involved with each other and, on the other hand, being distant from others outside the family.

On a political level this definition is indicated by any threat of loss or separation as recursively affecting the established enmeshment and consequently "triggering" more severe attacks of asthma than there were before. The recursion between the politics and semantics is that of asthma being perceived as behaviour that organises closeness when the meaning of distance in the family needs calibration. The family could also be seen as trying to complementarily maintain some stability in the face of the impending change. Following the work of Keeney and Ross (1992), the interaction between cybernetic complementarities is necessary to stabilise the organisation of a system. If the aim is to maintain stability (that is, the established enmeshment and closeness) the family will adopt complementary behaviour to do so (that is, the asthma attacks). Keeney and Ross further state that, viewing recursive complementarity in this way emphasises each family members' role in stabilising the family system.

Bella's attacks became serious when her husband upset her and got even worse after the death of her husband (semantics and politics) and recursively, Paula and Siphos attacks became more severe after their parents' divorce. Asthma can therefore be interpreted as behaviour that gives expression to the impending loss of the established belief in enmeshment and closeness with each other as a family. As stated previously, asthma becomes an expression of an emotional need to stay close and maintain the existing ties and enmeshment in the family whilst distance and disengagement from each other as family gets perceived as negative and "triggers" even more severe attacks (semantics and politics). Disengagement is only acceptable from others outside the family. Thus one realises the complementarity between enmeshed with each other as family members and disengaging even more from society.

Based on the above, the theme of being enmeshed with each other still feeds into the co-evolved idea around the definition of a family as open and connected with each other and complementarily being secretive, distant and disengaged from others outside the family. One also realises the recursion between the semantics of being enmeshed

with each other and the politics of disengaging from society.

Also in keeping with this, Bella gets attention and feels loved when she gets an asthma attack, and recursively, Siphon gets more attention from his mother when he and his sister have asthma attacks (semantics around enmeshment and expression of emotional need). Therefore any threat to Siphon's position in relation to his mother, makes him pretend to be sick, to confirm the idea that he is still loved and that his mother still cares about him (semantics).

Co-construction of Asthma as Weakness

The family over the generations, has also been connected around the theme of seeing themselves as weak because they have asthma. Bella describes herself presently as weak, unproductive, and unable to do what she used to before she had asthma. She defined herself before asthma as strong, hardworking, dressing elegantly, and being able to accomplish whatever she set her mind to (semantics). The family has therefore co-evolved the meaning of asthma as having made them weak. For Thandi, because she also had asthma as a child, she has also incorporated this definition of weakness in her self-description (meaning she gives herself). As stated previously, any description of an interactional sequence requires a shift to a semantic frame of reference, and recursively, a description of how "meaning" is acted out requires a shift back to a political frame of reference. It therefore follows that in considering the meanings that members give to asthma (in this instance, weakness), one has to look at how these are acted upon. Thus, the semantic frame of weakness given to asthma in this instance, has recursively impacted on the family behaviour. For instance, Bella no longer attends church meetings, she no longer dresses elegantly and no longer works. Paula does not take part in sports at school, (usually not prescribed by doctors for asthmatic patients), and is not as adventurous as she would want to be. Siphon also does not take part in sports for fear of his chest closing and him getting an asthma attack.

In keeping with the family's epistemology which follows linear, dualistic biomedical assumptions and biases, the family attributes causality to the onset of the

disease. Paula attributes the presence of a weak gene to the onset of asthma in her life. As Paula aptly puts it, "this weakness is a gene that I got from my mother". Thus, the presence of a weak gene implies that all family members in the present, the past and the future generations will most likely have asthma, because of the "weak gene". It therefore follows that the family will never be able to rid itself of the disease. This also feeds into the biomedical assumptions of asthma as a chronic disease. Based on this, one realises that the family's distinctions, ideas and reasoning around asthma are based on their dominant epistemology which follows the reductionistic linear biomedical perspective. Also in accordance with Keeney (1983) the distinctions that one draws flow directly from one's epistemology. For if one is aware of one's epistemology, one can be aware of how one comes to perceive and categorise the world. Thus it is due to a weakness in them that they have asthma.

In considering the weakness that asthma generates in this family, one needs also to consider the complimentary strength that having an asthma attacks also generates in this family. In keeping with Keeney (1983) one must embrace both sides of a distinction to be holistic. Indeed for Bella, Paula, and Sipho, asthma has generated some strengths on different levels, in that, in having the attacks, their emotional needs are responded to. Asthma has thus made them strong in demanding that their emotional needs of closeness be met, and communicating this to the other family members. It therefore follows that the family members' shared ecology of ideas and meanings around asthma, flows directly from their epistemology which attributes the presence of a weak gene in the family and consequently guides members' description of themselves as weak. This has become part of the family legend.

Meanings around Causality

Also tied to the family's epistemology is their attribution of a unilateral cause and effect relationship to the onset of their disease. As mentioned earlier, the notion of lineal causality is concerned with "combinations of discrete elements" (Keeney, 1983, p. 14) that are viewed as connected to one another through cause and effect. Any one part of a system is seen as being able to influence the other parts of a system in a

unilateral manner. Indeed for Bella, the "muti" that she was given by a jealous neighbour "caused" her to have asthma. She mentions: "I was given muti in other words, I was bewitched to have asthma." She sees herself as having no influence over what was done to her (being bewitched). For Thandi, her training as a nursing sister, shaped a number of her ideas around the "causes" of asthma. As mentioned earlier, the biomedical perspective attributes causality to the onset of disease. Furthermore, Thandi shares a lot of views regarding bewitchment with her mother and Siphon. It therefore follows that her ideas around "causes" of asthma are coloured by both the traditional and the western perspectives on asthma.

Following Gergen (1985), what constitutes "truth" is heavily influenced by the socio-cultural process of a particular time in the history of a society. Indeed for Paula, who lives in Johannesburg, her views around asthma are coloured by the dominant ideas of her time around causes of diseases. Siphon, who has been exposed to both rural perceptions and urban perspectives around disease, identifies with both conceptions around diseases.

Paula does not believe in bewitchment, neither does she believe that she was bewitched. However, she argues that her genetic predisposition causes her to have asthma. It thus follows that the family over the generations has been connected around the idea that an external force or a genetic predisposition, over which they have no control, caused them to have asthma.

Meanings around Treatment

In accordance with the biomedical model which forms the basis of this family's epistemology, the goal of treatment is to have maximum control over the symptoms with the minimum possible medication (Canny & Levinson, 1986).

What the family conceives of treatment depends not only on their epistemology but also on the meanings they attach to the symptoms. Indeed for this family medical treatment was insufficient in providing the necessary relief from the asthma attacks. Bella had evolved what, for her, was a useful way of coping with the attacks but

excluded the use of medications. Whenever she had an attack she would initially drink a glass of water which would provide some relief. If this failed, she would only use medications as the last resort.

For Paula and Sipho, there were times when their bronchodilators failed to arrest the asthma attacks. However, the satisfaction of their emotional needs of closeness would provide some relief from the attacks. This ties in very well with the above-mentioned meanings that the family together with the researcher have co-evolved around asthma.

In this family asthma has become the focal point in their lives. The centrality of this disease in their lives is evidenced by their willingness to comply with treatment (medical and traditional), and to relocate to Johannesburg, to live under the most uncomfortable conditions (live in a shack), and to participate in this research.

It thus follows that the meanings that the family has co-created around asthma (they are helpless in the face of asthma), recursively connects to their ideas around compliance with treatment (even if this takes the form of drinking water: meaning: somethings from outside will help them).

Ecology of Ideas Around Society

As mentioned earlier, the researcher accepts the basic premise that reality is socially co-constructed and these constructions form part of the morals, customs, and behavioural codes prevalent at the time, as well as in day-by-day social interactions (Cushman, 1987). According to Hoffman (1990) the process of social interaction gives rise to ideas, concepts and memories. It is in this regard that the researcher incorporates the family's ideas around society and how these recursively impact on their behaviour.

Together the family has co-evolved a clear idea of society. As stated previously, they see themselves as different because they have asthma, and therefore do not form part of society (semantics). Recursively, the disengagement from society complementarily brings them closer to each other as a family. Furthermore, in considering the family's disengagement from society one also needs to consider their connection with

society on a different level. The family has estranged itself from society for the following reasons: Bella sees society as dangerous and capable of bewitching her, she has thus co-evolved a distrusting relationship with society. Yet for Paula, society has co-evolved the idea of asthma being a serious disease that only affects old people (semantics). Therefore, Paula views society as having a patronising attitude towards children with asthma. This meaning frame that Paula attributes to society is acted out in her keeping it a secret that she has asthma.

Complementarily, the family is connected to society, in following the dominant beliefs and customs around asthma at a particular point in time. Bella's belief that she is bewitched by asthma, is in line with the dominant beliefs about the onset of disease in her time and cultural context.

Furthermore, Paula's attribution of a biological defect (weak gene) to the onset of her disease is also in line with her context and cultural perspectives of the time. This, therefore, is in line with Gergen's (1985) argument that people's constructions of the world are influenced by the prevalent views at the time, and furthermore that what constitutes truth is heavily laden in the socio-cultural process of a particular time in the history of a society (Gergen, 1985). Therefore, Bella and Paula's connections with society reflect different positions and context in time, thus illuminating how meanings over time have come to reflect a changing culture.

Even though the family has co-evolved clear ideas around society being untrustworthy and having a patronising attitude towards all those children who have asthma, this did not recursively impact on the researcher's interaction with the family. The researcher was not seen as part of society but was inducted into the system as one of its members. This is so because the family saw the researcher as part of the medical team that has always interacted with the family in an attempt to help them get rid of the disease. Therefore, the family punctuated its interaction with the medical staff differently from that of the other members of society. They regard the medical staff, including the psychologist, as being all insightful and able to help.

Whilst it may be clear that the family estranged itself from society, by regarding society as dangerous and capable of bewitching them or alternatively as having a

patronising attitude towards children with asthma, it nevertheless remained necessary to point to the connection between society and family members, and how they recursively impacted on each other.

Different Levels of Meaning

A further theme that emerges through the transgenerational passage is that of a different ecology of ideas around bewitchment for Bella. The idea of bewitchment, and consequently of dying, dominates her life. The dominant theme in her story is around significant people in her life dying from being bewitched (semantic frame). This has recursively impacted on her behaviour in that she also anticipates dying in similar ways (present meaning being influenced by pre-existing sign meanings). She begins by relating how her mother died when she was three years old from being bewitched and she had to be raised by her grandmother who also died from dyspnea (symptom associated with asthma) and wonders if she could have also been bewitched (semantic). Her husband died in 1987 of natural causes. One realises the strong associations that Bella makes between being bewitched and having asthma and consequently dying from that. Therefore Bella, who also believes that she was bewitched, hence has asthma. The ecology of ideas around having asthma is strongly associated with being bewitched.

As stated previously, Bella's ideas are instructed by the views and cultural practices of her time. In line with Gergen (1985) the "terms in which the world is understood are social artifacts, products of historically situated interchanges among people" (p. 15). Bateson (1979) also accords with this in saying that context gives meaning and understanding to words and actions.

Thandi's ideas around bewitchment are shaped by her experiences as a child raised in a community where there was a shared ecology of ideas around bewitchment and its impact on illnesses, and also by her present profession as a member of the medical personnel. We therefore realise that, as Thandi moved through different contexts, so her ideas and meanings changed. As a child in Natal her ideas were coloured by the dominant culture then, however, as she qualified as a medical staff

member, her ideas changed to incorporate the views of the time and the context within which she was a member of the medical staff. Thandi therefore believes that bewitchment does exist, but, Western medicine is also important in accounting for the onset of some diseases. Indeed for Paula and Siphso, their views are also coloured by the context within which they live.

On Power and Control Relations and Personal Views of Helplessness

Over the generations, the family has co-evolved a shared understanding of asthma as being a disease brought onto them, over which they have no control. This semantic frame renders them helpless and therefore incapable of having control over the disease. Indeed for Bella, being bewitching to have asthma, and consequently consulting an *inyanga* to help her get rid of the disease, is an expression of lack of power and control over the disease. Within the socio-cultural context of the time, *inyanga* is perceived as being some divine, supernatural being whose power and control can not be compared to that of ordinary human beings. Equally for Thandi, her belief in bewitchment and the power of *inyanga*' renders her incapable of having power to control the disease on her own.

Paula, shares the same ecology of ideas and meanings around asthma being a disease that has been brought over her over which she has no control. However, in languaging about this, she attributes her genetic disposition to her lack of control over the disease. As stated earlier, Paula's ideas and meanings could also be recursively influenced by the dominant socio-cultural perspectives around disease during her times which are different from those of her grandmother and mother. Indeed for social constructionism, each historical period creates its own specific reality. Corresponding to that reality is the creation of explanations and practices that reflect and to an extent uncover that particular era (Cushman, 1987). Still, for Paula consulting with medical doctors (which is a mode of social action, negotiated with others in the treatment of disease) renders her powerless because they too have no control over the disease, such that they are languaging about it as a chronic disease (a disease that can not be cured). Furthermore, use of medical resources such as bronchodilators does not

provide her with the necessary relief, except for the emotional response from her mother by caring for her and making her feel loved succumbs to the interrelational sequence for treating asthma.

Sipho, like his mother and grandmother, shares the same ecology of ideas and meanings around bewitchment and asthma. However he languages about it differently, such that he is seen as having control over the disease. He evolves a reality which is different but complementary to that of his family. This endows him with the ability to cope and therefore have power and control over the disease. In describing himself as being liked by most people and therefore not likely to be bewitched, he has evolved a way that "fits" for him in coping with the disease. This presupposes a different punctuation to that of his family. However, in pretending to be sick and eliciting the emotional response of caring and being loved, he shares the same ecology of ideas around asthma to that of his sister and grandmother. In other words asthma becomes an expression of a need for emotional closeness, and his mother's actions (taking him to bed) fit with this semantic frame shared by all.

Furthermore, Sipho, unlike his mother, sister and, grandmother, consciously decides when he wants to have asthma attacks, that is when his mother and sister ignore him. Indeed, this way of punctuating his relationship with the disease reflects his metaposition in relation to his whole family. This can be accounted for by the different context in time that Sipho has been exposed to.

As mentioned earlier, each historical period, creates its own specific reality. Corresponding to that reality is the creation of explanations and practices that reflect and to an extent uncover that particular era (Cushman, 1987). It therefore follows that Sipho's perceptions and meanings around asthma, are coloured by the different context and time frames he has been exposed to. Yet on the other levels he fits into the meanings/frames and behavioural patterns of his family, especially regarding asthma meaning closeness.

Summary

We have seen so far, how the different family members' narratives were

connected to yield rich and thick descriptions that reflect the patterns and meanings that connect. Following Bateson (1979), yet further understanding is created when, in addition to the combination of diverse pieces of information, a second language of description is provided that reflects on patterns and relationships.

The researcher's narrative about the family is aimed at generating the different levels of meaning that the family has had over three generations around asthma, and how these informed their behaviours. Therefore the recursion between the family's meanings and their behaviours was distinguished. The researcher distinguished certain patterns and themes that arose in the process of co-construction. These patterns are intersubjective, reflecting a social reality co-created by the researcher and the family.

Conclusion

The family co-evolved an ecology of ideas of themselves as secretive, closed, and unable to share openly their emotional needs and issues pertaining to their health. This ecology of ideas consequently draws them closer to each other as a family and complementarily estranges them from society, which they view as untrustworthy and capable of bewitching or rejecting them or not accepting their symptom (Paula and Siphon). Their belief in society being capable of bewitching or rejecting them robs them of control over the disease (asthma) as does the return of a "weak gene". Asthma becomes an expression of a need for emotional closeness in the face of threats to the established belief of being over-involved and enmeshed with each other. Through asthma attacks, the family was capable of maintaining the existing ties and belief in closeness, and connectedness. Therefore the strength in the asthma attack is realised through family members being able to get their emotional needs met.

CHAPTER 7

CONCLUSION

Introduction

This study aimed to give a three-generational description of the meanings that a family has co-created around asthma and how these informed their behaviours. The researcher used ecosystemic epistemology together with social constructionism as her guide.

Furthermore, ecosystemic epistemology and the social constructionist theory were juxtaposed with the biomedical model, and these differences between them were seen as differences in logical typing. The researcher refrained from giving a dualistic either/or conception of both models. A both/and conception of both models was thus afforded.

Using a naturalistic research paradigm, the researcher distinguished certain patterns and themes that arose in the process of co-construction of the disease. As mentioned earlier, these patterns are not the only true, and therefore static and a-contextual, features of the family per se, but arose in interaction with the family. The family's patterns and socially constructed ideas were also viewed in terms of their connection with society in general.

Use of Ecosystemic Epistemology

Ecosystemic epistemology involves seeing patterns of relationships in which the parts are embedded within a whole rather than dividing the world into dualisms of mutually excluding opposites. Through this lens, the researcher was able to perceive the biomedical model as yet another reality within a given context.

In contrast to linear epistemology, which defines a system as a particular social structure characterised by certain structural norms and roles, ecosystemic epistemology looks beyond the boundaries imposed by social norms, to consider the

network of meanings and intersubjective processes that organise the problem. The system in this study included all those who languaged about asthma as a problem. This included the family, the therapist, the larger community, health professionals and so on.

Ecosystemic epistemology points to the inclusion of the observer into that which is observed, thus emphasising the self-referential nature of any and all descriptions. This facilitated the understanding that the descriptions that the researcher made revealed as much of her own properties as those of the system under study (Keeney, 1983). Furthermore, the researcher acknowledges the influence of her experiences of asthma in her own family, and the epistemology that formed the basis of her training as guiding her in the constructions she made. In following this epistemology, a shift was made from considering clinical diagnoses as a process of ascribing a label to an individual so as to signify a particular pathology, to considering the network of complexly intertwined relationships around asthma. Furthermore, the focus was placed on the patterns of behaviour rather than on the descriptions of singular, isolated events.

In contrast to linear epistemology, which sees events as being connected by a linear cause and effect link, ecosystemic epistemology recognises the recursive connection between events. As stated previously, recursion is used to denote "repetition, recurrence and circularity" (Keeney, 1983, p. 58). Any item was described in terms of its relationship with other items. This way of looking at things, avoided blaming the individual as the "cause" of the illness/pathology within the family. Furthermore, it also challenged the researcher's position as the expert in the family. The concept of recursion, challenged the researcher to consider how health participates in illness, change in stability, weakness in strength, enmeshment in disengagement and so on.

Indeed, in ecosystemic epistemology emphasis should be given to both sides of a distinction to illuminate the relational aspects thereof. In this way the relationship between the two sides becomes self-referential as one side emerges out of the other and loops back again.

Use of Social Constructionism

As stated previously, social constructionism sees knowledge as residing in the patterns of social interrelations. What are assumed to be knowledgeable facts about the world are actually the products of social interaction. This epistemology allowed the researcher to consider the influence of the wider social context in constructing the meanings and ideas around asthma and the recursion thereof with the family's patterns of behaviour. By enabling a focus on the familial context of ideas and behaviour as well as their recursion with the wider social context, a different reality from the logical positivistic epistemology was facilitated. Social constructionism's focus on socio-cultural context and era, and its recursive contribution to the generation of meanings and beliefs around asthma, facilitated an understanding that the descriptions of these meanings can not be generalised to other contexts, but remain specific to the particular family and context under study. For instance, it was realised in this research that Bella's ideas, and meanings around asthma, together with those of Thandi, Paula, and Sipho, were connected yet reflected the evolution of the family because of the differences in the socio-historical eras of each family member.

Therefore the meanings, themes and patterns described herein, cannot be regarded as the "truth" in an objective sense, and can therefore not be generalisable across time and context. Furthermore, what counts as truth is socially negotiated with others (Gergen, 1985).

Through the use of stories, the researcher aimed at arriving at the meanings that the family has co-created around asthma. Stories provide a relatively easy way for the family to relate their experiences of asthma. Indeed for Epston et al. (1992) stories play a vital role in organising our experience and it is in these stories that we give meaning to our experience.

Thus, through the use of ecosystemic epistemology and social constructionism, the researcher was able to provide a contextualised understanding of the family's locally created meanings and how these informed their behaviours.

Establishment of Legitimacy

Consistent with the research epistemology that forms the basis of this study, the researcher needs to supply the readers of the research with the actual research interviews, video and audiotapes, for the readers to decide on the credibility of the researcher's constructions. This accords with Atkinson and Heath's (1987) proposal that the readers of the study be given full access to the process of research so that ethicality is maintained. Furthermore, it is the readers of the research who will establish whether the researcher's findings are credible or not (Atkinson & Heath, 1987).

According to Lincoln and Guba (1985) the onus on the researcher is to provide a "thick description" (p. 84) so that the readers can have a thorough understanding of the context within which the research was carried out. A thick description was provided in this study by the researcher considering both her co-constructions in interaction with the family members within the wider sociocultural context.

Narratives Around Asthma in the Family

As stated previously, narratives provide a useful metaphor for explaining and understanding behaviour. Our experiences are usually "storied" or narrated and through this storying, the meanings we ascribed to our experiences are determined (Epston et al., 1992).

The family in this study described its members as secretive, that is, members are unable to share issues pertaining to their health and their emotional needs openly. This was seen on a "political" level (Keeney & Ross, 1992) by Bella keeping away from her neighbours and Paula and Sipho not divulging to their friends that they have asthma. The family was described as enmeshed with each other and asthma was seen as an attempt to maintain the enmeshment (closeness) in the face of an impending disengagement.

The family, over generations, connected around the meaning of asthma as an expression of weakness. This weakness had been carried from the one generation to the next because it is in their genes. This is seen on a 'political' level (Keeney & Ross,

1992) by family members not engaging in activities that they otherwise would have, had they not had asthma. The family also co-evolved a clear idea around the concept of society. They conceived of themselves as different and therefore apart from society. However, on another level, the family connected with society in terms of supporting the dominant societal beliefs around illness and health. For Bella her views around health and illness were in line with the time and context that she found herself. This may be found in, for example, her views of being bewitched to have asthma. This was equally the case for Paula and Siphon. Their views were coloured by their context and time living in urban parts of Johannesburg.

Whilst some family members perceived themselves as weak and powerless in relation to asthma, others perceived themselves as powerful and therefore able to control their asthma attacks. This is so because, as stated above, different family members' views are coloured by their experiences at different points in time. Also, in terms of complementarity, the notions of weakness and control are in juxtaposition. Thus the meaning of outline revolves strongly around the parameters of controlled powerlessness.

Indeed, for this family, asthma became a metaphor for connectedness, enmeshment, distance, weakness and strength, powerlessness, and helplessness and this recursively informed their behaviours in that they withdrew from society and consulted with *inyangas* or medical professionals in an attempt to gain control over the disease. Furthermore, the relational issues such as connected meanings and behaviours create a context in which asthma may be maintained.

Implications for Therapy

Taking an ecosystemic and/or social constructionist approach has an added advantage of considering the relational context, which creates much wider possibilities to work with asthma sufferers in therapy. In defining the significant system as "all those that have coalesced around some problem," (Boscolo et al., 1987, p. 73) and not in terms of social parameters, the researcher was able to generate many more realities around asthma than would have otherwise been possible.

Taking an ecosystemic epistemology and social constructionist perspective facilitated a shift from blaming the “symptom bearer” and assigning cause to the onset of the disease. Thus, a non-blaming stance enabled members of the system to consider their contribution and the part they also played in maintaining the symptom.

Through focusing on the meanings and ideas that the family members have had around asthma over the generations, the researcher added yet another perspective to the prevailing view of the genetic transmissibility of the disease. This way of thinking challenged both the researcher and the family into considering other patterns of meanings and behaviours that could be maintaining the symptoms in their family.

This research has attempted to generate a “thick description” (Lincoln & Guba, 1985) about the meanings and ideas that the family members have around asthma and how these informed their behaviours. The wider social context was also taken into consideration, and how this impacted on the family was evident.

The researcher managed to successfully describe the pattern and themes that a family has around asthma over three generations. A consideration of the wider social context was also afforded and how this impacted on the family was evident. The biomedical model, which follows the positivist lineal epistemology, was juxtaposed with the ecosystemic epistemology in such a way that the difference between them was seen as a difference in logical typing.

Limitations and Recommendations

One of the major limitations of the study is the absence of more detailed information about the significant system. Not all family members from the first to the second and third generations were present. Too much focus was given to the meanings that the family members had co-created around asthma, and there was too little focus on the interactional patterns (behaviours). A much richer description could have been provided if the researcher had given equal attention to the behaviours or “politics” (Keeney, 1983) around asthma, within the family.

The second greatest limitation of the study was the lack of “member checking” (Lincoln & Guba, 1985, p. 80) which refers to the researcher testing her understanding

of the family with the family members, to establish whether or not they agreed with the researcher's narrative. This was not done due to the ethical problem within research of exposing a family to itself (LaRossa, Bennett, & Gelles, 1981) without follow-through.

Although the family would have agreed with how the researcher put forward their views, through their narratives, they may not have agreed with the researcher's interpretation of them. This issue can be resolved by remembering that the researcher's description of the family arises from her theoretical lens, as well as personal context, and therefore does not reflect the "truth" of the family but simply one way of describing them.

Certain questions about the disease and its role in maintaining relationships were not answered in this study. This lack of information indicates the need for the researcher to have a more prolonged embeddedness in the research context.

Conclusion

This study provided a three-generational description of the meanings and beliefs that a family has around asthma and how these recursively informed their behaviours. Certain patterns and themes were co-created by the researcher in interaction with the family. The wider social context and how the family members meanings and actions were connected to their particular historical, cultural and social contexts, was evaluated. Throughout the study the researcher acknowledged the use of her theoretical lens and her experiences of asthma in her own family of origin as guiding her punctuations. Furthermore, the researcher wishes to invite further researchers of this topic, to consider what other patterns exist that could be impacting on diseases and their treatment in the field of medicine and psychology. Of special value would be extending the approach used here to investigate compliance/non-compliance with treatment in asthma sufferers.

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APPENDIX A

SESSION 1

The first session took place at the Baragwanath Hospital's Child Psychiatry Department. It involved going through the genogram with all the names of people in the family including those that have asthma. Present at the session was Bella and the Researcher.

SESSION 2

R: Yesterday, we looked at the genogram, that is everybody in the family, and those that died and those that have asthma; can we go through the names of your children once again, to make sure I have it right?

Bella: As I said yesterday, I had seven children. The first of whom was John, he was born in 1933 and died immediately after he was born; then followed Zamazama, he was born in 1935, then Mzanywa, who was born in 1938, then followed Muzi, he was born in 1940, then Nobuhle was born in 1942, then Makhosazana in 1945, then followed by last born Thandi, she was born in 1947. Nobuhle got married in 1976 and she has four children, that is two boys and two girls. Her first child is 22 years old, his name is Noxolo, the second boy is, I have forgotten his name, his third boy is Mzwakhe, he is 18 and the youngest is Zakhele. Makhosazana is also married, she got married when Thandi finished school in 1976. She has three children, Sifiso, two other girls. Her children are widely spaced. Her last child is Bonga. Are their names necessary?

R: No, Bella, it really doesn't matter if you cannot remember?

Bella: Thandi married in 1979, and she has two children, namely Paula and Sipho. Her ex husband died. However, they got divorced before he died, in 1982.

R: Of all your children, are there others that have asthma?

Bella: Only Thandi when she was young and her children still have asthma. My other grandchildren only have had bad coughs not always though, just once in a while.

R: When was your asthma diagnosed?

Bella: I started having problems long time ago, before I had children. But the doctors just called it chest problems. But I also I have other problems like TB and was admitted to Springfields hospital.

R: So when were you first diagnosed as having asthma?

Bella: As I said, I initially had chest problems, these were only diagnosed as asthma later on.

R: Do you remember when that was?

Bella: Yes, I started to know that what I had all along was asthma only in 1985. I had all my children by then.

R: Was your husband dead by then? When dit he die?

Bella: He died in 1986.

R: So your disease was given the name of asthma a year before your husband died?

Bella: Yes.

R: Please clarify this to me. Yesterday you said long before you had your first child, you were sickly, having chest problems and you consulted a witchdoctor?

Bella: Yes. That was in 1933.

R: So how did it happen that you only got diagnosed with asthma only in 1985?

Bella: Listen carefully. Ntombezana (young girl). I got sickly long before I had children, and I thought I just had chest problems. I also had other diseases like TB. I only know that the name of my disease (isifo sa me) is asthma in 1985. I didn't know anything about asthma then.

R: So what did your first doctor say your problem was?

Bella: I don't know. I only heard that what I was suffering from was asthma in 1986.

R: OK then, now I understand, you started having chest problems, but these were given name of asthma in 1985. So, Bella, when you look at things, how do you think you contracted asthma?

Bella: As I said earlier, I was given muti, in other words, I was bewitched.

R: OK then, when your husband died, did he know you had asthma?

Bella: Oh yes, he knew. We were staying together and I told him that what I had all along is called asthma.

R: So what were his ideas about asthma? What did he think?

Bella: I don't know. He was very concerned when I got ill.

R: And how did he show his concern?

Bella: He just did not do anything. However I would just go to the hospital; which is kilometres away. Let me also add this, by the time I had severe attacks, he wasn't staying with me, he was a farmer in the village and by then I was working as a domestic worker in Thekwini (Durban).

R: So when did you see each other?

Bella: Only on weekends.

R: Can you describe to me what kind of husband did you have?

Bella: (Laughs) Keeps quite.

R: Tell it like you are telling a story about him.

Bella: He was a fine husband; except he used to get drunk sometimes.

R: So what did he do when he was drunk, that you didn't like?

Bella: He would just sleep, sometimes refused to eat, sometimes he would wake up very early to ask for his food.

R: How was he different when he wasn't drunk?

Bella: He was just the same to me. Sometimes he would be talkative.

R: How would you recognise if he wasn't happy?

Bella: He would just go and sit alone, sometimes shout at you, sometimes frown when he looks at you. He wouldn't want to talk to anyone.

R: How would he see if you are happy?

Bella: I would sometimes tell him.

R: How would he react if you did?

Bella: He would apologise. Sometimes when I am angry, he would give me money to go to the hospital.

R: Why would he give you money to go to hospital when you are angry?

Bella: Because he would sometimes think I would get sick.

R: Has it ever occurred that you got sick when you were angry with him?

Bella: Yes, quite often.

R: Can you recall an incident and tell me how he reacted?

Bella: Its such a long time back, I cannot remember.

R: When he realises you might get sick, would he go with you to the doctor or as you said just give you money to go to the hospital without accompanying you?

Bella: Yes, he would just give me money. The reason why he would give me money is that our hospital is very far from home where we lived. It would therefore cost a lot of money if it were two people travelling together.

R: Would he show concern, that you would go well or if you would come back?

Bella: Yes, I would find him waiting for me at the bus stop.

R: How was life for you before you started getting sick from asthma?

Bella: Do you mean when I had chess problems? Or after I was told my problem was asthma?

R: Yes.

Bella: Life was very nice to me. I enjoyed myself. I was strong. I really worked hard.

R: Did knowing that what you had was asthma change anything about you?

Bella: No.

R: Were you an emotional person or quite a patient person with your children?

Bella: I was strict with the eldest, the rest learned from their eldest siblings.

R: What do you miss most about life before you knew your diagnosis was asthma?

Bella: I miss working most, because when I was still working I could do everything I wanted.

R: What did you enjoy doing most?

Bella: I would use all the money on my children, buy them food and most of all I used to like dressing nicely. I used to like clothes.

R: One aspect we haven't explored yet, is the role of church in your life, which church do you belong to?

Bella: Methodist church.

R: Were you a regular church goer?

Bella: I used to like church a lot. Now I can't walk that much any more.

R: Was your husband religious?

Bella: Yes, he was.

R: What role did it play in your lives?

Bella: Church did wonderful things for me! My children are the way they are because of church.

R: How do you mean that?

Bella: My children are disciplined.

R: Seeing that you also believe in witchcraft and ancestry, how do you reconcile that with religion?

Bella: In my culture, ancestry and bewitchment are beliefs and ancestors are mediators between us and God.

R: So if a sangoma gives you medication, how do you understand the role of this medication?

Bella: God guides the sangoma as to what medication to give us.

R: OK, I understand, but have you ever asked God to guide the sangoma to help you treat this asthma that somebody bewitched you with?

Bella: Whatever "muti" that somebody had bewitched me with. I pray to God that he weakens the effect thereof.

R: Has this happened, that is, has God made it weak?

Bella: Oh yes, because I could have long died!

R: The way I see it, this disease has also made you weak compared to just how strong you were before.

Bella: Yes, it has weakened me to some extent, but I think now I'm just waiting for God to call me to His Kingdom.

R: When I look back at your life, you struggled a lot, you struggled to have children, then you struggled with the disease. So what else are you still struggling for?

Bella: A stable accommodation, because I am staying in a family house with my children and grandchildren.

R: If God could appear, and make a miracle and ask you to wish for three things, what would those things be?

Bella: I would wish for a house, to get well and take me wherever he wants to take me.
(Laughs).

SESSION 3

R: I want us to continue on what we said last time, about you having to go to Thekwini?

Bella: Oh yes. I told you, I had too many children. We had too little money, my husband was working on a farm, earning very little money. I had to take over the whole family financially. It involved moving away from the village to go to Thekwini (Durban) to work as a domestic worker, against his will. He was a stubborn person, he wouldn't let me go, but I had to force my way to Durban to go look for a job. There was no longer life at home. The children were starving. We couldn't even send them to school any more.

R: What was his reason for not wanting you to go work?

Bella: Traditionally, it is a man's duty to supply his family and secondly he felt I was too sick to work. However, after he realised the difference I brought into the family by working he was impressed.

R: How did he show he didn't like your working?

Bella: He told me.

R: Of all the people you were staying with a ixopo, were there other people who knew you had asthma?

Bella: No, only my family knew.

R: Why was it important for you that people didn't know you had asthma?

Bella: It was not a matter of hiding it from anyone, I wasn't able to talk to anyone about my sickness, our relationships were superficial.

R: If I had to say, you are a very closed person who keeps to herself, who feels that whatever happens in the family is not for the public to know?

Bella: Yes, I do not like divulging all my problems to others besides my husband and children.

R: It makes sense to me now, why people outside didn't know about your asthma.

Bella: Yes.

R: If I had to choose any person whom you trusted so much that you would be able to tell everything, who would that be?

Bella: That would be Malome (Uncle) the problem is that he is far away.

R: OK. Who of all your children are you closest to?

Bella: Zamazama. I am close to all my children but she is closest to me both by proximity and emotionally.

R: Who of all your children is like you?

Bella: Zamazama. She is hard working like me.

R: If she could have asthma, how would you feel?

Bella: I would die, because she is the pillar of the family. I sometimes wish she could have been a boy.

R: What about you and Thandi? What do you have in common?

Bella: Nothing, she is like her father.

R: Lets go back to the attacks. I want you to describe in your own words these attacks.

Bella: It starts at night with a cough. I'd try to breathe and sit up in bed; try very hard to breathe, after some time I would get out of bed to go get a drink of water, and gradually I would feel my chest opening up.

R: Don't you take medication?

Bella: I do sometimes. I end up not taking the treatment at all.

R: That's interesting. When this happens where is your husband?

Bella: I started experiencing severe attacks after my husband died.

R: During those times when your husband was around what would he do?

Bella: No he has never seen me experiencing severe attacks. He has seen only mild ones.

R: Could you associate severe attacks with the pain that you felt after your husband died?

Bella: I cannot be sure about that, but I do agree, because when I am upset I also start suffocating.

R: What was happening to you at the time when your husband died?

Bella: I was very worried about the future of the children, and the responsibility that I had to take over.

R: Oh! But from what I see, you have always been the "head" of your family. You worked for them whilst your husband was at home with the children. So how is

that different after your husband died?

Bella: Its not that kind of responsibility that I am referring to. It has to do with disciplining the children. My eldest son is very bully and has no respect for me. Only my husband was able to discipline him. Even though my husband later failed to discipline him because he was already too old to do so.

R: OK. Were you the type of person who would cry openly about issues with your husband whenever you were upset?

Bella: No, not openly, but I would just walk away, or run away whenever he wanted to beat me.

R: Was there ever a time that he would try to beat you?

Bella: Yes, whenever he was drunk, he would want to fight. I would run away to his mother and tell her he wants to beat me. I would spend the night at his mothers' house and go back the following day. He would have forgotten everything by then.

R: Earlier on, you said you used to bottle of things up. Could it be that asthma is an expression of some problem you are bottling up? Could it be a way of telling people around you that you have a problem that you are not talking about?

Bella: Yes, I wouldn't disagree with you on that.

SESSION 4

This session took place at a prominent township in Sowetu, at Thandi's house. Present during this session was Thandi, her mother Bella and the Researcher.

R: I want us to include you Thandi in today's session. If you still had asthma, how would you handle being ill together with your children?

T: I would probably die because I'm somebody who sympathizes a lot with myself. If I don't have anything good I feel very very bad about it and if I'm sick I become very sick because I think a lot about it.

R: Where do you get that from?

T: I don't know, its within me.

R: Did you perhaps get it from your mother? For instance, when you were sick as a child would she nurture you or spoil you, or would the attitude be more towards "No, it can't be that serious, get up and go to school, you will be well!"

T: No, she wouldn't say that because when my children were sick, she would quickly send them to the doctor.

R: You know, in most families, when children are sick, the tendency is for parents to spoil that child, nurture them. So with your mother, what was the attitude?

T: I would say she would spoil us.

R: So, can I say that, when you are sick, your feeling pity for yourself and or sorry, has to do with the way you were treated when you were sick as a child?

T: I would say so, because I am the youngest in my family. I am the last born and everybody was doing everything for me.

R: To you Gogo, if I could say that asthma represents suffocation. What in your life are you suffocating from?

Bella: The thing that makes me suffocate is the mucous plug in the chest. My chest gets filled with mucous that I cannot cough out.

R: What could you liken this mucous plug to, in terms of issues in your life that you battled with the same way that you are battling to cough out the mucous plug in your chest?

Bella: Let me explain it this way. I'll start with describing once again the attacks. It starts with a persistent cough, then my chest closes. I struggle to breathe, try as much as possible to breathe, after sometime I'll realise its not getting any better, then I will get out of bed to drink water, thereafter I'll feel a little better, then I will get out of bed to drink water, thereafter I'll feel a little better, after sometime it gets worse again, then I will take my medication. It is a very painful process I must say. You feel desperate to breathe, its really painful.

R: OK Gogo, I now understand the nature of your attacks and how they make you feel. However, if I had to be a sangoma and tell you that in coughing and trying to breathe there is a major problem that you are dealing with, that you are trying to cough out. What could this problem be?

Bella: (Laughs) I don't understand.

T: Lets go back to the process of the attack. In your life so far have you ever experienced a problem that follows more or less the same process as that of asthma? That closes your chest, makes you unable to breathe, looking out for solutions by talking to the other children, things looking better, then starting again. Do you understand?

Bella: The only problem I can think of, that makes me feel as if I will get an attack, is that of my son, he is unruly and very stubborn. However this problem only come about after I had been diagnosed as having asthma!

R: When your son realises that you are hurt and troubled by him, what does he do? Does he apologise and try to make you feel better?

Bella: No, he just withdraws. He would never apologise.

R: Does your son ever realise that he is hurting you?

Bella: I don't know.

T: I think he doesn't realise that because to him he is convinced he is doing the right thing. He is a man and should control all the women under him. Women are like children to him. Like his children.

R: Does he see and know that the things he is doing are making his mother sick?

T: No, he sees that he upsets his mother but he would never think of himself making his mother sick. I don't think he is able to comprehend that problems could make one sick.

- R: Should he ever realise that he is making his mother sick, how do you think he would react? Would he stop being a problem?
- T: I don't think he would stop; he has never seen anyone being emotionally sick because he is ill treated by others. Besides he wouldn't believe he is causing mothers' illness, because she started having the asthma long before he became a problem.
- R: If we had to explain to him that he seems to be partly responsible for mothers' asthma attacks. How do you think he would react?
- T: He wouldn't believe it and he would think you are instigating his mother against him. He would think, whoever is saying that, could be creating a barrier between him and his mother. I think so.
- R: If you mother tried to tell him, do you think it would make a difference?
- T: No. I don't think so.
- R: OK, Gogo, this is one the problems you have associated with asthma, could you think of any others?
- Bella: Problems have always have been there. However they were too many!
- R: Can you prioritise them, in terms of ones that affected you most?
- Bella: Yes, the most pressing was when I had to go to work in Thekwini, against my husband's wishes. I had to provide for the whole family. I had to feed them, dress them, take them to school, because there was no longer money. I lost my first job in Thekwini. I got even more worried especially about my children's education, particularly Thandi; because she was the bright one. Life was unpleasant at home. My husband was still upset that I was thinking of finding another job. I was distressed during this time. I withdrew from people. I wanted to be alone. I couldn't sleep nor eat.
- R: Was your husband aware that you were distressed?
- Bella: Yes, he could see that, but he couldn't change anything about it.
- R: How did you show him you were distressed?
- Bella: At that time, I would just keep away from him, and not sleep at all. However, he would take his blanket and go and sleep in another room.
- T: When my mother is unhappy she looks dull on the face, you can easily read her face, most of the time she doesn't talk.

R: So, your husband could read you from your face and through lack of sleep, that you were distressed.

Bella: Yes.

R: So, do you think your husband left you to go sleep in another room when you were distressed, because he didn't know how to comfort you or to react or what to do, to make you feel better?

Bella: What can I say ... He would go out because he wouldn't know how to react.

R: Gogo, of all your children, who notices first when you are unwell or unhappy?

Bella: (Laughs, looks at Thandi.) Thandi was still very young at home. She stayed with relatives. Sifiso's mother, Makhosi, was the one that noticed first. She would come and ask me if I'm well or ask why am I crying. Then I would tell her I'm OK, because I wouldn't want to hurt them.

R: Children are very perceptive. They usually realise it when you don't tell them the truth. Do you agree?

Bella: Yes. Makhosi would come back time and again and ask me, if I'm well. I could also see she did not believe me when I told her I am well.

R: When you realise they don't believe you, what would you do?

Bella: I would try and convince them, but you know children, they believe what they want! (Laughs.)

R: Yes, I agree Gogo. I think we have covered all we needed to.

T: Oh, that was long hey!

R: Today is even better; yesterday was even longer. Thank you very much.

END OF SESSION

APPENDIX B

SESSION 1

Present at the session was: Thandi (T), Paula (P), Siphon (S) and the Researcher (R)

R: Thank you for being here, what do you think is the reason for coming here Siphon?

S: To talk about asthma.

R: What about asthma?

S: That is bad.

R: Is asthma bad to you, Siphon?

S: Yes.

R: In what way is it bad?

S: Because I cough a lot at night.

R: So does it cause you sleepless nights?

S: Yes.

R: To you Thandi, I want us to go back to what you said in the previous session with your mother. I want you to think about what facilitated your recovery from asthma, what factors contributed to you getting well?

T: Eimm! It is a difficult question, because I wouldn't know really, because I was about 4 years or 5 years when I was told I outgrew my asthma!

R: OK, hold on to that, we will get back to it later ... Imagine all other factors that contributed to it and how those facilitated your recovery from it. OK, what about you Paula?

P: What, Do you want me to respond to the same question?

R: Yes.

P: Well, my medication help me when I have an attack. I become well after taking them and my chest clears up.

R: By the way. Paula, you are the link between me and your family. If I hadn't met you, at the clinic, this meeting wouldn't have possible.

P: (Laughs) Looks at her mother.

- R: By the way, when were you diagnosed as having asthma?
- P: Looks at her mother.
- T: When she was two years old.
- R: When she was two. She was still a baby. How were the attacks then?
- T: They were severe and very frequent.
- R: And how did you handle this?
- T: I was very frustrated. We used to visit the hospital regularly. In fact I needed to get a helper to stay with us, so she could look after the children when I at work.
- R: OK, so when was Sipho diagnosed?
- T: He was diagnosed in 1988 when he was a year old.
- R: Did his diagnosis coincide with your Fathers' death?
- T: No, my father died in 1986.
- R: So Sipho, why do you think you have asthma? If you have to think carefully about it?
- S: I have asthma because I like playing with mud and water.
- R: Do you think you will ever recover from it?
- S: No, because I really like playing with mud and water and I don't think I'm going to stop.
- R: So, it means you don't want to get well from it, hey?
- S: Yes.
- R: Why wouldn't you like to get better from it, why do you like your asthma so much?
- S: (Laugh). Looks at mother and sister.
- R: Paula, why do you think your brother enjoys having his disease?
- P: (Laugh) I don't think he means what he is saying because when he is sick, he gets miserable, irritable and easily upset. He doesn't communicate.
- R: Does he get like this when he has asthma only or when he is also sick from another disease?
- P: Also when he has flu, he reacts in the same way. Anyway, his flu gets worse and becomes asthma.
- S: I like getting sick from asthma because I miss school.
- R: Oh, so you don't want to go to school? What else?

- S: I play inside the house.
- R: Is there ever a time when mother lets you play in the house when you are not sick from asthma?
- S: Yes, sometimes she does.
- R: So, there is no difference when you are sick from asthma and when you are not? Can you see? So what's special?
- S: When I'm sick from asthma, she lets me stay in bed, so that I can stop coughing.
- R: When you cough, what does she do?
- S: She tells me to stop coughing and then I try and she tells me to cover myself in bed.
- R: So do you enjoy playing in bed?
- S: Yes, its fun!
- R: In what way is it fun?
- S: I play with my cars in bed, I fantasise about playing with others who then ask me questions and I answer in return.
- R: So when you don't have asthma doesn't she let you play in bed?
- S: She does, sometimes. Sometimes she doesn't and I get angry.
- P; He doesn't get angry, he gets moody, then I tease him, and then he gets even more moody.
- R: So what does your mother do?
- P: My mother spoils him.
- R: Is that so?
- T: Yes, I tend to, because when they start coughing and their chest gets tight, it feels as if its me getting ill. So I feel very sorry for them. Sometimes because I know, that when they are in an upright position, they cough less. I let them lie on my shoulder and sleep straight in a proper position.
- R: Oh, so that must be another thing they enjoy.
- T: I think so (Paula and Siphon laugh).
- R: It must be fun for the two of you isn't it? So, Thandi, this ties very well with what you said earlier about being sympathetic and full of pity.
- T: Yes, worse still, if they are sick, I cannot fall asleep. It worries me a lot that they are sick. Even if they eventually manage to fall asleep. I never do, I will lie

awake till dawn.

R: Do you ever get worried that they might die from asthma?

T: Yes.

R: And you, Siphho?

S: Yes, I do.

R: You do, so why is that?

S: Because when I cough too much and I cannot breathe properly, then I think I'm dying.

R: What is so scary about dying?

S: People won't see you, and I will also miss them.

R: Who would miss you most?

S: My mother, my sister and my friends.

R: And you Paula?

P: I never think about it.

R: Why?

P: It has never crossed my mind.

R: Do you think your asthma is controllable and you wouldn't die from it?

P: (Nods) in agreement.

R: Why do you of all grandchildren have asthma?

P: Because I'm weak.

R: Are you the weakest of all the grandchildren?

P: I cannot compare myself with the others but I know I am weak.

R: What makes you think you are weak?

P: I get ill frequently and I get sick easily.

R: Where do you get this weakness?

P: From my genes, my mothers' genes.

R: So, you think your mother is weak?

P: Yes (looks at mother and laughs). Anyway I don't know.

R: If you didn't have asthma, how different could things be?

P: I would be more active at school because I am less active now. I don't do a lot of sport. I think I would be involved in a lot of things because I am naturally active. But my asthma is better now.

R: Why is that.

P: Because of the medications I use.

R: It must be frustrating to you, that you can't get as active as you wish.

P: (Nods) in agreement.

R: Siphos, if someone comes to you and says asthma, what is the first thing that comes into your mind?

S: I get angry.

R: You get angry? Why is that?

S: Because it is a bad thing. I hate it.

R: Is it a bad thing to you?

S: Yes.

R: Is it terrible to you, your asthma?

S: Yes.

R: But you said, you don't want to wish it away.

S: No, I do want to.

R: But if you do wish it away, how will you get all the attention you get when you have it?

S: I will pretend I am sick.

R: Do you ever pretend you are sick?

S: Yes, I do.

R: When you do pretend you are sick?

S: When mother ignores me.

R: Do you ever notice, when he pretends to be sick?

T: No, I don't. I actually never realised that.

R: So you, Paula, do you ever pretend you are sick?

P: No, I never.

R: So, it's only Siphos who does, we have talked about things that are bad about asthma do you have any positive things that you could tell about having asthma?

P: No, I can't think of anything. There's nothing positive about having asthma. It's terrible.

R: So, when you have an asthma attack, how does your mother react?

P: She usually notices it first, before I have an attack.

- R: How do you manage that?
- T: I have stayed with her for the past 14 years. She usually starts with a cough. She coughs persistently. You can feel there is something irritating her, that doesn't want to be coughed out. Sometimes, I think it's a sputum, when they do cough it out, they become better. But when she starts coughing, I tell her to get the spray. It usually gets better with the spray.
- R: So, it starts with a cough. Then spray helps. Does it ever occur that the spray doesn't stop the cough?
- T: It hasn't done so in a long time since we moved to Johannesburg. But since we moved to Johannesburg we haven't had a major problem. Once they start coughing, I give them the spray; and it gets better. But whenever the wheezing starts, I bring them to hospital. It was only once that I had to bring them to hospital in Johannesburg.
- R: Let me see if I got this right. When she starts coughing, it feels like there is something blocking her chest. What do you do then, do you get anxious or irritated?
- T: I get anxious, I want to take it out, but I know I can't. The spray will get it out.
- R: So if the spray cannot get it out, do you get desperate and want to take it? Or do you carry her to hospital?
- T: No, I wait until she starts wheezing. When she starts wheezing I know there is a problem.
- P: But I can't use a spray when I start wheezing. It usually doesn't help, besides I haven't had a wheeze in a long time. Neh mum?
- T: Nods.
- R: When was the last time the spray couldn't help?
- P: It was in Durban; not here ...
- T: When we arrived here in 1991 ...
- P: It was in Durban, around April or May.
- R: Do you remember what was happening then?
- P: It was during the exam time, I think.
- R: Were you writing exam?
- P: Yes.

- R: Was it stress from exams or what was it?
- P: No, I don't think it was stress. I was in a panic state.
- R: What kind of panic was that?
- P: I couldn't think of different things at the same time. Like the other time, I had to think of many things at the same time.
- R: And then, did you start wheezing?
- P: No, I just got a panic.
- R: I want to think of another time that this happened, that you were writing exams and it happened again that you got a panic and started wheezing.
- P: No, I can't think of another time.
- R: Can you think of another time that you got a severe attack?
- T: I think it was in 1991.
- R: Do you remember what was happening then?
- T: No.
- P: No, I can't.
- R: Were you upset with someone or was something bothering you?
- P: No.
- R: Do you ever get attack when your mother shouts? What I am trying to get at is, is there any other thing except allergies and climate that causes your asthma?
- P: No.
- T: No, because I shout now and then so they are used to it.
- R: Maybe if you stopped shouting, she would get attacks because it would be something unusual? What do you think?
- T: (Laugh) No.
- P: (Laugh) Nods in agreement.
- R: So you do not remember what was happening then?
- T: I don't think there was much happening because it was late at night, they couldn't go to hospital because transport was scarce. I noticed she had a problem. She was wheezing but not much, so in the morning. It was a Sunday morning, I was supposed to come to work, and I brought her along to work, to have her examined. There wasn't anything unusual happening.
- R: Since you are a nursing sister, do you find that sometimes you have to leave

your children alone to come to work?

T: Yes. Fortunately that time, I had a nanny staying with us.

R: But now, do you still have someone?

T: No, because of the finances. I do not have anyone.

R: Has it ever happened to both you and Siphos that you got an attack and your mother wasn't around to help you?

T: It has never happened because when we got here the climate was so good for them. He didn't have any wheeze until one day he got flu and they discovered that there was some underlying asthma to it. They then treated both flu and asthma.

R: And you Paula? Has it ever happened that you got a cough so bad that you started wheezing and your mum wasn't around?

P: It happens at school, but its never serious. I use the spray.

R: Have you ever had one very serious attack and your mum wasn't around?"

T: She had when she was admitted in hospital in Durban.

R: Oh, so when they were in Durban, were they staying with Grandmother and were you in Johannesburg?

T: No, they only stayed in Durban without me for the time that my transfer wasn't through yet, for 1 1/6 months only.

R: Oh, only for 1 6/12 months, so when you all were staying in Durban, who were staying with you?

T: Myself and the children, plus my mother, but we used to have visitors frequently.

R: So, can one say it was never just the four of you as a family?

T: Yes, we used to have more than one or two visitors.

R: You say, their asthma then was very bad because of the climatic conditions?

T: Yes.

R: So, when you were staying with your husband just the four of you, did you have any problems?

T: Yes.

R: So, when you were staying with your husband just the four of you, did you have any problems?

T: No, we didn't have problems with asthma, because Paula's asthma started when

she was 2 years old and his started when he was one year old. We had already been divorced by then.

R: So when did you divorce?

T: 1982. The children's asthma started when we were on separation.

R: So, did we know about the children's asthma?

T: Yes, when we were not staying together, the children had chronic chest problems and were diagnosed asthmatic, he used to come and visit the children and I told him about it.

R: What did he think about asthma? Did he think it was something bad?

T: Really, we didn't have much to talk about.

R: OK, what did he think about diseases in general?

T: He used to think people get sick because they are not getting vitamins and are not well cared for.

R: If you have to think of asthma as suffocation, being unable to cough out something that is making you suffocate. For instance the mucous, what else could be feeling to cough out, or what you can call this thing that is making you suffocate.

T: 1982. The children's asthma started when we were on separation.

R: So, did he know about the children's asthma?

T: Yes, when we were not staying together the children had chronic chest problems and were diagnosed as asthmatic, he used to come and visit the children and I told him about it.

R: What did he think about asthma? Did he think it was something bad?

T: Really, we didn't have much to talk about.

R: OK, what did he think about diseases in general?

T: He used to think people get sick because they are not getting vitamins and are not well cared for.

R: Could he have thought the children were not well cared for?

T: No, he thought they got the cough from my mother. My mother was infecting the children. He was blaming my mother.

R: If you have to think of asthma as suffocation, being unable to cough out something that is making you suffocate. For instance the mucous, what else

could you be failing to cough out, or what can you call this thing that is making you suffocate?

P: What? ... stubborn.

R: OK, is it stubborn?

P: Yes, because I am failing to cough it out, OK?

R: And for you Siphos?

S: I didn't understand the question.

P: Siphos she is asking you to give a name to this flame that you are failing to cough out, when you have asthma.

S: Nothing, I cannot call it anything else.

R: What else could make your mother so angry that she even gets blocked threatening to have an asthma attack?

P: My marks at school.

R: Why your marks? Do they make her so angry?

P: Because she wants me to do very well at school.

R: And for you Siphos?

S: Also when I don't do well at school.

R: And for you Thandi, what could make you get an attack again? After you haven't had it for so long?

T: Problems would. However I had serious financial problems not so long ago. I couldn't sleep. I was even sick, I couldn't breathe properly.

R: Were you able to meet your financial demands?

T: Yes, I was unable to meet my financial demands?

R: Did you have alternatives around them?

T: I had none, because the way I was feeling, I was very sick.

R: Where were the children?

T: They were staying with me.

R: Were they aware of your problems?

T: No, they could just see I was sick but they didn't know what was worrying me.

S: I think I remember that time, I could see you had problems.

R: Oh, so did you tell the children about this?

T: No, I didn't. It's very difficult to tell them everything, that now I'm in such a state

that I cannot move but sometimes I feel Paula is old enough. She has to know some of the things. Like I would tell her that today don't have any money or bus faire for you to go to school.

R: How does she take it then?

T: I don't know, but you feel she is withdrawn but at the same time she knows that if I say I don't have money, then I really don't.

R: Its good that she can trust that you wouldn't

R: How does she take it then?

T: I don't know, but you feel she is withdrawn but at the same time she knows that if I say I don't have money then I really don't.

R: Its good that she can trust that you wouldn't let them if you had money.

T: Yes.

R: So, do you tend to conceal some of the things that happen to you from your children?

T: Yes, because I think she easily gets hurt. She is like me, it will affect her.

R: Has it ever affected her to the extent that she gets sick from asthma?

T: No.

R: Do you think she gets stronger, wanting to help or does she become weak, because I think some children look up to their parents.

T: I think she becomes strong, wanting so much to help because she would come up with suggestions on what I should do to help her get a part time job so she could help me financially.

R: OK, Paula, what kind of problems do you anticipate either now or in the future that could precipitate your attack.

P: OK, Paula what kind of problems do you anticipate either now or in the future that she could help me financially.

R: OK, Paula, what kind of problems do you anticipate either now or in the future that could precipitate your attack.

P: I haven't thought of any right now. I think, as I said, when I have a lot on my mind, and I have a lot of work do to? I think I could have an attack.

R: Do you prefer doing things at your own pace? Do you dislike a lot of structure?

P: Yes, I do but I sometimes prefer structure to help me organise my things.

- R: Have you ever thought of some problem that you have or could have that could make you very sick from asthma?
- P: No.
- R: What if you loose your mum?
- P: Well, I don't know, I never think of that because I have also experienced serious problems in my life and never got an attack.
- R: Do you ever think about that?
- P: Well, I don't know, I never think of that because I have also experienced serious problems in my life and never got an attack.
- R: Do you never think about that?
- P: Yes.
- R: Why is that? Is that too scary?
- P: Yes.
- R: So, if you don't like something or something scares you too much, you don't think about it?
- P: Nods in agreement.
- R: What do you think Thandi, do you think she usually blocks off things she is most scared of?
- T: I think she does.
- R: So you also think her way of coping with things that are too scary for her is by blocking them off?
- T: Yes, but some things that she is most scared of, she talks about like the hijacking, kidnapping of girls in the townships, rapists, and so on. She has now changed bus stops, she no longer alights where she used to because she is scared of the boys who gather around at bus stops.
- R: So you're not sure of how she responds to things she is scared of.
- T: Yes, I am not sure of how she responds but she would still come to me for advise. Like she would ask: "Mummy how would I handle it if I got raped?"
- R: What would you do if the most scary thing happened to you?
- P: I don't know. I really don't know.
- R: Do you think you would be able to cope?
- P: I don't know!

R: Do you ever think that if you do talk about something bad, you might wish it upon yourself?

P: Yes, I do.

R: So you're not sure of how she responds but she would still come to me for advise. Like she would ask " Mummy how would I handle it if I got raped"!

R: What would do if the most scary thing happened to you?

P: I don't know. I really don't know.

R: Do you think you would be able to cope?

P: Do you even think that if you do talk about something bad, you might wish it upon yourself?

P: Yes, I do.

R: So you are not thinking about things that scares you most has something to do with being afraid that you might be wishing them upon yourself?

P: Nods in agreement.

R: Is it ever like that with asthma?

P: No, its not like that.

R: If I had to say, choose another disease that you could replace asthma with, what would this disease be?

P: Tonsillitis.

S: I would also choose tonsillitis.

R: But it also make people sick, for instance you cannot swallow.

S: That will be better!

R: When you are at home, just the three of you, what do you talk about?

P: I only talk to my mother. I ignore my brother.

R: No wonder he pretends to be ill.

P: We talk about what other people at school do, where they stay and what they say.

R: Do you ever talk about asthma?

P: No, just that time when I was sick.

R: But do you ever talk about how it is impacting on your life?

T: Yes we do, but not very often. We talk by way of educating then, what to do and so on.

- P: We talk about how to prevent it, like the medical aspects of it.
- R: Do you ever think of becoming a medical doctor?
- P: No, I don't want to.
- R: So, who will treat your asthma?
- P: Other people would.
- R: What is your wish? Name your three best wishes.
- S: A wendyhouse and a bicycle only.
- R: What about you Paula?
- P: To be well, money for my mother and to finish school.
- R: Lets hope your wishes come true. OK? And what about you Thandi?
- T: For my children's well being, good health, a comfortable house and a car.

END OF SESSION

APPENDIX B

SESSION 2

Present at the session was Siphon (S), Researcher (R), Paula (P) and Thandi (T)

- R: Siphon, do you remember what your homework was all about?
- S: Yes I do, I had to draw about something that I can liken to Asthma, because of what it does to me!
- R: Very good, so what do you liken to Asthma?
- S: Casper.
- R: Tell us about Casper!
- S: He is a ghost, he and his friends don't like each other.
- R: So he doesn't get along with his friends.
- S: Yes.
- R: Why is that?
- S: Because his friends tried to tell him to go away.
- R: Why would they do that?
- S: Because his friends want me to cough all day and have asthma.
- R: Is that so! So what happens when you cough all day?
- S: When I cough all day, my chest gets sore and I get asthma.
- R: Siphon, you said the last time we spoke, that you don't want to wish your asthma away, that you like your asthma. So if Casper takes it away won't you get upset with him?
- S: No.
- R: Why not? Because you enjoy having it?
- S: Yes. I did say I enjoy my asthma because I tend to stay at home. I don't go to school.
- R: OK, so if eventually Casper manages to get rid of your asthma, how are you going to manage to stay away from school?
- S: I am going to say: "Casper, get your friends because I need to get sick".

- R: So what is so nice about having asthma?
- S: You don't go to school, you only play inside, you can put your toys wherever you like all over the floor and you can play with Casper.
- R: So once you no longer have asthma, you won't be able to enjoy any of that, like playing inside, and so on?
- S: I will pretend I'm sick.
- R: Oh, do you ever pretend you're sick from asthma?
- S: Yes, but sometimes I pretend I'm not sick if I feel like playing outside.
- R: So, Thandi, do you ever notice when he pretends to be sick?
- T: No, I don't.
- S: Yes, you do, when I just have a cough, sometimes you can tell I am not sick.
- R: So can you see now, mothers know these things. They can tell when you're pretending to be sick (coughs). So Paula, what about you? Have you thought of something that you can liken to asthma?
- P: Yes, having asthma is like being in prison, you feel restricted, you cannot do everything you like. I feel I am not free. I feel confined to certain things.
- R: So, do you ever imagine yourself free from this prison?
- P: No, I don't think I can ever be free from this. Its like a life sentence, in prison.
- R: Do you anticipate dying from asthma?
- P: When I am old, yes. I might die from asthma. Otherwise presently I am still very young.
- R: OK, so you don't believe that you could die from it now. (Paula nods in agreement.) So what about you Thandi? What can you liken to having asthma?
- T: Having asthma in my family is like being in a long dark tunnel, and I think, I have been in this tunnel for long. I can only see a glimmer of light at the furthest end of the tunnel.
- R: So you do see light even though you are presently still in the dark?
- T: Yes.
- R: So do you ever anticipate your children recovering from asthma in the same way that you did?
- T: I hope that they would. As I said, they are much better now. Their asthma was worse in Durban.

- R: Thandi, what are the ideas of people in Durban about asthma? re they different from those of the people in Johannesburg?
- T: To me, there isn't much difference. They all feel sorry for people with asthma, because it is a chronic disease.
- P: I think people in Johannesburg, once they get to know that you have asthma, are more relaxed about it. In Durban, those, that know, would patronise you, and say to you: "Oh, you are so young, shame!" and I don't like that.
- R: Are people who suffer from asthma in Durban very old or do they think old people should have the disease and not young people?
- P: Yes. They think you cannot have asthma, when you're so young.
- R: What do you think Sipho? Do you agree?
- S: Yes, I do, they also say to me I am too young to have asthma.
- R: OK, now I want us to go back to what we talked about with your mother Thandi, you said, your mothers' views about bewitchment are influenced by the place that she comes from. You also believe that bewitchment has a role to play in the transmission of disease. What about your children?
- T: Yes, as I have said, I have seen people who were successfully treated with traditional medicines when Western medications couldn't help.
- R: So what about you Paula and Sipho?
- P: No. I don't believe in bewitchment. There is no scientific proof there of. Even the 'muti' that they give to people, we don't know what its chemical composition is.
- R: So you don't believe you were bewitched?
- P: Yes, I don't.
- R: What about you Sipho?
- S: Yes, I believe it is possible for people to bewitch each other. But people cannot bewitch me because they like me a lot.
- R: So, Sipho, are you saying that you do believe in bewitchment? However, you don't believe you were bewitched because people like you a lot.
- S: Yes (smiles).
- R: OK, what we see now is that Sipho agrees with his mother and grandmother, that there is such a thing as bewitchment. However, his grandmother believes she

was bewitched to have asthma, while you Siphon, was not. Do you agree with what I am saying? (All nod in agreement.) Thank you very much for taking part in this research. Till we see each other again. Goodbye.