CHAPTER 12

LOOSELY STRUCTURED INTERVIEWS: THE STORIES BEHIND THE STATISTICS

EXEMPLAR

Blaxter, Mildred (1993) 'Why do the victims blame themselves?', from Radley, A. (ed.), *Worlds of Illness: Biographical and Cultural Perspectives on Health and Disease*. London: Routledge. pp. 124–42

What you need to understand in order to understand the exemplar
What questionnaire researchers are trying to achieve by 'forcing' responses to questions – structuring the data prior to collection, and by adopting a standardised way of administering a survey. *See Chapter 10, section 14 and Chapter 16, section 1*
What problems the above give rise to and how loosely structured interviews are seen to solve them. *See Chapter 16, Section 2*
The meaning and procedures of the 'thematic analysis' of qualitative data. *See Chapter 16, section 2*
The kinds of generalisation which qualitative studies can produce. *See Chapter 16, section 8*
For any terms which are unfamiliar, try the index.

Introduction

With interviews that involve a questionnaire there is usually a prescribed order for asking the questions, and a prescribed wording for asking them, and only such matters as are already included in the questionnaire get recorded. This means that to a considerable extent the responses are already shaped before any respondent actually answers a question. For a loosely structured (or 'in-depth') interview the researcher will typically have a list of topics which the interview is supposed to cover, but latitude to ask about them in any way and in

any order that seems appropriate, and the researcher will feel free to follow up previously unpredicted but interesting lines of enquiry. Such an open-ended approach then generates data which have to be organised after the interviews have been conducted.

The exemplar for this chapter provides a contrast between questionnaire research on the one hand and loosely structured interviewing on the other. The author, Mildred Blaxter, was one of the team involved in the large-scale Great Britain Health and Lifestyle questionnaire survey. With a large representative sample this was able to produce reliable generalisations about patterns of health-relevant beliefs and behaviours on the one hand, and patterns of morbidity and mortality on the other. However, while a questionnaire survey can gather data from a large and representative sample, it does this at the cost of only collecting small pieces of information from each respondent on each relevant topic. Typically, as in this case, most such data are in the form of yes/no/don't know or in the form of strong to weak agreements on a four- or five-point scale with statements provided in the questionnaire – a so-called Likert scale. Representative and reliable such responses might be, but what people mean by them can be puzzling. For every 'yes' and every 'no' to the same question there are almost certainly a variety of meanings. The loosely structured interview study reported by Blaxter investigates what respondents might mean by their responses on the Health and Lifestyle questionnaire to a question about whether people are personally responsible for their own state of health. The relevant page of the interviewer's instructions for asking questions is given as Figure 16.1 in Chapter 16. The exemplar also illustrates the thematic analysis of qualitative data (see Chapter 16, sections 2 and 6).

WHY DO THE VICTIMS BLAME THEMSELVES?

Mildred Blaxter

This investigation of what it means to say that 'the victims blame themselves' is presented as an example of the interaction of qualitative and quantitative methods. The question, raised by the inevitably superficial results of larger-scale surveys, is: Why do those who are most vulnerable to the environment seem to be most likely to stress self-blame for illness and self-responsibility for health? Can a biographical approach suggest some answers?

There are, of course, two perspectives on the determinants of illness, and especially the causes of social inequality in health: the idea that ill-health is primarily 'self-inflicted', and has behavioural causes, and the view that the major causes are structural and located in the environment. The extent to which people themselves

subscribe to one view or the other is a topic which surveys often investigate, and though the alternatives are not necessarily mutually exclusive, the brief questions of surveys ('What is the cause of heart disease?', 'Do you think people are responsible for their own illnesses?'), perhaps with forced choice answers, tend to create dichotomies. One consistent finding is that although most people, of whatever social group, have learned very well the self-responsible lessons of health promotion, it is those who are most 'unequal' and most exposed to environmental risk who are least likely also to be aware of the structural perspective. Those who are in the lowest social classes, or have the least education, are most likely to confine their explanations to behavioural causes. The idea that the socially fortunate may be healthier is often flatly resisted.

The survey evidence

As evidence of this, a brief summary is offered of data deriving from the Health and Lifestyle Survey (Cox et al., 1987; Blaxter, 1990), a national sample survey, conducted by interviewers, of just over 9,000 respondents of all ages 18 and over. The design and analysis of the sections on beliefs and attitudes of this particular survey were strongly influenced by the experience of qualitative work. The relevant questions – about the causes of specific diseases, about the healthiness of the respondent's life and the perception of 'healthy' behaviour, about effects on health 'nowadays' for society in general, about the reasons for naming a 'healthy other person', and about attitudes to various health-related areas of life – were, deliberately, asked several times, in different contexts and in different ways, and almost always in open-ended format. Thus, the conclusions which follow are derived from the patterns of reply to many different questions throughout the survey schedule.

This method permitted the analysis to accommodate, in an imitation of qualitative methods, the sometimes contradictory and seemingly confused answers which any individual can produce on the complex subject of health. In particular, context was shown to be all-important. When the questions were about specific, named diseases, behavioural answers were overwhelmingly predominant: poor diet or lack of exercise could be the cause of almost any chronic disease. For ill-health in the abstract, considering 'what makes people unhealthy', voluntary behaviours were again primarily indicted, with little differentiation by social class or education. A surprising number of people asserted that more people smoked nowadays, compared with a generation ago, and illegal drugs received a perhaps undue emphasis. In the context of their own health and their own lives, rather fewer gave behavioural replies, as common sense might suggest: nevertheless, this was still the most popular form of answer: my life is unhealthy because I can't control my weight, because I smoke; it is healthy because I take exercise, because I watch my diet. [. . .]

It can be concluded, on the evidence of this one large-scale survey at least, that the lessons of public policy and health education – 'you are responsible for your health' – have been accepted, or at least that the population is aware of the 'correct' answers to give about the causes of health and ill-health. And, though it depends on the context in which the question is asked, it is those with higher incomes or better education who are also likely to be aware of the evidence of sociology and social epidemiology which stresses structural and environmental factors. [. . .]

The search for explanations

Why should this be so? There are possible explanations of a rather facile nature. It could be argued, for instance, that although this emphasis on the behavioural, as a taught response, has been generally very well learned, alternative or additional modes of explanation are more available to those who are better educated or more exposed to 'scientific' media presentations. The middle class are also more likely to belong to contemporary consumerist and environmentalist movements. It might also be suggested that these findings are no more than an artefact of method: the more articulate are more likely to give elaborate answers in the survey situation, and the less well educated or those without a ready vocabulary of abstract concepts are likely to seek the line of least resistance and give the easiest answers perceived to be the approved ones. Certainly, it was true in the Health and Lifestyle Survey that education of the respondent was, in general, clearly associated with the length of their open-ended replies or the number of different concepts that an individual expressed.

Are such explanations sufficient? If they are given time to express themselves in a situation less reminiscent of a 'test', is it true that those who are in the poorest social and economic circumstances are still least likely to place the blame for ill-health on their environment? And if it is, how do the disadvantaged, in fact, interpret the relationship between their health and the circumstances of their lives? To answer these questions, ideally, new and clearly focused research should be mounted. In the absence of this ideal, there is the possibility of an alternative strategy: to return to a re-analysis of the qualitative material which initially provided some of the themes guiding the analysis of the Health and Lifestyle Survey.

The qualitative data

The data referred to are long tape-recorded conversations with a group of 47 Scottish women of about 50 years old (Blaxter and Paterson, 1982). For other purposes of the study, they had been randomly selected from women who, at the time of their first childbearing 30 or so years before, were in social classes IV or V, and whose adult daughters lived in the same city and were still in the lowest social classes. Thus they belonged to families, neither geographically nor socially mobile, who were likely to have some generations of economic deprivation behind them: a group among whom the relationship between social circumstances and ideas about the cause of ill-health could be clearly tested. The data used here consist of interviews, usually lasting for an hour and often much longer, in which the conversation was guided to cover the woman's health and health history, and her attitudes to illness, doctors and health services.

It must first be noted that the personal and family histories of the women demonstrated not only social deprivation in past generations, in their own childhoods, and at the time of their childbearing (in the early 1950s), but also the very clear association of this deprivation with ill-health. As Herzlich and Pierret (1984) noted of their French respondents, 'the memory of the terrors of the past remained astonishingly vivid'. Diphtheria and scarlet fever had swept through families:

> Because I remember when I was taken away with scarlet fever. I mean, that night is as clear to me as though it happened last week. I wis only four, right enough, but I remember the hospital being packed wi' kids. My husband – there was him and his two brothers – the three of them were taken out o' the house one night and my husband wasnae expected to come back. And after he did come back from the hospital he took it again. (G37)

Six of the 47 women had had TB, and several of their own children: one woman described how her son had caught TB from 'sharing a bed with a lodger, when he came home from sea – we didn't know he had it, you see'. A stark lack of adequate food, clothing and housing was described in the days before the Second World War:

> I always had sore throats, septic throats and that. Before I had diphtheria we stayed in an old house – my mother blamed that. We'd only one room and there was six o' us in one room, two beds in one room at that time. An' your sink was just on the stair an' outside was your toilet. (G3)

As young women in the 1950s their circumstances had been little better. Many husbands had been working away from home or otherwise absent, and almost all the women began married life either subletting crowded rooms from parents or other relatives, or renting crowded, damp slum property often without running water or inside sanitation. They represented themselves, at that time, as having little control over their fertility. Over half had conceived their first child before marriage, and twenty-nine of the forty-seven women had borne four or more children.

They were very conscious that part of the ill-health of the past had been due to an absence of medical services, and told many stories of not being able to afford or obtain care:

> When you had to pay for a doctor – well, to this day my mother still says that wa the reason I took rheumatic fever. Cos I took scarlet fever – and I was ill for a few days, and my mother took me to the dispensary. Now, I had to walk there, cos my mother didn't have the tramcar fare. With the result – I got my chill – we had to walk to the dispensary because it was free there, we couldn't afford to pull in a doctor. Cos my mother would have had the doctor in her house – well, at least twice a week, because she had eight of us. (G1)

[. . .] They were, however, very conscious that 'things had changed'. These family stories were usually told in the context of praise for the National Health Service, universally given credit (together with the 'medical advances' that had provided a cure for TB and, in their eyes, had been responsible for 'conquering' the childhood killers of the past) for major advances in health. One woman concluded by saying 'We hinna got that worry nowadays.'

Many of the women were of rural background. This acknowledgement of the effects of poverty produced some conflict with another strong and almost universal theme: the wish to present the days of their youth as in some sense 'healthier', with simple good food, fresh air and sensible living. This was an obvious appeal to a 'golden age' of the past, a response to all they disliked about modern life or all that irritated them about the way in which their grandchildren were brought up; in part, it represented the childhood memories of the rural as opposed to the urban, perhaps typical of a generation experiencing the period of rural depopulation. [. . .] At the same time, it would certainly be untrue to say that these women did not have a clear perception of the causes of their own specific, current chronic conditions lying in past circumstances. They seemed to be saying that their simple, healthy childhoods (leaving aside infectious disease, which was simply an ever-present but unavoidable danger, now removed by medical science) had provided

them with a reserve of good health, better to withstand the attacks that later life circumstances might make. At the most difficult period of their lives, which most saw as their young married days, neglect of their own health had been inevitable. One woman was clear, for instance, about the cause of her long-term arthritis:

> Well, put it like this, when you've got young family you've got a lot of hard work. More so when you have five. It's nae easy work. And we'd nae washing machines, nae hot water, nae sink – well, we had a cold sink in the corner . . . there was a lot of hard work, there was stone floors. (G19)

Another had similar views about arthritis in her knees:

> Gaun aboot wi' auld shoes on – gaun aboot getting my feet soakin' – maybe, if I'd taken mair care o' mysel' earlier on. But wi' kids, no money for yoursel', you couldnae dae it. (G23)

Later, however, this same woman talked at length of the simple, austere upbringing of her own children, and explained how 'healthy' their childhoods had been by the same sort of reasoning that other women applied to their own childhoods:

> Well, my four was healthy. They was never pampered and wrapped up. They niver wore scarfs and hats in the winter time. They were jist out in a' weathers. And they jist ate a' thing that was going. And yet they were healthy.

To neglect their own health in the way they now admitted they had done meant that they were responsible, but on the other hand no one could have behaved differently:

> Three times in the city hospital with tuberculosis – I called it neglect. Well, I had pleurisy before my twins were born, and I cracked my ribs just before A. was born, and I had pleurisy, and I had naebody in, wi' six o' them, you know. And I had pleurisy, and there was naebody to look efter me, I just used to come an' get my poultice and heat it at the fire and put it back on. It was really neglect – my own – well, no my own fault, I had to look efter my bairns, you understand. (G7)

Many other women similarly struggled to reconcile a strong sense of self-responsibility with the conviction that all their health problems stemmed from childbearing and the difficult days of early motherhood. To present the process as one of self-sacrifice and 'good' motherhood was an obvious solution:

> When they were young, if I was ill, I couldn't afford to be ill and that was all there was to it. Because he was at sea and there was naebody. There wasn't anyone to watch the kids. If I was ill I still had to get up and work, you know – you couldn't be ill. (G25)

Immediate causes

This was all in the past, and things were different now. All the women felt themselves to be in at least 'comfortable' circumstances now. The privations of the 1950s were the bad old days, and now the NHS was available. In discussing their more recent illness, or the day-to-day fluctuations in their chronic conditions, the self-responsibility theme was paramount. A few complaints were ascribed to the environment, usually the weather or the immediate environment of their housing:

'dampness in these houses', 'the bedroom walls are running', 'there's something in this water'. Generally, these seemed to be expressions of dissatisfaction with their present house, in situations where they wanted to move and had perhaps got a 'doctor's line' in support of their application for different council housing. The women did not belong to more middle-class pure air or unadulterated food lobbies, and to complain about more general 'dangers of modern life' would have gone against their firm knowledge or conviction that living circumstances had improved. Nor did they perceive any dangers in over-medicalization, in any real way: many described how they 'didn't like pills' or criticized those who relied on them, but in fact they were observed to be very heavy users of prescriptions from their doctors. There were perhaps two exceptions to this trust of prescribed drugs: the contraceptive pill, and psychotropics. Both of these could be the cause of many problems. They were special, it seemed, because so intimately connected with the life events – marriage, childbearing, tragedies, growing older – which were the framework of their medical biographies.

Their working history – on the farms, or the cold, unpleasant work of fish processing when they were young, the hard work of hospitals, shops, and domestic service in later life – also represented both the hardships of their lives, and their strength in endurance. Work was also an important part of biography, and could be associated with the beginning of a variety of illnesses.

At a more superficial level, however, it was behavioural causes that were offered for almost every disease – certainly in the abstract, or in other people, but also for oneself. This seemed largely to be the recital of what they had been taught. Twenty-three of the forty-seven women suffered from chronic chest complaints, of this group twenty smoked, and all except one volunteered their smoking as a cause or at least a contributory factor. Lengthy reports were given of their interactions with doctors on the topic, in the course of which the women might express some degree of scepticism: 'If I did stop smoking I'd die of a heart attack overweight'; 'I've smoked since I was 14, so if there's anything going to happen it'll happen.' Nevertheless, at later points in the interview the association of smoking with bronchitis would always, and repeatedly, be ruefully acknowledged: 'that's smoking, of course', 'I'm breathless, I have to put it down to smoking'. Similar friction with doctors, spirited self-defences, but on the whole guilty agreement that it was their own fault, related to obesity. 'Blood pressure' was often the sufferer's own fault, for 'rushing around' or 'doing too much' and several other disease conditions were subject to discussion about 'what one had done' to get them: diabetes was described by more than one woman, for instance, as being caused by an over-fondness for sugar.

Health as biography

It thus seems that, if the women are considered as a group in this way, survey results are supported. Behaviour was the simplest 'public' answer to 'what is the cause of illness', the known 'expected' answer, and the one which they believed was medically authorized (Cornwell, 1984). To consider typical answers in this way, however, is largely to misrepresent the women's real thinking about cause. If, in a different manner of analysis, a single respondent's way of thinking is traced back and forwards throughout the hour or two of conversation, these answers are seen in context. In fact, nothing has one cause. Alternatives are tried out, rejected,

associated with each other, traced from one period of life to another. Examples are given of different cases, and the different factors that might apply are reasoned out. An attempt is made to achieve that 'experiential coherence' (as distinct from abstract, theoretical coherence) which has been shown (e.g. Pinder, 1992) to be sought by those trying to interpret their own chronic disease. [. . .]

The women seek to answer the 'Why me? Why now?' questions in a way which, in Herzlich and Pierret's (1984) words, 'transcends the search for causes and becomes a quest for meaning'.

(*Editor's note*: The first example given by Blaxter is reprinted in Chapter 16, section 2.)

G19 – aged 43, five children

Major current problem is that she is waiting for a hysterectomy, 'I'm aye awfu' tired'. Ever since the fifth child (at 30) 'I've felt really tired and done.'	childbearing
Has also had bronchitis all her life. It 'comes back wi' the weather'. 'And of course I smoke.' It started with 'teething bronchitis' and runs through the family: 'My father had it, and my sister and myself, had it, and my daughter has it aff me, and her baby here, seven weeks old and it already has a whistle, so it must be taking it aff the mother.'	weather behaviour heredity
Returns to gynaecological problems. 'It's mental strain – and bringing up five kids is bound to leave something, I mean it's a' right for him [husband] – he gaed round the world when my kids was little, he cam home and put me pregnant and gaed awa' again!'	stress
Further talk of family history of chest problems, which leads to story of own mother's death from cancer.	heredity
Gynaecological problems: the state she is in is largely 'my ain fault' for not consulting earlier. 'It's jist anither phase of life. There's different things in life occurs, and you go on to anither phase of life. Me, I've come through all I've come through, it's only me I'm hurting now' (by neglect of health).	self-neglect life stage
Nevertheless 'healthy enough'. No reason to coddle self now. In comparison with days when children were young, life is easy. At that time she was almost overwhelmed with illness, but pulled herself through by her own efforts.	stress social circumstances
Returns to talk about mother. 'This is aye at the back o' my mind. Naebody kens until you're actually opened.'	some diseases unpredictable
Seems to retreat to talk again of bronchitis, which is more familiar and understandable: 'I mean, we're all made of an impression on our ancestors, arn't we? So if you've a weakness it must come out some way.'	heredity

One extended quotation is added from the respondent above, as an example of the lively, sophisticated and independent way in which the theme of stress and resentment as the cause of illness could be worked out. It also shows how, as Crawford (1984) noted, 'in the mind-over-matter formulation, one discipline is substituted for another': illness again becomes the sufferer's fault.

> When I wis bringin' up my kids, I was forever in at the doctor and I had like a chemist shop – I had tablets to mak' me sleep, I had tablets for heidaches, an' tablets for stomach aches, an' I just said tae mysel' tablets, tablets – I ta'en them a' an' I pit them in the bucket. I says, now they're nae helpin' me, I've got tae dae it mysel. So I got to work an' worked things oot mysel' . . . When I first got that heidaches, I thought I was goin' aff the heid. They put me to the [psychiatric hospital]. He [husband] says, 'You're a nut'. I says, 'Well, I'll be a nut, but I'll find out I am a nut, I'll ging to a psychiatrist.' A' they asked about was sex – well, it had nuthin' a'dee wi' sex. An' then it dawned on me fit it wis – the strain o' the kids were gettin' ower much for me an' I wis against him [husband] for aye bein' awa'! See? An' then, when things would crack up, I'd maybe smack them, for maybe little. I would sit doon an' greet – I shouldn't have hutten them. Ken? An' the heidaches would get worse an' worse – an' worse . . . Ken, gettin' tae ken things, has a lot to dee wi' it – ignorance is a lot tae dee wi' bad health. (G19)

Chains of cause

Several themes run throughout these accounts. First, there is the constant emphasis on life events, especially those identified with their female roles: childbearing, the care of elderly parents and their deaths, the menopause, widowhood, the deaths of children. Almost every chronic condition had its 'real' origins in one of these events. In particular, childbearing had been the crucial event: 'a woman's never the same after she's had children' was a popular aphorism.

These were all links in the chain of cause. A second notable feature of the accounts was the strain to connect, to present a health history as a chain of cause and effect, with each new problem arising from previous ones. There was a common concept of one disease 'going into' another, and many causes were sought in past injuries. A cough would 'go into' bronchitis, meningitis was caused by 'a knock', accidents many years before were blamed for arthritis. Accidents, like surgery, were assaults upon the body, unnatural breakings or openings which would leave it susceptible. Occasionally, disease might be seen as striking randomly: cancer is the most common example, though it must be noted that the reluctance to discuss cancer at length seemed also to be an expression of a taboo. Often the disease was not directly named, or the voice was dropped to a whisper. For most diseases, however, cause was not random. The women resisted the idea that one part of their body might have 'gone wrong' at one time, and another at another, without there being any connection. One thing must lead to another: there must be a logical biography.

These chains of cause stretched back through generations. Thus heredity and familial patterns were another pervasive theme in the talk of their own disease. In part, this was simply a natural human tendency towards 'pattern making', and, since families in the past had been large and certain diseases very prevalent, there was a high likelihood that if patterns were sought they could be found. Family weaknesses often lay in stomachs, or chests, or some other part of the body: 'They've all been bothered with their legs'. Alternatively, families could have some inherent strengths, resilience to certain types of condition. These discussions of family history, often

very long, were commonly quite sophisticated, with the women working out in great detail exact degrees of relationship, the evidence of changes in environment (many older members of families had emigrated), or the different likelihoods of infection, direct inheritance, or 'susceptibility'. G37, for instance, explained:

> I think family traits have a habit o' – you know, cropping up. You might have a family that's prone to rheumatics. Rheumatics aren't infectious, but if it runs in a family, to me, you know, as it comes down the line, there's always going to be somebody that's sorta inclined to take that. In this climate . . .

This was set in the context of a recital of the lives and deaths of her own parents, siblings, and grandparents, and then of her husband's family. A digression considered the effects of voluntary lifestyles: her paternal grandfather died young, but he was a well-known drinker; on the other hand so did his father, 'and he was a very religious churchgoing man, he didn't smoke or drink'. The conclusion was:

> . . . families can be long-living families or short-living families. I think it must be something to do with the genes.

This fondness for familial 'explanations', as for connecting up the events of their lives, could be understood as a liking for continuity, a desire to give meaning to their lives. Their family histories, together with their own experiences, constituted their identity. Their present health status, including all the emerging problems of middle age, had to be accommodated into that identity.

Conclusion

In summary, it seems probable that if these women had been asked the brief direct questions of the Health and Lifestyle Survey, their answers would have been in accordance with the class patterns found. Illness was primarily one's own responsibility, not only at the superficial level of quickly offered survey responses, but also at a deeper level of claiming responsibility for one's own identity. They did not dwell on class inequalities because, though they were very conscious of the perils of the environment in the past, by contrast life seemed to be largely without such dangers now. They were perfectly capable of holding in equilibrium ideas which might seem opposed: the ultimate cause, in the story of the deprived past, of their current ill-health, but at the same time their own responsibility for 'who they were'; the inevitability of ill-health, given their biographies, but at the same time guilt if they were forced to 'give in' to illness. With this emphasis on selfhood and self-responsibility, and their knowledge of greatly improved general social circumstances, a rejection of ideas about (contemporary) 'inequality' was understandable.

Many such qualitative studies have shown that people reconstruct biomedical concepts, including those of aetiology, in the light of their own biographies. Perhaps sociologists and social epidemiologists may have to accept that their concepts, too, may have little reality at the level of individual perceptions.

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What you might do now

This study analysed qualitative data thematically, and assumed that what people said was evidence of their ways of making sense of their experiences. But there are other ways of analysing qualitative data, and different assumptions may be made as to what such data stand for. Read sections 5 and 6 of Chapter 16 and then reconsider Blaxter's data

Carry out a more systematic appraisal of the study using 'Questions to Ask about Qualitative Research' in Part 4 of this book

What you might do now

Consolidate what you have learned about the relative strengths and weaknesses of questionnaire surveys on the one hand and loosely structured interview studies on the other by reading Chapters 10 and 16 and perhaps some of the further reading cited there

Use the Appendix to find some research of interest to you based on loosely structured interviews and appraise it using 'Questions to Ask about Qualitative Research' in Part 4 of this book