Treading the qualitative tightrope: data as 'atrocity stories' and data as fiction.

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SOME BACKGROUND TO THE ORIGINS OF THIS PRESENTATION

- ‘Aren’t these just atrocity stories?’
- Drawing on data from a study of women (who have experienced domestic abuse) talking about their interactions with general practitioners to:
- Illustrate and explore the analytical challenges of *doing justice* to one’s data:
  - Start a conversation about surfacing hidden/implicit practices in analysis and presentation of qualitative data and, to
  - Propose a set of questions to help elucidate these practices.

BACKGROUND TO THE DATA – POLICY & PRACTICE PURPOSE

- Series of qualitative interviews with women who have experienced abuse.
- Part of a Chief Scientist Office funded evaluation of a scheme to communicate domestic abuse incidents to GPs so as to increase opportunities for disclosure of abuse and to improve subsequent care to women – Police To Primary Care.

BACKGROUND TO THE DATA – THEORETICAL PURPOSE

- Candidacy (Dixon Woods) & Structural Competency (Metzl & Hansen) – the two theoretical concepts explored
- Data on women's experiences of engaging with GPs in the context of DA – did GPs recognise the symptoms of abuse, did they seek disclosure and how were women's circumstances understood and taken into account in consultations over time.

- Paper submitted to Sociology of Health & Illness: 'You certainly don't go back to the doctor once you've been told, "I'll never understand women like you."' Seeking candidacy and structural competency in the dynamics of domestic abuse disclosure. Sociology of Health & Illness 41(6): 1159-1174 https://doi.org/10.1111/1467-9566.12893

- Reviewer 2 comments – advising me to be mindful of atrocity story-telling and to position myself in the great atrocity story debate ….

EXPERIENCES OF DOMESTIC ABUSE AND RESISTING 'ATROCITY STORIES'

- The atrocity story (Carol Thomas)
  - Transatlantic feud about the purpose of sociology and the qualitative interview
  - Emerging from medical sociology and relating to how patients talk of their doctors and of how health care professionals with less status talk of their higher ranking colleagues. Narratives as performances.
  - Atkinson – researchers should attend to the form rather than the content of a narrative account – be mindful primarily of the social processes that it reveals and to be mindful of truth claims. Avoidance of the individual showcasing at the expense of identifying social structures.
  - Bochner – narratives as stories through which we learn of experiences – qualitative researcher as advocate

EXPERIENCES OF DOMESTIC ABUSE AND RESISTING 'ATROCITY STORIES'

- My reaction to the 'atrocity story' critique.
  - Initial reaction that labelling women's narratives as potential 'atrocity stories' is a form of symbolic silencing – silenced by their victims, they have often been silenced by service providers and now by research?
  - Considered reflection that my data were not being told as atrocity stories, that material and structural connections were being made across individual stories and that my analysis foregrounded such.
  - That researchers can be critical friends of their data – recognising the socially constructed nature of narratives, attending to social processes WHILST taking the gist of narratives as non-fiction.

‘We acknowledge that such narratives are social constructions produced by research participants as they interact with researchers rather than a verbatim report of speech and emotions generated by events in the sometimes distant past. Instead, in our view, they provide an important window into how women reflect on their experiences and, like Thomas (2010), we view such constructed narratives as emerging from material realities. Identity management and other discursive practices patently are at play, as they would have been in an imagined set of GP narratives, but, even so, unless we view such narratives as elaborate fictions or even falsehoods, we can still use them to see glimpses of material circumstances and structural forces at play over time’. Mackenzie et al (2019)

EXPERIENCES OF DOMESTIC ABUSE AND RESISTING 'ATROCITY STORIES'

- Researcher reaction to the 'atrocity story'
  - Initial reaction that labelling women's narratives as potential 'atrocity stories' is a form of symbolic silencing – silenced by their victims, they have often been silenced by service providers and now by research? An offensive term guilty of the sensationalism it abhors.
  - Considered reflection that my data were not being told as atrocity stories and that material and structural connections were being made across individual stories
  - That researchers can be critical friends of their data – recognising the socially constructed nature of narratives, attending to social processes WHILST taking the gist of narratives at face value.
  - BUT a recognition that greater transparency is called for and greater guidance is needed in achieving that transparency.

SHOWING MY ROUGH WORKING

- Took a data extract and undertook, retrospectively, to do the following:
  - Understand my analytical approach
  - Understand the ‘truth claims’ being made by participants and by myself as researcher reflecting on the methods used to gather the data
  - Describe how, implicitly, I was attempting to ‘purpose’ the data
  - Consider ethical aspects of using the data

MARIANNE

‘I think they were just waiting, that’s the most horrible thing tae be told, “D’you know something, we’ve been waiting on this for ages.” My GP personally was just kinda like, “Oh aboot time!”’.

‘They’ll look at you and think, ‘Well you’re still with him, so it’s your own fucking fault’. . . . “Are you still in a relationship wi’ Kevin?” I’m like, “Yeah.” An’ they just sorta look at you, “Well see you next weekend then?” ‘I don’t wanna bad-mouth my doctor in that sense ‘cause it’s bound tae get a bit like frustrating like, . . . “So are you still in a relationship wi’ this guy?” “Uh huh.” An’ they go, “Right,” like it’s your fault, like “okay, I’m sorry.” “Well just leave him.” I’ll just go home an’ leave him tomorrow an’ that’s it”. It’s never that easy. An’ the amount of phone calls I made because I couldn’t get him away from my flat. I got him out the house but I couldn’t get him away from my flat. An’ the doctor doesn’t know the half of what I’ve went through’.

‘he kinda just yawns upon my appointments now, “Oh is it you Marianne?” That’s how bad it is . . . I feel he’s bored, he’s bored of my situation. I think they’re all bored of it really . . . I felt like I was being a burden tae them so sometimes I just wouldn’t go’.

ANALYTICAL COMMENTS

Construction and repression of candidacy: The recognition of Marianne's abuse is hampered by GP failure to ask the question and by a perceived lack of interest in her case. This is thought to be exacerbated because Marianne is currently using drugs.

Structural competency: The data point to features of perceived service provision which are insufficiently attentive to the ways DA is practiced – this limits the potential for sensitive health care.

Stigmatisation: This example carries echoes of Groves 1978 concept of 'the hateful patient' where doctors identify: 'dependent clingers, entitled demanders, manipulative help-rejecters and self-destructive deniers' as a category of 'insatiable dependency' (p. 883). Marianne's doctor does not need to use this language explicitly for her to identify an implicit judgement.

RESEARCHER RESPONSE TO THE DATA

- Emotional response to the data
- Recognition of power of/in data
- Recognition of fit (alongside contrasting and corroborating data from other participants) with conceptual frameworks and of theory-building potential
- Recognition of the ways in which the interview (and perhaps previous narrations of DA experience) will have shaped the telling of the story
- Identification of truths even if not literal truths.
- Identification of policy/practice recommendations.

ETHICAL CONSIDERATIONS – FOR WHOM DID I IMPLICITLY CARRY ETHICAL RESPONSIBILITY?

- To Marianne – 'truthful rendition' of what she has said (and meant?)
- To the wider population of women of whom the study intends to speak
- To the imputed professionals (whose voices are not heard)
- To wider disciplinary/policy learning

AVOIDING ATROCITY STORY TRAPS

- Recognising that there are no parallel data from GP in question and telling the story as though whole from only one perspective.
- Avoiding making ‘atrocity’ generalisations to a homogenous professional group
- Seeking and representing counter examples (as part of a broader strategy of seeking examples of consensus, conflict, absences)
- Reflexivity around our own emotional responses to the data
- Recognising potential/implicit tendencies to clutch onto confirmatory or sensational quotations
- Commitment to examining data through conceptual frameworks that attend to the patterning of social phenomena.

EMERGING QUESTIONS TO SELF

- What do you expect data to do and for whom?
- How do methodological, analytical, ethical considerations play in?
- How to achieve critical balance between atrocity story fact and fiction?
- What are the markers in qualitative accounts of that balance?
- How much rough working do qualitative researchers need to show to conform to the emerging research integrity and openness agenda?

WHAT DO YOU THINK?

REFERENCES

Mackenzie, M., Gannon, M., Stanley, N., Cosgrove, K., Feder, G. (2019) 'You certainly don't go back to the doctor once you've been told, "I'll never understand women like you."' Seeking candidacy and structural competency in the dynamics of domestic abuse disclosure. Sociology of Health & Illness 41(6): 1159-1174. https://doi.org/10.1111/1467-9566.12893

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