WHEN PARENTS TELL THEIR STORIES

NARRATIVE INTERVIEWS WITH PARENTS OF SMALL CHILDREN IN THE CONTEXT OF CHILD HEALTH CARE [1]

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”Everything was just great, I was, well, 27,
and I was like, starting to long to have a baby, you know,
Kennet, he’s already got two kids, and he’s older than me,
but I guess he thought that, well, a bit too early,
we’d been together for a year or so when we started Emma,
but everything was pretty, pretty good, or,
now afterwards you notice that maybe it really wasn’t that great
when you start thinking back on it,
but I thought, well, we’d talked it over and it was OK with him
and we did want to have a baby, so then, then we started Emma ...”

(Quote from an interview in this project, with permission)

In 1988 I had been working many years as a family counselor and wanted some more specific skill training. Finding no program in Sweden that I liked, I approached Einar Øritsland, secretary of Church family counseling in Norway. Could I enter their Further Education program, that I had heard very good words about? Einar shook his head, smiling, ”I don’t think I have very much to teach you, but ask Harry Goolishian in Galveston. He has the kind of training you are looking for!” Traveling from Dalarna, a rural district in central Sweden to Texas was a big change. It took me some time to grasp that the change in thinking would be yet bigger. Bit by bit I understood that what I would get was something much wider than skill training. The ideas around language and dialogue, the generosity, the openness of the faculty in showing their work, it all thrilled and confused me. I also learnt about Tom Andersen’s work in Norway and took part in conferences on both sides of the Atlantic over the years.

In 1996 I was taking part in a new training program, this time actually taking place in Norway. As part of the program I was to do a research paper. I saw this as a new chance to explore how relationships are formed in language, in ever-changing stories. Here I want to tell about this recent study, and about some scientifical and clinical dilemmas I have run into through this little piece of empirical work. As my dilemmas seemed to occur in the midst of solving practical problems I have chosen to describe some of the stages of the study in detail, rather than talk about principal issues.

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[1] The outline of this study was presented at a seminar at the Houston Galveston Institute in February 1996. I want to thank the faculty for the inspiring discussion and good advice on literature and procedures and for the E-mail encouragement from then on.

STARTING A FAMILY

As a family counselor I often met women in a divorce situation explaining the difficulties in their marriage: ”Well, I think it started when I came home with our new-born child.” They told, in detail, as if it had happened yesterday, about feelings of confusion and abandonment the first weeks with the first baby, and how this disappointment had marked the relationship from then on, maybe for many years. I was intrigued with how significant and vulnerable that time seemed to be in the shaping of a family’s life.

My interest in the time around infancy remained. I was given the opportunity to work as psychologist within the Maternity and Child Health Care. The work included consulting with midwives and home visiting nurses around infant-parent relationships. I met nurses and doctors who worked diligently with troubled families and with children who were in danger of being neglected or badly treated. Some of these families came back in my thoughts, over and over again. They needed help and asked for it. But they were not content. Even the professionals were not satisfied with their own contribution. Did they fail to understand what the parents tried to say, or had the parents not come to terms with what kind of help they needed?

I became more and more curious about what this dilemma would look like from the families’ side. What would the ”psychosocial approach” that was written in the Child Health Manual mean in these situations? In the ”Galveston-corner” of my mind I pondered, how about paying more attention to the parents’ description of their own family life? What would that perspective say about the family’s need of support in a tricky situation, what could be said about the relationship between family members and professional helpers? I approached the Regional Child Health Care Unit and the Dalarna Research Institute about a study including interviews with parents, got very good support there and started the study in cooperation with these institutions.

THEORETICAL FRAMEWORK

Origins/foundation/underpinnings/for my interest in this kind of research is doing family therapy and staff consultations along the lines of collaborative language systems theory (Anderson 1995). It is also inspired by/This in turn builds on ideas about languages as shared activities (Gergen 1985), about scientific enterprise as socially constructed together with the people involved in the study (Shotter 1993) and about meaning originating at the boundary where systems meet (Seikkula, Altonen 1995).

To make an inquiry from the position that relationships are formed in language, what would that mean? The way I tried to apply the ideas was to create the study together with the institutions I was interested in, to give the interviewees feedback from my thinking about our conversation and to describe the process and outcome of the study in a way that would facilitate dialogue with the local health service professionals. In this paper, as a part of the same approach, I want to describe the context where the study was carried out.

CHILD HEALTH CARE IN SWEDEN

The Maternity and Child Health Care is part of Public Health Care, and is free of charge. The services are not mandatory, but very rarely is there a family living in the district who do not turn up at all at the station.

Child Health stations were established in Sweden in the late thirties. Mainly, the aims were to support breast feeding, teach good personal hygiene and give vaccinations. In our country the threats against children's health are no longer malnutrition and T.B. Today's health problems for young children often touch areas of caring, parent - child contact or difficult circumstances around the family. Psychosocial aspects enter into health care; issues concerning relationships within the family and between family and community.

Psychosocial Aspects

Child Health Care today is founded on a comprehensive perspective on health in families. However, when nurses and doctors make efforts to include psychosocial aspects in their daily work they often seem to run into difficulties in defining the aims of the work, and some end up in a lot of frustration of not being able to help needy families. Those who stay in a medically defined role for their health care work do not seem to have the same difficulties. The Health Care Manual highlights a comprehensive perspective, but rarely explains what this means in the daily work.

When Society Defines the Problems

These is an important theoretical dilemma in the establishing of a health oriented approach in comparison with a more treatment oriented approach. Preventive work is based upon what it is supposed to prevent. This implies a risk that the definitions of what should not happen will guide concept formation and classification/categorization of information. The ideas of language as not just representing reality but also forming reality have brought about a critical view on the fact that psychological terminology to such a great degree describes dysfunction, and thereby contributes to defining people by their problems and deficiencies (Andersen 1996) (Gergen 1994). In the Maternity and Child Health Service, the expert language of dysfunction also contributes to practical difficulties in seeing the psychosocial aspects of health work, and what the staff at the Health station are to do with it.

In the sequence of pregnancy, childbirth and infancy many things happen, a lot of experiences, happy, terrifying, or confusing, are processed, and a lot of actions have to be taken. In the midst of these events, experiences and actions, the child is forming a sense of self, and the parents - and other people around as well - are, more or less, changing their sense of self. A comprehensive view on Health Care could benefit from taking into account these relational issues of identity and basic orientation in life.

Connection Between Health and Social Support

A longitudinal English study about the relationship between class inequality, social support and health service for mothers and children (Oakley, Hickey, Rigby, 1994) highlights the importance of social support. Oakley et al started from the statistical evidence in many studies, that poor economy is somewhat connected to poor health. When the factor social support was added, the results split up. With good social support, both from family and friends and from health service there was no evidence of differences in health between richer and poorer families. When social support was lacking, there were considerable differences in health in between the groups. From this perspective it is particularly interesting what kind of support that the parents themselves identify as supportive.

FINDING A PLATFORM FOR A STUDY

The fact that the health visiting nurse (district nurse) comes home to all new-born babies means that you have a structure where you start a treatment relationship where the patients not neces-

sarily define themselves in a patient role. This quality of relationship can continue when ”everybody goes there” to the Health Station for check-ups and vaccinations. Doing the study in the Child Health Care environment therefore enabled me to see parents who did not connect our meeting to a predefined category of problems or symptoms.

The aim of this study was to look into what kind of psychosocial needs that families have, and how they could get support from Child Health Care. Offering a broader understanding of *how* families can express their needs and how the needs can be seen by the staff, that was the idea. It therefore became important to seek a method of exploring psychosocial aspects of health care issues without being bound to predefined categories. Finding ways of interviewing and interpreting that served the purpose of the study also was crucial.

Planning the Project

In the study I chose to interview parents with small children and invite them to tell about the family’s life and situations when they had been in need of support. In the context of the parents’ description of the life of the family, I wanted to study how ideas of ”need of support” are expressed. Also I wanted to study what meaning would be ascribed to the encounter with the health care people in that context. The interviews were analyzed along the lines of/according to/as narrative research.

I wished to explore how parents described their need for support within their description of their lives through their years with the children. With permission from the parents, I was allowed to take part of the health files of the children. Guided by a regional survey that all district nurses involved in Child Health Care had taken part in, I chose a district that filled /the/ two requirements I had set up beforehand: a district with many young families, difficulties around unemployment and social instability plus nurses who were interested in psychosocial issues.

The Ethical/Ethics Committee

As the study was to take place in a medical environment I had to have permission from the Medical Research Ethics Committee. Unexpectedly, the committee turned down my project. They stated that they didn't understand my description and that there were too few interviewees to make the study "scientifically justified". I wrote another application with a detailed description in an ”expert supplement”. This time I got a slightly confusing message. The committee regarded the study as quality check/quality rating/evaluation of quality, lacking the criteria necessary for research ethical review. They had no objections against the study being carried out, but wanted to clarify that this was not to be considered as an approval.

To suddenly realize that I was outside the ”scientific realm” was a challenge. Looking back, I realize that this influenced the study both positively and negatively. On one hand, I spent many more hours reading about qualitative research and testing my ideas in various ways, which gave me an overview that I very much appreciate today. On the other hand, my supervisor, child psychiatrist and psychoanalyst Björn Wrangsjö, commented that I was almost too hesitant in making interpretations and drawing conclusions from the interviews and the literature.

CARRYING OUT THE INTERVIEWS

The doctor in charge of the Health Station I chose was willing to allow my study and suggested which nurses should take part. I met with two experienced health visiting nurses working full time within the Child Health Care, and interested in developing their work. We talked a couple

of times of the aims of my research. I asked them to invite parents currently in touch with Child Health, which meant that the children were 0-6 years old, parents who seemed to have some kind of difficulty or hindrance in the contact with the nurses and doctors. The nurses then chose families from their district, contacted the parents and introduced the possibility for the parents to take part in the study. I was given name and telephone number of the parents who had agreed to be interviewed. Six mothers and three fathers were interviewed.

As ”need for support” was the main topic in the study, it was important that parents who were not altogether happy with their contact with Children's Health, felt free to speak up. Therefore I decided not to interview the nurses who gave me the names of the interviewees, or give them any information from the interviews. The nurse gave the parent an information sheet with a short description of the aims of the project, and a sign-up sheet. The information sheet explained that the Child Health work is founded on a comprehensive view, and that this view requires more knowledge around families need of support. The sign-up sheet said that they were free to drop out of the study at any time without giving any explanation.

I met with the parents on two occasions, interviewing each parent individually at the first visit, if both were available and willing to take part. At the first interview I asked parents to tell me about how life had been during pregnancy and the years with the children to this day. I made a transcript and some preliminary analysis of the interview, and, provided I got the parent's permission to look at the child's health file, I used some of that information. My tentative interpretations were discussed with the parents at the second interview. In the second interview the parents where both had been interviewed could choose to be interviewed together, which all couples did.
All the families who the nurses approached about participation were Swedish, so I chose to include a preliminary interview I had done at the outset. The parents in that family had immigrated to Sweden from two different countries. I interviewed the mother and we talked about many aspects of what it meant for her to establish a family in a foreign country.

TRYING TO UNDERSTAND THE TEXTS

Life Studies

My first framework for interviewing was a narrative research approach, labeled ”Life Studies” (Fischer-Rosenthal 1995, Josselson, Lieblich 1995). The interviewee is invited to tell about life as a whole through the years. The telling is not regarded as a report of what has happened, but a symbolic construction which is formed over time in dialogue with people and life events. The interviewer is also part of the context that will influence the telling.

By making a careful transcription including pauses and intonation I tried to get closer to what the interviewee had expressed in the situation. Many nuances inevitably got lost, but yet, some of the rhythm, pacing and accentuation shone through even in the written text. The main feature of this way of transcribing text was that it highlighted some ”stories in the story”. It was evident in the text that sometimes the interviewee made a conclusion, or repeated something that seemed not very easy to explain.

The Life Studies approach was fruitful as a start, but soon I found that the dialogue in the interviews tended towards a more thematic, less chronological telling. Possibly that had to do with the short range of time I asked them to tell about, 1-7 years, and also with ”the interviewer being interested in child health issues”. This probably encouraged a more thematic telling than had I

for instance been an ethnographer interested in what people remembered from their childhood on. Before the first interview I had had a hope that I would see processes over time, e.g. how the parents at first look out for help in their own network, and, when that is not enough, turn to the Health services. This first interview did not give a time span like that, even when I asked a few questions to get to the ordering of events in time. I also found another problem with finding out that sequence. As the check-ups at the clinic are very frequent in time during the first months, it is hard to find out in retrospect on which occasions the parents have tried to manage on their own or made efforts to get help in other directions before turning to the nurse.

Narrative Analysis

The text analysis involved other problems. The interpretations in the Life study tradition often seemed to imply psychoanalytical ideas of what was ”behind” the telling (Bar-On, Gilad, 1994). I had to look into a wider range of qualitative research ideas in order to find instruments for further thinking and sorting of my ever-growing transcripts and literary sources. I got inspired by papers which included interviews and were outlined from a social constructionist perspective (Levin 1993, Hydén 1994). The booklet ”Narrative Analysis” (Riessman 1993) provided a simple framework for thinking about research, ”five stages of recording an experience”, Attending, Telling, Transcribing, Analyzing and Reading. Each new level contains changes, losses and additions, and the task of the researcher is to be interested in these changes. For research to be meaningful, something of the first level must still be there in the fifth. I applied the scheme to this study, in order to highlight the efforts to lose as little as possible in the transition between the stages:

> The transition Attending/Telling was facilitated by the fact that the nurse was a person the families had known for quite some time. That the interviewees could choose to meet at home or at the Health Station also might have helped a little. (All of them chose to meet at home). The careful transcription reduced the deformation in Telling/Transcribing. A second interview with the same interviewee gave a chance to reflect on Transcribng/Analyzing. Material from the study will later be used is used in further education program for Health Care professionals. This might provide some feedback from Analyzing/Reading. In qualitative studies it is essential to describe the whole of the research process, by making the changes between levels of recording and recalling as visible as possible. (Steedman 1991). Yet, reflecting back and forth between different stages, highlighting the changes, could be seen as the core of every research process.

Categories of Telling

At the outset I didn’t want to sort the text in different kinds categories according to the style of telling. Soon enough, however, I found the text overwhelming and tried to find a way of sorting that would obstruct the text as little as possible. Dr. Susan B. Levin at The Houston Galveston Institute directed me towards ”Qualitative Interviewing, the Art of Hearing Data” (Rubin & Rubin 1995). There I found a lot of practical aspects of interviewing, an also some categories of telling that fit nicely with my material. The types are illustrated with examples from my interviews. NARRATIVE represents a rather straightforward, not very emotional telling, ”Coming home with my first child, I got a lot of comments from my mother, like... and then... ”. FRONT is referring to an generally acceptable attitude, ”I don’t think that children always should get their way”. ACCOUNT is an explanation of something that might be regarded as not socially acceptable, ”I’ve found a wonderful baby-sitter, therefore I can work long hours”. STORY is a telling that communicates a moral, or something that cannot be said in a straightforward way ” ‘I

asked the nurse [after the delivery of the baby] are we supposed to take care of her now?' She answered: 'Yes now, and for the next 18 years' ". The last category, not represented here, MYTH, is a story that is shared among many and communicates an explanation of otherwise mysterious phenomena. By doing the thorough transcript from the life study tradition, and thereby seeing the rhythm in the telling, and then sorting the parts that had come out that way into these boxes, I could interpret a focus on the different parts, and get good questions for the recurring themes of each interview/the main themes that were coming back in each interview respectively.

When assigning these categories to different parts of the interview text I noticed that there were no variations in proportions between/of different categories for men and women./The differences/variations in proportion between different categories of stories were not tied to whether the interviewee was a mother or a father. The most noticeable difference was that parents who were in an ongoing conflict situation had more "front" and "account" parts. Parents who talked about the difficult times as something that they were through by now had a larger proportion on story and narrative telling.

Should I Interpret Interviews One by One or Together?
Although the interviewees did not share a lot of information about family background and I did not ask very personal questions, some different foci for each interviewee come out very profiled, and show how many different lives, and how many different needs there are when in the process of forming a family and coping with various challenges. I asked myself: "Should I turn to the kind of interpretation that stays within one interview, and not try to look at how other interviewees had mentioned the same theme?" I decided to go two ways. I made one set of 'main theme' sorting, finding an important message that the interviewee told early in the dialogue and kept coming back to. I also looked at how some topics were more or less frequent in different interviews.

The quote at the beginning of this paper is what I saw as a main theme from one of the interviews. Having read through the whole interview, I saw this quote as a poem expressing all the feelings about what the interviewee expressed in prose later in the telling; the great love for her daughter, the shock of discovering that the relationship was not workable, the decision to leave during pregnancy in/to a new town with a new job, finding ways of managing the situation through childbirth and the first months afterwards.

Issues of Identity
Looking for main themes gave thoughts on self narrative, and the interviewees were weaving complex and intriguing stories about their life with their children. One mother of two announced that "both the births were easy ones" and continued by telling how she had screamed at the nurses at the Delivery ward, and had tried to bite her husband's hand, and "never again I wanted to go through this", then mentioned again a little later in the interview that the births were easy. For this woman "becoming a mother" was an issue she had worked a lot on. She described how she looked at other mothers, wondering how they could hear their child cry and know if the baby was wet or hungry. "But now, having my second child, I know more of what I can check on, so I don't worry any more that I still cannot hear what they are crying for.

COMPUTER AIDED STRUCTURING

The material had become so large that I wanted some way of sorting themes and yet keeping the focus on the interviewees' stories and ways of telling. In a late stage of the project I did some categorizing within the software QSR NUD*IST (Richard & Richard 1994), Nonnumerical Unstructured Data Indexing, Searching and Theorizing.

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I made one indexing applying the categories of telling mentioned above (Rubin & Rubin 1995) and one set of indexes for various topics like ”talking about doctors”. Assigning categories is a very subjective activity, but the possibilities of different ways of indexing and sorting the material enables more ideas to be tested. As many of the themes mentioned in the interviews could be of interest for professionals, I appreciated to get an overview. To be able to look at all the things the interviewees had said about doctors could gave idea of a range of expectations on doctors that differed very much from the expectations on the nurses. Some of the topics were mentioned only by women, others only by men in the interviews. Several women, but none of the men, asked ”is this the way most children are? Only women mentioned difficulties or ambivalence between mother and grandmother. Only men talked about parenthood as something you need to mature into and mentioned how life is changed after the first child and commented on the socio-economic issues for families with children.

Checking out Preconceived Ideas

Had I used the program earlier on in the transcription work I might have been able to sort through more issues of preunderstanding. Now only some instances were highlighted, when some things did not turn out as I, unknowingly, expected. In the beginning of the transcription work I had an impression that the men used a more emotionally loaded language than the women. Looking more closely at the material I found that men and women were about as emotional through the interviews. In that way I noticed my earlier expectation that the men would be less emotional.

I interviewed a mother who shared how much her own mother meant for her during the first year of her daughter's life. She described their relationship vividly, in a very warm way. After a while she hesitated, saying, ”Maybe I should have managed more on my own, not crying out for mom as soon as I got into trouble.” While transcribing the interview I wondered if this comment was something that you were supposed to say to an interviewer/professional in our independence-oriented culture. She also described the relationship to the nurse at the Health station as warm and reliable.

In the second interview I mentioned that the mother had talked warmly about her mother and also hesitated some. She more or less repeated what she said the first time. Similar things happened with other interviewees at the second meeting. The choice of narrative interviewing seemed to contribute to a situation where the interviewee comes very deeply into his/her own story. The researcher's questions from reading and interpreting is ”another story” which does not fit with ”my story”. Nevertheless the first interview told me something about how interrelated the support from family, and support from professionals can be at that stage in life.

RELEVANCE AND APPLICABILITY

Although categorization of text is a very subjective matter, looking for categories of telling rather than psychological categories enabled a reading where several themes emerged that were not there in the planning of the study. The careful transcription made it easier to see what the interviewee emphasized at the moment. The extensive and very personal search for literature in the

field enabled new connections of ideas, but will probably make it more difficult to assess the relevance of my interpretations compared to other possible ways of looking at similar situations.

One interviewee had related how she had disliked the interest the nurse and doctor took in her own life when she went to the Health Station with her first child; she wanted only to talk about the baby. Now she had her second child, and liked their interest and support very much, and particularly appreciated that the nurse had continued the contact with her through the years, despite her negative attitude at the outset. ”Do you never get tired of me?” she had asked. ”No, I don’t” the nurse had responded. My interpretation was that the nurse’s intention to stay in the relationship enabled the mother to be aware of needs of support that she did not have, or did not recognize before. The same sequence could be looked at from attachment theory point of view. The nurse provided a secure base that the mother could start from in developing a secure base for her children.

Staying close to the interviewees’ own interpretations can be seen as a way of validating the study. On the other hand, applying more widespread ideas could increase communication with other cultural and scientific arenas. Apart from very technical descriptions of combined qualitative and quantitative research designs (Sells et al 1995) I have not seen so much of alternative ways of thinking on any one area of interest in a study. Does the classical academic ”defending a thesis” pattern set the rules even for qualitative, multicultural and social constructionist writers?

THE CONTINUING DIALOGUE

The outcome of the study is meant to be used in the Continuing Education program for the regional Child Health Care. In a local meeting for Maternity and Child Health Care staff I shared the story of the mother who refused personal contact with the nurse until the second child came along. One of the nurses declared that she and many of her colleagues probably had regarded their work as not very good, if they had been met with/faced similar attitudes. She described them/hersef and her colleagues as wanting immediate feed back in order to have a sense of efficiency in their work. The discussion that followed showed me a glimpse of that a dialogically oriented study, close to the participants’ perspective, can be fruitful for professional development.

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