**Original article- qualitative research**

**Title: Mothers' decision-making during times of stress as a lone parent: a qualitative study**

# Abstract

Little empirical evidence exists to identify the impact that a partner’s absence or presence has on the mother’s decision-making, and her consequential help-seeking behaviour, when her child is unwell. This three phase study used qualitative design using focus groups and interviews involving 31 parents from a British Army garrison. The study explored Army mothers’ help-seeking behaviour as a lone parent when her child was unwell during the out-of-hours period. The findings demonstrated that Army life created a combination of stressors for Army mothers which altered their help-seeking behaviour when their child was unwell. When their partner was available, mothers contacted health services as a last resort, once all other avenues had been exhausted. However in contrast, during their partner's absence, health services were contacted as a first resort. An algorithm was generated from the findings which illustrates the importance of ascertaining whether the mother is alone at the time of the consultation. Increased emotional vulnerability intensified their need for reassurance and affected a mother’s decision-making ability. Primary health care staff should ascertain whether mothers are currently lone parents at an early stage of their assessment, as this may influence the entire consultation.

# Keywords

Qualitative research, lone parent, decision-making, military families, case study

# Introduction

Mothers go through a complex decision-making process when their children are unwell which is influenced by the mother’s psychological state1 (Raphael et al 2010). Mothers from a military family are often alone and emotionally vulnerable when their partner is absent on deployment. They may have to make decisions about their sick child when they are feeling emotionally vulnerable themselves because of fear for the safety of their absent husbands2 (Lester and Flake 2013). The Army as an organisation emphasizes its ‘duty of care’ and moral responsibility to support the soldier’s family, as well as the soldier himself3 (Ministry of Defence 2013). However, little research has been undertaken investigating the impact that being a lone parent, due to her partner’s absence, has on the mother’s decision-making when her child is unwell.

Many mothers within military families with children under five years old have to make decisions about their child’s health when their partner is absent4 (Cozza 2014). estimated that Consultations concerning children make up a large percentage of the calls to doctors during the out-of-hours period, with 17 per cent of calls relating to children younger than four years of age5 (Turnbull et al 2010). This suggests that mothers find it is a frightening experience when their child is unwell, especially in the middle of the night.

During the last 25 years, the literature surrounding help-seeking behaviour and decision-making emphasizes the multiple factors that mothers take into account before they decide to seek professional help when their child is unwell during the out-of-hours period. These include the mothers’ perceptions of the health services available to her6  (Wensing and Elwyn 2003) 7(Kelly et al 2010) 8(Philips et al 2010), whether she is a lone parent or supported by a partner 9(Shipman et al 1997), the child’s presenting symptoms10 (Kai 1996) 11( Langer et al 2013) and the subtle changes in her child’s behaviour12 (Neill 2010) 8( Callery 2013) 13 (van Ierland et al,2014)14([Drescher](http://link.springer.com/search?facet-author=%22Benjamin+J+Drescher%22) et al 2013). The perceived accessibility of services15 (Knowles et al 2012), previous experience of out-of-hours services16 (Shearer et al 2014) and previous level of satisfaction with health services17 (Booker et al 2014) are also identified as important.

Many studies reflect that mothers’ experience heightened anxiety when consulting about their child 18(Neil et al 2014) 19 (Jones et al 2014); 5(Turnbull et al 2010). As a result, it is difficult to obtain an accurate record of the reasoning process that mothers went through prior to deciding to consult. Parents are recalling an event in retrospect and are likely to have gone through a process of rationalisation after they have accessed help20 (Lupton 2013 ). Additionally, they have witnessed whether the treatment has been effective or not which may change their view of the care received 21 (Polat et al 2014).

Lone parents, without family or friends nearby to support them, were more likely to seek medical aid during the out-of-hours period when their child was unwell than if they were well supported by family and friends with whom they could share the decision-making 22 (Shipman and Dale 1999). However while this research was undertake over 15 years ago, it was the only paper that could be identified that explored the impact of being a lone parent on help-seeking behaviour accessing out-of-hours care. This demonstrates a paucity of literature regarding the impact that being a lone parent has on a mother’s decision-making.

It was not possible to conclude from the literature the influence that military enforced separation (i.e. deployment and training exercises) has on becoming a lone parent and how this impacts on a mother’s decision-making when her child is unwell. The literature lacks clarity as to whether Army life triggers Army mothers to require additional or different support to their civilian counterparts. Also, there is little evidence regarding how a mother’s emotional state impacts on her decision-making and the coping strategies that are used by Army mothers. The emotional vulnerability caused by both frequent mobility and the impact of deployment may increase a mother’s need to access health services when their children are unwell.

This study adds to the existing evidence by describing the impact of being a lone parent, particularly when fearful for their partner’s safety and the coping strategies employed by Army parents to combat the challenges presented by Army life.

# Aim of the study

The aim of this qualitative case study was to explore an Army mother’s help-seeking behaviour when her child was unwell during the out-of-hours period, particularly during a period of intense and dangerous military conflict when many mothers were lone parents for several months. Specifically, this study aimed to determine how the impact of military life, particularly the turbulence caused by military enforced separation, impacted on the decisions that they made when a lone parent. An Army mother was defined as a mother whose partner was a serving soldier regardless of whether she herself was serving or not. This appears to be the first qualitative study to investigate the impact of been a lone Army parent on decision-making when their child is unwell.

# Method

A qualitative case study design was used given that the philosophical beliefs of constructivism were underpinning the research, its aims and research questions. Setting the boundaries for a case study is crucial to providing it with a distinct identity and ensures that the study remains focused on the phenomenon being studied23(Denscombe (2014). Four focus groups (Phase 1) and 14 interviews (Phases 2 and 3) were conducted using a purposive sample of 31 Army parents who were recruited from approximately 200 serving and non-serving mothers and fathers living or working within the garrison between 2008 and 2010. Parents were selected from parent and toddler groups, nurseries, primary schools and Regimental coffee mornings. Fathers were included to give their perspective as how they felt military life impacted on their spouses as mothers. [Welfare](http://www.wisegeek.com/what-is-welfare.htm) workers (who ensure the safety and well-being of military families) and nurses working in the medical centre recruited the participants as they knew which parents were likely to be ‘key informants’ to maximise an understanding of the phenomenon24 (Kitzinger 2013, p 24). This avoided the risk of coercion by the research team as those recruiting did not hold a rank themselves. Data were generated in each phase until data analysis confirmed that no new themes were being generated, so theoretical saturation had been reached for that phase. Unanswered questions from each phase focused the topic guide for subsequent phases. Data collection continued until a clear theory which integrated all of the findings and data was generated.

The inclusion criteria emphasized that, due to the turbulence of the Army population, parents had to be living or working within the garrison for the subsequent 3 month period to enable participation in the study. Any mother whose partner had been fatally or seriously wounded during the concurrent intensive conflict was excluded from the study. This ensured the researchers did not add to their distress by interviewing them at such a time of extreme emotional vulnerability.

Once participants had expressed a willingness to take part, the principal investigator contacted them to explain the study and its implications. Focus groups took place in a convenient location in the garrison; the interviews were conducted in the participant’s home (except for one who chose to be interviewed at his place of work) (See Table 1) An independent researcher, who had no understanding of Army life, captured the group dynamics and observations of the focus groups in order to minimise preconceived ideas.

An informal discussion with a group of mothers from one of the regiments within the garrison was used to determine the topic guide for the focus groups, given the lack of evidence in the literature regarding the impact that Army life and being a lone parent had a mother’s decision to access out-of-hours care (See Table 2 - Topic guide). Each focus group for Phase 1 lasted approximately one hour. The interaction between the participants generated findings to develop an understanding of the impact that military enforced separation had on decision-making. Moderation of the focus groups ensured that the environment respected the participants’ opinions and beliefs. The themes identified in Phase 1 provided the topic guide for in-depth interviews with some parents from the focus groups held in Phase 2 (Table 2). These included how Army life impacted on what they needed from health services and what factors influenced whether they accessed health services or not. Phase 3 provided the opportunity to interview 7 different mothers with experience of seeking a health professional’s advice to treat their sick child (Table 4). The in-depth format of these interviews allowed mothers the freedom to narrate their own story in detail of making decisions when their child was unwell. None of the participants interviewed in Phase 3 had had any previous experience of hospitalization or chronic illness of their child.

# Analysis

The data were transcribed verbatim and analysed using thematic analysis. Codes and subsequent categories were derived using an inductive iterative approach and allowed to emerge from the data as patterns and themes developed. NVivo 7™ software was used to assist the process as recommended 25 Patton (2015) 26 Pope and Mays (2006). Use of the ‘constant comparison’ process ensured that data were coded correctly26 (Pope and Mays 2006, p 78). A matrix was used to identify the commonality and differences between the categories and themes being generated from each focus group. This illustrated that whilst some themes were common across all the participants, the perspectives of individuals varied. The content of each matrix from each phase was merged so that the themes generated from that phase could be seen visually in a table and data could be integrated across phases. This determined how dominant each theme was in each phase and how it was interpreted by the participants. Patterns of commonality, differences, and contradictions between each data set for each phase were identified.

## **Trustworthiness**

Participants gave oral and written consent prior to the focus group or interview taking place and were reassured that their contribution was confidential, would be stored securely and that all the data would be anonymised to protect their identity. The researcher discussed with each participant prior to the interview how they wished to proceed if they became upset. Ethical approval was given by the Ministry of Defence Research Ethics Committee (0744/129).

# Findings

Four themes emerged related to decision-making: making sense of the illness, knowing your own child, fear for their partners’ safety and lone decision-making. The combination of stressors ‘Army’ mothers faced during their partner’s deployment altered their helping seeking behaviour and increased a need for reassurance from a General Practitioner (GP) or triage nurse when their child was unwell.

Other themes developed from the analysis related to the disruption created by military life and the impact that frequent mobility and military enforced separation has on the family. This will be reported in a second paper due to the word limit. Data generated by fathers mainly focused on the turbulence of their Army working life and how this disrupted family life, rather than help seeking and decision-making behaviour and so are not reported here.

## Making sense of the illness

Mothers tried to make sense of their child’s illness but acknowledged a “*tipping point*” when certain symptoms, such as a pyrexia, caused them to feel out of control, particularly if they were on their own. Their need to be in control of the symptoms influenced the urgency with which they sought medical aid rather than the seriousness of the illness.

*It just like – it just came on all of a sudden and she just started breathing really rapid, and struggling to breathe as well. If you can’t control – you can’t contain them or stop it, what else do you do? We took her straight down to the out-of-hours clinic then.*

Interview Phase 2 Non-serving mother Participant 2

Mothers spoke of using external sources as a valuable source of advice when their partner was present, such as *“just go to Boots* [pharmacy]*”* or a pharmacy where they could receive advice.Fathers preferred the less personal approach and used the internet. Accessing a health professional was more urgent if they were unsupported by family as well as a partner. The thought of missing a serious illness in their child, such as meningitis, “*terrified*” them and increased their desire to transfer the responsibility of treating their child to a health professional. Stories of other children being “*dead in the morning*” from meningitis increased their anxiety and fear, particularly as it was more difficult to be rational about matters related to their own child. Parents described their panic if such a scenario occurred with more than one symptom of meningitis, as one father explains:

*If he’s got a temperature, I can’t get it down – and then all of a sudden he’s getting blotchy skin, you think about that leaflet - ‘Meningitis kills.’ And then - ‘That’s two out of five’ then three out of five and think - ‘Oh hang on! I need help now’, the exaggeration comes out, the assumptions come out - ‘Oh my G\*d, what’s happening?’*

Focus Group Phase 1 Serving father Participant 22

Mothers were unlikely to contact the doctor concerning their own ill health unless it prevented them caring for their children. Mothers reported that they felt *“really guilty having to bother the nurses or doctors”* or of *“being stupid and neurotic when at the end of your tether*”. Consequently, mothers wanted to be reassured that they were “*doing the right thing*”. They wanted to give responsibility for the wellbeing of their child to a health professional if they felt that they had exhausted their ability to deal with the illness or injury themselves

## Knowing your own child

Mothers emphasized that knowing their own child meant they were better placed than health professionals to determine if their child was ill and if they needed their professional support - common expressions used included *“not right*” or “*wasn’t himself* or “y*ou know your own child” .*

*She didn’t seem herself, she’s normally really cheerful, really happy, and she was just really hot, really sleepy and she just wanted to cry and cling, and she wouldn’t stop crying, which I found really unusual. She was just not herself and that upset me initially, so I picked her up, got her in the car and I just thought - ‘Right, I know that the medical centre will see her’.*

Interview Phase 3 Non-serving mother Participant 31

Theywere less concerned if their child was unwell but not distressed *“despite* *not being* *himself*’”. Some spoke of a *“waiting game”’* and hoped that their child would get better without seeking the help of a health professional, particularly if accessing health services was logistically difficult, such as if they could not drive or did not have access to transport.

## Fear for their partners’ safety

Fear for their partners’ safety during deployment added to their emotional vulnerability and consequently increased their propensity to overreact to minor illnesses much more than when their husbands were away on military training. Mothers conveyed a sense of catastrophe when their child was ill during times of deployment when a lone parent The inability to contact their partners directly because of their deployed location, added to their level of stress (Box 1). This had a major impact on their help-seeking behaviour and resulted in them contacting the out-of-hours service as a first resort, rather than as a last resort after consulting with others, as they did when their partners were at home to assist with their decision-making.

*Being on your own, your worries are compounded. I think when the men are away, everything becomes exaggerated. Because you’re worrying about the situation, they’re in, your child becomes ill, say with a cold, but they’re a little bit drowsy, well that all of a sudden it could be meningitis. Because you start thinking - ‘Oh my G\*d my child’s ill! My partner’s in Afghanistan, I’m on my own. What if they have to go into hospital?’ You play through that story! Your mind goes wild and you ring the out-of-hours straight away.*

Focus Group Phase 1 Non-serving mother Participant 8

## Lone decision-making

Mothers spoke of the “*rawness*” of their emotions when their partner was away; of *“panicking*” at the slightest thing and of being “*much more emotional and ratty*” than when their partner was at home. Some talked of reverting to childhood behaviour; one had suddenly become “*scared of the dark”* when she was alone in the house with her children at night. Such factors increased their emotional vulnerability and meant that childhood illnesses seemed much more of a threat when their partner was away, creating a greater degree of alarm and the increased likelihood to contact health services if their child was unwell. Some addressed this by developing a coping strategy of creating close relationships with their neighbours. This seemed a strategy to increase their resilience:

*You have to learn to cope in Army life. You have to learn to deal with things. You have to get on with it, bounce back for the sake of the children. It’s part of Army life to cope; you’ve got to.*

Interview Phase 2 Non-serving mother Participant 12

The mothers in this study found making decisions alone very stressful, particularly when the fear for their partner’s safety made them feel particularly emotionally vulnerable. They talked of a much more lengthy decision-making process and expressed a far greater reluctance to call the out-of-hours service when their partners were at home. Not only did they talk of deciding to call a health professional for advice sooner when their partner was absent, but they did so with much greater urgency. Participants had a palpable sense of fear as they told of their experiences of their child being sick when their partner was away. The onus was on them to get their child “*sorted”* as quickly as possible.

*If I had a medical emergency in the middle of the night, if you’ve got your partner behind you, who is normally the voice of reason in our house, when I’m like – ‘Ooooh, they’ve all got meningitis! They are all going to die horribly!’ And he’s like ‘Don’t be stupid, he’s hot and got eczema!’ You are more likely to ring up for less serious things if you are on your own.*

Focus Group Phase 1 Non-serving mother Participant 4

Of all the scenarios that these mothers had to face during their partner’s absence, their child being ill in the middle of the night was the one that they feared the most.

What made these mothers’ stresses significant was the likelihood that, irrespective of their serving status, they have to cope with such an acute accumulation of life stressors at the same time. They spoke of concurrently moving home, the loss of their extended family and long-term friends living nearby to provide emotional and psychological support, military enforced separation from their partner, complicated by having to cope with their sick child at a time of immense emotional stress when they feared that their deployed partner would be seriously injured or killed. The following extract from a non-serving ‘Army wife’ and mother exemplifies the reality of being exposed to so many demands at once, which she perceived had “*totally destroyed us*” when in reality she had ‘coped’.

*I moved back from* [British Forces] *Germany to UK on my own with three children when my partner was in Iraq, and the children had to start new schools, nurseries, new everything and they were utterly upside down for months. My son had croup I thought he was going to die. But I thought - ‘Am I being paranoid because I’m on my own with no one to ask?’ It was awful having to cope with so much at once but I did because I had to. It is frightening when he’s away and really, really frightening when you’re on your own when your children are ill.*

Interview Phase 2 Non-serving mother Participant 1

Participants expressed their disappointment if health professionals did not treat them with empathy and understood their circumstances. This was especially important for them during times of military enforced separation, when they had the greatest need for reassurance when making decisions alone at their most emotionally vulnerable.

The main findings are summarised in Figure 1 to illustrate how the partner’s presence or absence altered a mother’s help-seeking behaviour and decision to consult.

# Discussion

The findings gave clear examples of the factors that influenced mothers’ help-seeking behaviour and decision to access emergency services during the out-of-hours period. Making sense of the illness, knowing their child, fear for their husband’s safety and the impact of being a lone parent all influenced their decision-making when their child was unwell. The mothers in this study found making decisions alone very stressful, particularly when the fear for their partner’s safety made them feel particularly emotionally vulnerable. It was clear that frequent relocation and separation increased anxiety and emotional vulnerability, this is supported in the literature 27(Giles 2005) 28(James and Countryman 2012) 29(Green et al 2013).

Anxiety during military enforced separation was exacerbated while their partners were away. The increased anxiety during military enforced separation made the incentive to seek help more urgent and led to these mothers’ need for increased reassurance in their decision-making ability. Mothers talked of needing to telephone the out-of-hours emergency number straight away when their partner was absent and of misinterpreting a cold for meningitis. The dramatic change in their decision-making is not supported in the literature. The greatest fear of missing a serious, life-threatening illness such as meningitis has been well documented in the literature for over 30 years 9(Shipman et 1997) 10(Kai 1996) 30(deBont et al 2014),31(Farmer et al 2006), 32[Enarson](http://pediatrics.aappublications.org/search?author1=Mark+C.+Enarson&sortspec=date&submit=Submit) et al 2012, 33Callery 2013, 34[Drescher](http://link.springer.com/search?facet-author=%22Benjamin+J+Drescher%22) et al, 2013, 35Langer et al 2013), 36(Allen 2014). Indeed, education and media information campaigns do not appear to dampen parents’ fears 22(Hugenholtz et al 2009) pointed out, particularly as doctors are cautious in such circumstances. Certainly the participants’ fear of missing a diagnosis of meningitis indicates that the Department of Health and the Meningitis Awareness Foundation’s campaign”37 (Meningitis Research Foundation 2015) has not provided the reassurance that it intended. However, the mothers’ expressions of overwhelming guilt if they had missed a diagnosis and so not sought medical aid appropriately was not identified in the literature, nor their view of being a “*bad mother*” in such circumstances.

Mothers acted as gatekeepers and advocates for their children who were too young to decide to access health care services themselves. Reducing their child’s distress was one of the main reasons for contacting the out-of-hours service when their child was unwell. The impact that a mother’s own stress had on her decision whether or not to seek help during times of lone decision-making reflects38 Mechanic (1964),39Zola (1973) definitive work. An individual’s psychological state or stress level has a major impact on whether they seek or delay seeking medical help for themselves or their children39. Many mothers acknowledged that their partner’s mere presence enabled them to be able to make rational decisions when their child was unwell, even though they did not rely on their partner’s ability to make appropriate decisions. This finding was not reflected in the literature except in terms of lone parents being more likely to access health services. However, it is known that adults crave security from a ‘protector’ or a stronger person on whom they can depend40 (Maslow 1987).

The data confirmed that mothers in this study had concluded that the call handlers and triage nurses failed to acknowledge the extensive decision-making that they had undergone before contacting them or that as a mother, they knew their child best. Policy makers have a responsibility to be responsive to the diverse needs of the population of their country41. Yet, none of the participants reported being asked about their circumstances, such as whether they were a lone parent. This was surprising given large number of lone parent families and the wide media publicity of the situation in Afghanistan. Mothers interpreted a lack of questioning about their circumstances as a lack of empathy by the health professionals regarding the emotional and practical pressures they experienced. This increased their anxiety levels further and reinforced their own fears that they were wasting a health professional’s time. It is clear from the data that a mother’s circumstances play a crucial role, from instigating the call in the first place to potentially affecting the development of the consultation. Studies confirm that empathy by doctors improve health outcomes following the consultation42 (Street at al 2007) 43(Riva et al 2014). A great deal of research has focused on the importance of building up trust during a consultation 44 (Plomp and Ballast 2012, 45 (Tarrant et al 2008, 46(Hudon et al 2013). Trust was an important issue for these participants, both in terms of accessing services as well as trusting their neighbours as a coping strategy to combat the turbulence of Army life.

Social support plays an integral part in the coping process, even if it is perceived rather than actual support47. This explains why the mothers in this study had an increased need for reassurance in their decision-making abilities when their child was unwell. In light of Coping’ in the context of this study is concerned with Army mothers’ ability to manage the challenges that they face and the emotions that they experience, particularly when their child is unwell48. The psychologist Lazarus49 (2006) conceptualised a theory of coping, describing it as *“an integral feature of the emotion process*” 49 p10 (Lazarus 2006, p 10) as it relates to how an individual interprets stress and how it affects their wellbeing. Stress is likely to remain under control if coping strategies are effective, but if they are not, damaging consequences on health, morale and social functioning are likely to result49. Assessing a person’s ability to handle their stress necessitated an assessment of both ‘the person’ and ‘the context’ in which they are living49 p10.

These participants developed the ability to ‘*cope*’ and ‘*bounce back*’. Resilience is an “*enduring force*” that caused a family’s dynamics to change so that they could cope with the problems that they encountered 50 p 636. It is the individual’s ability to maintain a sense of control to help them to recover easily or “*bounce back from unpleasant damaging events*” 50 p 639. The military literature 51 (Fitzsimons and Krause-Parello 2009) 52 (Davis et al 2011) referred to resilience as an important strategy but did not define what was meant by the term and). Understanding the term resilience gives insight into what the term ‘coping’ means within the context of this study.

It was substantiated in the data that military enforced separation challenges a mother’s sense of safety because of fear for her husband’s well-being, which increases her anxiety and feelings of emotional vulnerability. Each of these scenarios (having a sick child or undergoing military enforced separation) could be viewed as a ‘magnifier’ as their impact is enlarged, amplified or increased in certain circumstances.

## Future Research

Undertaking a similar study as this with single mothers who may have a more established support network, such as extended family living nearby may give insight into the impact of being a lone parent from a different perspective, particularly in terms of the vulnerability they feel. How social support plays an integral part in the coping process should be explored to build upon other’s work47. Further research also needs to be undertaken to explore the consequences of separation on the mental health of military parents in the longer term.

The knowledge that health professionals have of their population and the psychological impact of being a lone parent also warrants detailed investigation to develop other’s research52 (Street at al 2007) 53( Riva et al’s 2014) work.

## Limitations

This study was undertaken at a particular time and place and within a certain context. As participation was voluntary, it is possible that those who took part did so because they wanted to highlight particular issues about Army life or access to health care during the out-of-hours period. However, there was no evidence that the findings were reporting an extreme or distorted view of being a lone parent within a military environment. Those who volunteered to take part were mainly non-serving Army mothers who did not work full-time, so the findings were primarily from their viewpoint. This may have put limitations on the study findings. Despite this possible limitation, the willingness of serving fathers to participate and ensure that their views were represented broadened the perspective given and demonstrated serving personnel’s commitment to the study.

# Conclusion

This study confirmed that having a child who is unwell during the out-of-hours period is a stressful situation in its own right. HTherefore, having to care for a sick child at the same time as being fearful for her husband’s safety means a mother faces both ‘magnifiers’ at the same time. The additional stress causes by this combination of ‘magnifiers’ impacts on her ability to make rational decisions when her child is unwell. While this study has given insight into the particular context and life of being an Army parent, it gives an insight into the impact of being a lone parent. Such a paucity of evidence in the literature regarding lone parent decision-making has meant that this study has filled an important gap in understanding the decision-making process of mothers during times as a lone parent; particularly when they are anxious and fearful for their loved one’s safety.

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# Conflict of interests

None

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# Table 1 Demographics of each focus group

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Focus group** | **Serving** | **Rank range of serving** | **Non-serving****mother** | **Average number of children per participant** | **Average age of children** | **Experience of out-of-hours service** | **Total number that took part each focus group** |
| **1** | 1 Father1 Mother | Sgt; SSgt | 6 (1)[[1]](#footnote-1) | 2  | 4 years 5 months | All | 8 |
| **2** | 1 Father | Cpl | 4(3)2  | 2 | 8 years | All | 5 |
| **3** | 1 Father | Sgt | 7 (1)2 | 2 | 2 years 6 months  | All but one | 8 |
| **4** | I MotherI Father (1 father)2 | Sgt; Maj | 1(5)2 | 2 | 11 years 10 months | All  | 3 |

# Table 2 Topic guide

|  |  |
| --- | --- |
| **Focus groups Phase 1****Interviews Phase 2 (in greater depth)** | **Interviews Phase 3** |
| * What Army life is like
* Where to go for support
* Why/ when to access health services
* Expectations for out-of-hours services

Impact of military enforced separation  | * Process of decision-making when accessed emergency health services when child ill
 |

# Table 3 Demographics of participants Phase Two

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Interview** | **Serving (s) or non serving (ns)** | **Mother or****Father** | **Focus group** | **Rank****if serving** | **Spouse serving or non serving** | **Number****Of children** | **Age** |
| **1** | NS | Mother | 1 |  | S | 3 | 2, 4, 6 years |
| **2** | NS | Mother | 3 |  | S | 2 | 1, 3 years |
| **3** | S | Mother | 1 | Sgt | S | 1 | 1 year  |
| **4** | S | Father | 3 | S Sgt  | NS | 2 | 14, 16 years |
| **5** | S | Father | 4 | Sgt | NS | 1 | 4 years |
| **6** | NS | Mother | 3 |  | S | 2 | 1, 3 years |
| **7** | S | Mother | 4 | Maj | S | 1  | Nearly 2 years  |

# Table 4 Phase Three: Child’s symptoms that instigated consultation

| **inter-view** | **Serving (S)****Non serving (NS)** | **Length of time part of Army****Popul-ation** | **Number of children in family** | **Ages/ gender of children[[2]](#footnote-2)** | **Symptoms of child** | **Reason for accessing the out-of-hours service** | **Time lag between seeking treatment for child and interview** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | NS | 8 years | 2 | **21 months Girl**4 Months Boy | Struggling to breathe, wheezy, high temperature.  | Struggling to breathe. | 43 days |
| **2** | NS | 8 years  | 1 | **3 years 11 months Boy** | Rash on chin.  | Needed diagnosis to conform If infectious and whether child permitted to attend pre-school next day  | 9 days |
| **3** | NS | 13 years  | 2 | **8 years Girl**6 years Girl | Infected ear lobe due to earrings. | Advised by school, daughter in much pain. | 27 days |
| **4** | NS | 6 years  | 2 | **8 months Girl** 2 years 8 monthsGirl | High temperature, coughing, not eating or drinking, difficulty breathing, not settling. | Coughing, not eating or drinking, not settling. | 36 days |
| **5** | NS | 4 years | 1 | **10 months Girl** | High temperature, coughing, epileptic fit (rigor due to high temperature).  | Floppy, fit, epileptic fit (rigor due to high temperature) | 35 Days |
| **6** | NS | 7 years  | 1 | **11 months Girl** | Diarrhoea and vomiting, high temperature, irritable. | High temperature, irritable. | 20 days |
| **7** | S  | 10 years  | 1  | **17 months****Girl** | Chesty cough, wheezy, sleepy, limp.  | Sleepy, limp.  | 28 days |

# Figure 1 Mother's decision-making process

 Yes

 No

**Mother identified that child unwell**

**e.g. by change of behaviour**

**Assessment of child**

**e.g. check temperature, degree of distress, not eating**

**Making sense of the illness**

**Undertook to manage problem e.g. give medication**

**Assessed symptoms**

**Decided if could control symptoms**

**Weighed up situation e.g. disrupt other children versus fear of missing serious illness**

**Monitor child’s condition**

**Contacted others for advice**

**e.g. family, friends, internet, pharmacy, NHS Direct**

**Needed reassurance of second opinion**

**(Due to fear of missing serious illness, need to transfer responsibility, fear of accessing services inappropriately)**

**Is husband present?**

**FACTORS AFFECTING**

**DECISIONS**

**Psychological**

**-Loss of voice of reason**

**-Loss of shared decision-making**

**-Degree of emotional vulnerability**

**Degree of fear, anxiety and fatigue**

**Practical**

**-Time of day (day or night)**

**-Access to transport**

**-Care of other children**

**-Previous experience**

**-Expectations of health services**

**-Medical knowledge**

,

**Discussed, shared decisions with husband**

**Reassess if can control symptoms**

**Assessed which service appropriate considering time of day and seriousness of injury/illness**

**e.g. GP, ED, emergency/ urgent care medical helpline service**

1. Number committed to taking part but unable to do so on the day the focus group took place [↑](#footnote-ref-1)
2. Consultation was with child whose age/ gender is highlighted in bold [↑](#footnote-ref-2)