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Assembling life history narratives from quantitative longitudinal panel data:

What's the story for families using social work?

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Abstract

Embedded within quantitative longitudinal panel or cohort studies is narrative potential that is arguably untapped but might enrich our understanding of individual and social lives across time. This paper discusses a methodology to assemble the life history narratives of families using social work by drawing on quantitative data from the British Household Panel Survey. It explores whether this person-centred approach helps us to understand the counterintuitive results of a parallel multivariate analyses, which suggest that families using social work fare worse than similar others over time. Our findings are tentative, due to the experimental use of this narrative method and the limits of social work information in the dataset. Nonetheless, the life histories presented bring to light complexities, diversity and the non-linear pathways between families' needs, support and outcomes that the aggregates obscure. We conclude that reconstructing families' lives in this way, especially in the absence of complementary longitudinal qualitative data, affords the wider opportunity to interrogate and better understand the findings of quantitative longitudinal studies.

Keywords

Introduction

This paper explores the narrative potential that lies within quantitative longitudinal panel data, to deepen our understanding about the lives of families who use social workers. It complements the authors' secondary multivariate analysis of four British longitudinal panel/ cohort studies to identify the predictors and outcomes of social work use. The paper begins by exploring the narrative properties of quantitative longitudinal data and introduces a

methodology for mining their potential to generate life history narratives. It then outlines the counterintuitive quantitative findings that set the backdrop for this analysis and the narrative method used to interrogate them, followed by presenting two families' stories. Discussion then turns to critical appraisal of what these life histories can offer, concluding with reflections on their strengths, limitations and potential for further work.

Methodology: bridging the divide

Narrative and life history research methodologies are understood and practised in diverse ways (Denzin, 1999; Giele & Elder, 1998). By narrative methodologies, we are referring broadly to approaches that have temporal, meaning-making and social qualities - organising events sequentially in ways that are meaningful and offer insights into the changing relationship between the individual and the social (Hinchman & Hinchman, 1997). By life history methodologies, we are talking about approaches that privilege personal stories to capture individuals' lived experience through past and present (Plummer, 1983). Conventionally, both approaches are associated with qualitative methodologies, albeit at times complementing quantitative enquiry. Most narrative and much life history research relies on texts spoken and written, and attends both to the telling and the told. We are all too aware that qualitative researchers may raise eyebrows at our co-opting the terms 'narrative' or 'life history' for the analysis of quantitative data.

Nonetheless, statistical analyses of longitudinal data have a 'temporal or chronological dimension that gives them a certain narrative quality' (Elliott, 2007, p1). Furthermore, multivariate analyses of the predictors and outcomes of individual or social phenomena commonly raise questions about causality, exposing the need for interpretation, for which narrative may offer a meaning-making device. This is the sense in which Elliott argues that narrative is well suited not just to qualitative but also quantitative research, to complement and interrogate quantitative data. In turn, this invokes a methodological orientation that bridges the quantitative/nomothetic and the qualitative/idiographic divide.

In this paper we explore whether using narrative practices with quantitative data can help us understand parents' and children's wellbeing trajectories and outcomes. Specifically, we are assembling lives through constructing life history narratives from quantitative longitudinal panel data collected in the absence of accompanying qualitative data or complementary qualitative studies. One of us has previously tried this, using British

Household Panel Survey (BHPS) data, to explore the impact of chronic illness on employment, income, mental health and health service use (Holland, 2006). The analysis revealed how the onset of illness sparked a chain of adverse health and social events that remained hidden in multivariate analysis of the same data.

An innovative methodology for constructing 'narrative life histories' from quantitative data was pioneered by Singer, Ryff, Carr & Magee (1998) when exploring the pathways leading women to different mental health outcomes. Alert to the limitations of nomothetic approaches which, since they search for causal relationships between variables taken in isolation, can obscure the complexity of individuals' lives, Singer and colleagues were also critical of idiographic qualitative studies whose reliance on small samples prevents statistical generalisation. Intending to overcome these deficits, they brought a 'person-centred' life history methodology to the variable-centred affordances of a large cohort study. Effectively, this involved crafting meaning-making narratives that reconstructed women's trajectories toward better or worse mental health outcomes.

Our approach draws on that of Singer and colleagues, so we describe their specific methods when introducing our own. What is original to our project is first that it experiments with this little used methodology to explore the relationship between social/professional interventions and outcomes. Second, we use it distinctively to explore whether this innovative approach can help to bring meaning to counterintuitive aggregate findings.

Predictors and outcomes of social work use: quantitative analysis and findings

Our quantitative analysis drew on four longitudinal panel/cohort studies to look at the predictors and outcomes of routine social work use among families and children in Britain. Social workers in the UK are mandated to support, protect and empower people who are vulnerable for reasons that may include health or disability, abuse, parenting or family difficulties. The roles of social workers practising routinely with parents and children vary widely from, for example, short-term needs assessment, advice and/or onwards referral, to medium-term parenting support, or long-term support for children placed in care.

We had several reasons for looking at parents and children using routine social work. Relatively little is known about this group and how they fare over time compared to others with similar adversities but without social work. Previous UK quantitative studies – including those few using cohort/panel studies (for example Sidebotham & Heron, 2006; Wijedasa &

Selwyn, 2011) or administrative data (for example Wade, Biehal, Farrelly & Sinclair, 2011) have focused on specific interventions, such as child protection or adoption. UK social work administrative data have been of limited use: centrally, until recently, they were collected only in aggregate and locally they lacked standardized recording or depth. Social work case files have depth but lack of systematization or follow-up after case closure limit their utility. Meanwhile, with the possible exception of Scandinavia (for example Helgeland, 2010), longitudinal qualitative studies, either stand alone or complementing quantitative research, are few and far between in social work research. Those that exist also focus on specific not routine interventions, such as children's placement in care (for example McSherry, Fargas-Malet & Weatherall, 2013) or adoption (for example Selwyn, Meakings and Wijedasa, 2010).

In contrast, quantitative cohort/panel studies may lack qualitative texture, but they nonetheless offer unique potential to explore comparatively the determinants and outcomes of routine social work use, without recall bias and over a longer time-span than ever previously studied. Of course, those studies with timescales sufficient to allow us to look at outcomes over time refer to social work use some years ago; this is an unavoidable limitation, whatever the data source.

Our quantitative analyses drew on the BHPS, the Longitudinal Study of Young People in England, the Avon Longitudinal Study of Parents and Children (ALSPAC) and the Millennium Cohort Study - selected because they asked about social work use and yielded sufficient social work sample size to afford analysis. Our findings have been published in Henderson, Cheung, Scourfield and Sharland (2015), Henderson et al. (2016a, 2016b) and Zhang et al. (2016). We summarise them just briefly here, concentrating mainly on those from the BHPS (Henderson et al., 2015) since this is the dataset from which we have crafted life histories. The BHPS started in 1991 with a representative sample of 5,500 British households containing 10,300 individuals (Taylor et al., 2003). Across 18 annual waves, detailed, structured self-report information was collected from adults and, since 1994, from young people aged 11-15 years. It covered many domains of their lives, from employment and financial circumstances to lifestyle, family and social relationships, attitudes and behaviour, health and wellbeing. At each wave adults were asked whether, among other health and welfare services, they had used a social worker during the last year.

To minimize attrition effects, we included in our analysis the 6,857 parents in households which appeared in all of waves 1-6 (1991-1996). The proportion using social work

ranged from 1.5% to 2% in any one year. Using logistic regression, fixed and random effects models and inverse probability weighted regression analysis, we were able to isolate as far as possible the structural, neighbourhood, family and individual factors (Strand, 2011) that predicted parents' social work use, and to identify the relationship between parents' social work use, their mental health outcomes and their children's subjective wellbeing. We anticipated that parents' social work use might over time improve both their own and their children's wellbeing, since there is a known association between these two (Duncan & Reder, 2000; Smith, 2004). Parents' mental health was measured by the 12-item General Health Questionnaire (GHQ) (Goldberg & Williams, 1988) and children's subjective wellbeing through structured questions to parents and young people. Since too few young people whose parent(s) used social work also completed the Youth Questionnaire, our quantitative analysis relied on fathers' reports of 'how happy [the child was] with life as a whole', because this correlated best with young people's own responses.

We found that the predictors of parents' social work use were: parental health problems or disability, having caring responsibility, being unmarried, having more children and being in rental accommodation. More surprising, compared to apparently similar individuals who did not receive social work, those using social work fared worse, and both parental mental health and children's subjective wellbeing appeared to worsen, not improve, over time (Henderson et al., 2015) These findings are not only surprising but potentially highly controversial: taken at face value they appear to suggest that a publically funded welfare service does more harm than good. Our analyses of the other three datasets echoed these findings (Henderson et al., 2016a, 2016b; Zhang et al., 2016). Among the further adversities found leading to social work use were: homelessness, unemployment, divorce or separation and parental depression. Teenagers receiving social work due to behaviour problems were more likely to be girls, of mixed race, to have special needs or come from a lower socio-economic background. Social work use was not associated with change in children's emotional and behavioural difficulties, or with teenagers' mental health or aspiration to go to university. However, teenagers receiving social work had poorer exam scores than similar others, and were less confident in being accepted at university if they applied.

In all our publications cited above, we have discussed in detail the limitations of these findings. Put briefly, we must be cautious about extrapolating to the present day from findings concerning social work use in the 1990s and 2000s. But even taken in their own time, there

are shortcomings which present challenges for interpretation. The datasets are based on self-report and may be subject to misattribution (of who is a social worker) or reporting bias due to perceived stigma (of being in need of social work). We do not know the reason for social work involvement, its quality, intensity or duration. Many interventions may, for example, have been brief and minimal, since social work services were already at this time becoming increasingly rationed (Jones, 2014). Importantly too, our modeling could not take account of time-variant variables not captured within the datasets - child maltreatment, for example, is reported only in ALSPAC. It may also be that our measures are not sufficiently sensitive or accurate, or that those people using social work fared worse because they experienced more severe adversities, or simply that social work played a minor part in much more complex life stories. However, our quantitative findings are consistent enough to suggest it might also be true that those receiving social work did worse as a result, in which case we need to understand why and what might be learned. In the absence of complementary qualitative material, quantitative life histories seemed worth trying, to catch a glimpse of the stories beneath the aggregates.

Method

We begin by outlining the method used by Singer and colleagues (1994), from whom we borrowed our own. Using the Wisconsin Longitudinal Study, they selected sets of between three and six women according to each of four mental health outcomes, and constructed for each woman a 'narrative biography' based on her responses to 250+ variables across three survey waves spanning 35 years. By extending three-fold the number of cases, they produced pared-down 'generic life histories' characterising the main pathways observed towards different mental health outcomes. From these they distilled 17 core variables defining each pathway, and tested their power to distinguish between women with resilient and poor mental health outcomes. Though they had mixed success with the test, the promise of their approach lay in its versatility in marrying qualitative narrative approaches with quantitative data and analysis.

Our approach was less ambitious. At this exploratory stage we followed just the first steps of Singer and colleagues' method, to see whether assembling the life histories of a few families using social work might shed some light on a puzzling bigger picture.

Each of the panel/cohort studies used for our quantitative analyses presents distinctive advantages and disadvantages for assembling life histories. But since the BHPS captures from both parents and young people the most extensive array of information about multiple domains of their lives, this dataset appealed most.

When choosing which families' stories to trace, conventional wisdom might have suggested selecting 'outliers' to interrogate our quantitative findings by using examples that contradicted them (Sullivan, 2011). However, our quantitative findings themselves contradict widely upheld policy, practice and tax-payer expectation that those receiving social work should fare better, not worse, over time. So our logic took us in the opposite direction. At this early stage of experimenting with the method, our priority was to focus on those whose outcomes appeared consistent with our unexpected quantitative findings, to see whether tracing their life histories helped explain the counterintuitive. If it did, we might go on contrast these families' stories with others that followed the direction policy and practice would have us expect.

As with our quantitative analysis, we began with all households where the same single or couple parents participated in the study 1991-1996. From these, we identified thirteen cases where one or both parents reported using social work between 1994 and 1996, and a child completed the Youth Questionnaire during the same period. In order to look at outcomes, we narrowed these further to the seven who remained in the study for at least two years after first reporting social work use during 1994-1996 (so, for example, if they first reported social work use in 1996 it must be possible to follow them though to 1998). We mapped the timeline of these families' social work use against their scores on the key outcome variables used in our quantitative analysis. This allowed us to identify four families who appeared to do worse after using social work.

To craft their life histories, we drew on 300+ variables, recorded across some or all waves. They included: socio-economic, financial, employment and housing circumstances; social support, family and parent-child relationships; individual attitudes and behaviours; health, wellbeing and life satisfaction. This extensive array covered most of the adversities (family separation, poverty, parental physical or mental illness, disability or substance misuse) identified by Davidson, Bunting & Webb (2012) as impacting on children and families' outcomes, though unfortunately a few (parental antisocial behavior, domestic abuse and child abuse/neglect) were not captured in the BHPS.

We were clear from the outset about what might or might not be claimed for these narratives. Grounded in self-report responses to standardized questionnaires, their content reflects the researchers', not the respondents' priorities. We have also crafted these life histories remotely from the subjectivities of those who reported, let alone lived them. Nonetheless, we believe they offer us the chance to access the people behind the data.

For reasons of space, just two families' stories are presented here, and necessarily more succinctly than can convey the detail we were able to assemble. BHPS data are anonymised, but we have used pseudonyms for ease of reference. We have also structured the families' histories as far as possible to follow their social work timelines.

The Cox Family: Cumulative troubles taking their toll

Ann and Jim Cox were white, UK born, and lived with their children Daniel, Sarah and Emma, respectively aged eight, six and five years in 1991. Both parents participated from 1991 to 1998 and Daniel completed the Youth Questionnaire from 1994 to 1998.

1991-93: Before social work

Ann was employed as a part-time carer and Jim as a full-time bar worker. They owned their home with a mortgage. In 1991 they felt they were 'doing alright' or 'comfortably off' financially, but by 1992 'just about getting by'. Ann was experiencing increasing ill-health, describing her health as poor in 1991, and thereafter very poor. She had had two serious accidents during the year 1990-91 and visited her general practitioner (GP) six to eight times; these visits increased over the next two years; by 1993 she had also spent one week in hospital. Her symptoms included problems with arms/legs/hands, migraines/frequent headaches and sight problems and latterly chest/breathing and 'other' physical problems. In 1991-2 Ann also reported in her GHQ some anxiety/depression below clinical level, but by 1993 this soared, indicating significant clinical distress. By 1992 her health restricted the kind of work and daily activities she could do, and by 1993 the amount of work too, with her working hours reducing from twelve to six per week. Jim, in contrast, described himself in excellent or good health. Nonetheless he mentioned drug or alcohol problems in 1991, and problems with his arms/legs/hands from 1992 onwards, with some impact on daily activities and the kind of work he could do.

Childcare was mainly Ann's responsibility in 1991, and the couple also had caring responsibility for Jim's parent and for a friend/neighbour; Ann did the lion's share at 10-19 hours' per week. From 1992 childcare became joint, perhaps reflecting Ann's increased ill-health, and they were no longer caring for Jim's parent. In 1991, Ann reported good social support with more than one person whom she felt really appreciated her, would listen, help in a crisis and give comfort. But by 1993 only one person fitted this bill. For Jim, either one person or more could provide such support throughout.

1994-96: During social work

In 1994, 1995 and 1996, Ann reported she had used both a social worker and a home help (for personal care or domestic support) within the previous 12 months. 1994 clearly marked a low point in family circumstances. Ann's health had deteriorated significantly. Her physical symptoms now also included stomach/digestion problems, and she had spent almost the entire preceding year (330 days) in hospital. Her mental health was still very poor, improving just slightly in 1995 and 1996. By 1994 she had left paid employment and begun to receive Disability Living Allowance. Seemingly childcare remained joint throughout, but Ann now ceased other caring responsibilities.

In 1994 Jim left employment and became Ann's carer for 20-34 hours per week. He did not receive unemployment benefit, and both partners said they were 'just about getting by' financially. By 1995, things were somewhat improved: Jim was back in full-time work, still caring for Ann, but for fewer hours per week. By 1996 they felt they were 'doing alright' again, helped by Ann's benefit income. Their own relationship seemed good - in response to questions asked only in 1996, each said they were very satisfied with their partner. Both were also satisfied with their home, and Jim with his job, health and life in general, albeit his general health was now only 'fair' and inhibited somewhat his daily activities and work. However neither partner had strong social support, both were dissatisfied with their social life and leisure, and Ann with her health and life in general too.

In 1994, Ann described theirs as a household with few rules but strictly enforced, whereas Jim reported many rules but variable enforcement. Broadly, however, both parents and their eldest son Daniel described an attentive parenting style, albeit including corporal punishment, since Daniel was last smacked at age ten. Ann and Jim agreed they kept a regular eye on homework and Daniel confirmed they checked how he was doing at school, watched

him very closely and set limits on his television viewing. Both parents took very or extremely seriously children smoking, drug taking, stealing, truanting, lying to parents and swearing, and, excepting the last two, Daniel agreed. All confirmed that Daniel told his parents where he was going, always in 1994-95 and usually in 1996. However, all three also reported difficulties in their relationship, evident in 1994 (when family circumstances took their steep downturn) but worsening later. Arguments between Daniel and his parents escalated from once per week or less in 1994, to most days in 1995, by which time his parents found Daniel quite difficult to manage. They reported talking with him about important things most days in 1994-95, but less than once per week by 1996, while Daniel said this happened hardly ever after 1994.

By 1994 (aged eleven) Daniel was struggling with some difficulties of his own. His parents described him as fairly happy with life, family, friends and his appearance, though neutral about school work. Daniel concurred, and also thought himself likeable with good qualities. Yet at times he felt useless and no good at all. He had three close friends but none had visited his house the previous week. Strikingly, he reported one to two nights spent awake worrying during the previous week, and both he and his parents agreed he had been unhappy/depressed on four to ten days in the last month. In 1995 Daniel reported much the same, but his parents thought he was now less happy with life, family or school work and unhappy/depressed for 11 or more days in the last month. Daniel now reported his close friends had reduced to one, rising just to two by 1996. By 1995 (aged 12) he said he had smoked once, though apparently not drunk alcohol or been tempted to take drugs. In 1995 and 1996 6 he described quite often feeling lonely, being a bit worried about bullying, and having twice in the previous month got into fights.

Unfortunately, we know nothing about Emma, the youngest, and only a little about Sarah, the middle child. But, in contrast to Daniel, in 1996 Ann and Jim described their relationship with Sarah as friction-free; she was easy to manage and, they believed, happy with family, friends, school work and life in general. Interestingly nonetheless, they reported that she too was unhappy/depressed for four to ten days within the preceding month.

1997-98: After social work

Ann remained unemployed and receiving Disability Living Allowance. It is not clear whether Jim was employed in 1997, but by 1998 he was in full-time work, and both partners felt they

were 'doing alright' financially. Social work contact had by now ceased, though home help continued in 1997. Nonetheless, the family's struggles continued – and in some respects their cumulative impact became accentuated.

Ann's mental health reports still indicated clinical anxiety/depression. Her chronic physical symptoms remained similar in range, but their severity may have worsened by 1997, since Jim was now caring for her 50-99 hours per week. Jim's reported mental health remained fine. But significantly, though his physical symptoms remained the same in range, it is possible they too increased in degree since Ann now also reported caring for Jim for more than 100 hours per week. Childcare responsibility too became mainly Ann's. By 1998, when home help ceased, things may have eased: each partner now cared for the other 10-19 hours per week, child care was once again shared and social support for Ann slightly improved.

Now aged 14-15 years, Daniel's relationship with his parents remained difficult – they all described frequent arguments. His parents found him quite difficult to manage and by 1998 they reported he only sometimes told them where he was going. Daniel said he hardly ever talked with them about things that mattered. In 1997 Ann and Jim reported Daniel was unhappy/depressed for one to three days in the last month, and Ann felt this worsened by 1998. Interestingly, they described Sarah as similarly unhappy, though unfortunately there is no more information about her.

During this period, Daniel described himself as happier with family, friends and school work, but in 1997 still unhappy/depressed for four to ten days in the last month and in 1998 awake worrying for one to two nights' per week. He now had three or four close friends, but still friends rarely visited him, and at times when with friends he felt left out. By 1998 he no longer had a girlfriend, and this was what he most wanted to change. Other signs were more worrying. Whilst it mattered to Daniel to do well at school and he expected to continue to sixth form, by 1997 he was unhappy with his teachers, felt they were always getting at him and he didn't care what they thought. This improved slightly by 1998, but he now reported often playing truant from school. In 1997 (though not 1998) he also reported having been out after 9pm more than 10 times in the last month. He was not asked whether he took drugs, but he reported some of his friends did. Though not a gang member, in 1997 he reported having had between two and five fights in the last month and vandalising property once or twice in the last year. By 1998 he reported vandalising 'often'.

The Johnson Family: Suffering and resilience in midst of adversity

Carol and Phil Johnson were white, UK born and lived with their only son Jack (aged 8 in 1991) in a house they owned with a mortgage, in a neighbourhood they liked. Phil reported no qualifications, but Carol was a qualified nurse. Throughout the study period, the couple were economically inactive and either one or both claimed Income Support benefit. Phil described himself as long-term sick/disabled, and Carol reported herself either the same or as 'caring for her family'. Carol participated in the study from 1991 to 1997, Phil from 1991 to 1996, and Jack completed the Youth Questionnaire from 1994 to 1997, and the adult questionnaire in his own right in 1998.

1991: First social work use

In 1991 both Carol and Phil reported using a social worker during the previous year. According to Carol they were 'just about getting by' financially, while Phil said they were 'finding it quite difficult'. Both felt they were worse off than the previous year because they had more expenses and they expected their situation to worsen.

Both partners confirmed that their health problems limited daily activities and prevented some types of work 'a lot'. Each suffered from some anxiety/depression, but not at clinical levels. Each too reported having a skin condition and 'other' health problems, and each had made more than ten visits to their GP during the previous year. In 1991 Phil was registered disabled and the couple reported caring for each other for over 100 hours per week. It appears that they had limited social support. Carol said there was more than one person who really appreciated her and could offer comfort, but only one person to relax with or help her in a crisis. Phil had just one person to listen to him, relax with, who really appreciated him or could offer comfort.

1992-94: Without social work

Throughout 1992-94, the couple continued reporting financial difficulty; each year they felt worse off than the previous year, and expected this to deteriorate further. In 1994, in addition to Income Support they received Housing Benefit.

During this period, the couple did not report social work use, though there was no sign of matters improving and Carol began also using a health visitor in 1994. Both partners described their health as fair or poor, at most points inhibiting their daily activities and

preventing some types of work. Their GP consultations remained high. Their anxiety/depression also persisted, in Carol's case at the same level, but in Phil's case now clinically very significant. This coincided with an increase in the range of his physical symptoms – from 1992 he reported problems with his heart/blood pressure, stomach/liver/kidney and arms/legs/hands, and with alcohol/drugs as well. In 1993 Phil again reported being registered disabled. Meanwhile Carol too now mentioned additional physical health difficulties, with her stomach/liver/kidney and her chest/breathing in 1992-94, and her arms/legs/hands in 1993. The couple continued to care for each other, though Phil's reported care for Carol reduced to less than 20 hours per week while Carol's caring hours were not recorded. There was no sign of change in the external social support available to either of them.

1995-97: Further social work and other services

During these waves, Carol again reported using a social worker, though this time Phil did not. Carol also continued using a health visitor until 1996, and in addition, in 1997, used a home help.

Though they continued to struggle financially, in 1996-97 their Income Support was supplemented both by Housing Benefit and Disability Living Allowance for Carol, and as a result she reported they were better off than the previous year. Still, the couple continued to report only fair or poor health, limiting their daily activities and preventing some types of work. Both were registered disabled in 1997. While Carol's GP visits reduced, she reported the same physical symptoms as before and her mental health appeared slightly worse - in 1996-97 she was 'rather more' unhappy/depressed than usual, with moderate to high GHQ scores. For Phil, the picture was bleaker. In 1995 he was still reporting more than ten GP visits per year (there were no data thereafter) and he had had a serious accident in the previous 12 months. Along with continued physical ill-health throughout, he suffered the return of anxiety/depression in 1996-97 and problems with alcohol/drugs in 1996. In 1997 he reported spending 5 days in hospital during the previous 12 months.

In the midst of this, Carol nonetheless reported in 1996 that she was satisfied with her partner and home, and fairly satisfied with her health and life overall. She was neutral about her social life but fairly dissatisfied with the amount and use of her leisure time. In 1997, she still indicated poor social support. Though there was still more than one person who really appreciated her and could offer comfort, she reported there was just one person who would

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relax with her, listen to her or help in a crisis, and no-one outside the household who would help if she were depressed. Unfortunately there was no information on satisfaction or social support from Phil.

Throughout: Jack's relationship with parents, behaviour and wellbeing

Throughout their difficulties, Carol and Phil's relationship with Jack, and Jack's wellbeing and behaviour (all reported from 1994, when he was aged 12, onwards), appear to have been good. For this reason, they are described here across time.

Every year, Jack reported being completely happy with his family, and said they rarely quarrelled. Carol and Phil agreed with this in 1996, though in 1994-95 they reported quarrels most days, and in 1997 more than once per week. They were not strict about household chores, though they gave different accounts of rule-keeping within the family: Phil said there were lots of rules strictly enforced, but Carol disagreed. Although in 1994 they reported last smacking Jack when he was aged 12 (Jack said age 11), both parents described him as easy to manage. They appeared watchful, keeping a regular eye on Jack's homework and setting limits on the amount (1994) and type (1994-96) of television programmes he could view. All three agreed that Jack confided more frequently in his mum and not often in his dad about important or personal matters. But up until 1997 he always told them where he was going. All three regarded as serious behaviours such as truancy, lying to parents, stealing money, smoking and taking drugs. Jack said his parents had talked with him about smoking and drugs; he did not smoke or drink alcohol, none of his friends had used drugs and he was not tempted. In the month before interview Jack had never been out after 9pm.

Jack seemed happy, confident and well throughout. Every year he reported very good health, he enjoyed exercising and had never been on a diet. He felt he had a number of good qualities and was likeable, and he strongly disagreed that he was a failure or (apart from 1995) felt useless. At all times too, he described himself as 'completely happy' or 'happy' with his appearance, school work, friends and life as a whole. He never spent nights worrying, or days unhappy, and he consistently reported having five close friends, with several friends visiting in the previous week. In 1998, despite his parents' poor and limiting health, Jack was not providing care for them. Contrary to his parents' reports of their financial circumstance, he also believed they were 'doing alright' financially, that this was true of the previous year and would improve further the next.

Discussion: What can we learn by crafting narrative life histories from quantitative data?

Reflecting on what have we gained by assembling the lives of the Coxes and the Johnsons in this way, our first question is: Can this person-centred approach taken to quantitative longitudinal data enrich our understanding of the lives of families using social work? We are clear that these life histories leave many gaps unfilled and of course the Coxes and the Johnsons would have told their own stories differently had they done so in their own way. Nonetheless, we are confident that the narratives allow us to bring these parents and young people to life, in ways that can enrich our quantitative findings. The following observations illustrate this.

The two families were in some ways similar. As we would expect, both suffered adversities consistent with the predictors of social work use identified in our multivariate analysis. But what their narratives expose in ways that our quantitative analysis can obscure, is how these adversities fluctuated, intersected, may have generated and compounded each other. Chronic physical ill-health or disability brought intermittent or permanent unemployment, financial insecurity and reliance on welfare benefits, along with caring responsibilities between already unwell partners, and diminished social lives and leisure activity. Their mental health suffered too. Both families' trajectories also expose the cumulative effects of adversities over time, and that these adversities and their impacts ebbed and flowed, not always in one direction or predictably. Carol and Phil Johnson became increasingly physically unwell over the years, with Carol's mental health and social support deteriorating. Conversely their financial situation, though strained throughout, improved a little over time due to welfare benefits. Phil suffered a serious accident in 1995. He also experienced a peak of anxiety/depression in 1992 but this settled, until worsening again in 1996, combined with the return of his alcohol/drug problem. Ann and Jim Cox's pathways were similarly complex, pointed towards cumulative deterioration over time, but were non-linear. There was a crisis in Ann's physical health in 1994, precipitating her long-term exit from employment; but this was already preceded by her significant depression/anxiety in 1993. Her mental health improved a little over time, and welfare benefits slightly improved their financial circumstances. But there was another dip in 1997, with the couple becoming intensively engaged in mutual care, suggesting that Jim's health had now worsened too.

Compiling their stories in this way begins to tell us more about the complexity of the lives of parents using social work than could be told by quantitative analysis alone.

The same is true for their children. Both couples, despite their troubles, appear to have been attentive parents. Daniel and Jack were teenagers during most of the study period – a time in their lives when we could expect them to be unsettled, their relationships with parents to become more challenging, and much to shift from one month, let alone one year, to the next. So it is perhaps not surprising that Daniel argued increasingly with his parents, and felt dissatisfied at times with his family, friendships, school and himself. But tracing his story allows us to see that his difficulties became quite marked, and though their trajectory did not directly follow the ebbs and flows of his parents' troubles, the connection between the two looks likely. Daniel was unhappy for several days per month throughout, and he continually lost sleep through worry. His friendships appeared precarious and few or no friends visited. Other difficulties developed cumulatively - he began to stay out late, became less happy with school and started truanting, fighting and vandalising. But where Daniel's story further enriches our understanding is in the contrast hinted with his sister Sarah and stark with Jack Johnson. We glimpse Sarah all too briefly and only through her parents' eyes. Nonetheless, though she too seemed frequently unhappy and worried, unlike Daniel she seemed easy to manage, with few arguments, and content with school, friends, family and life in general. Jack, for his part, appears to have remained happy, sociable and self-confident throughout his parents' adversities. He got on well with his parents, and at age 16 was neither caring for them nor alert to their financial straits. It seems that Carol and Phil may have succeeded in shielding their son from their troubles in a way that Ann and Jim could not.

Assembling and contrasting their life histories in this way draws our attention to the complexity and heterogeneity that exist within and between families using social work. Their stories alert us, for example, to diversities of resilience. We know that resilience arises from complex interactive processes between individuals, their families and environments (Daniel, Wassell & Gilligan, 1999), processes far more complex than our data can explain. But crucially, our method allows us to bring this diversity to light, in ways that quantitative analyses, concerned with aggregate patterns or variation, render invisible.

Our second question is more exacting: Does assembling life history narratives in this way help us to understand the role and impact of routine social work use in families' lives? In particular, does it help to resolve the riddle posed by our quantitative findings that parents

using social work and their children appear to do worse over time? Here our response is a more qualified yes. Both families' stories expose the interactions of multiple adversities over time (Davidson et al, 2012). They also afford us some important insights into the patterning of social work use. For both families it looks likely that parents' deteriorating health was the trigger for social work, alongside other health and care service use. More critically, both families' stories show that the fit between their time of significant need and their use of social work was less than exact. For Ann Cox, social work started with her physical health downturn in 1994, not her mental health difficulties in 1993. It stopped by 1997, when her mental health was slightly improved and her physical health, along with their finances, was still poor but more stable. However, Ann and Jim remained in difficulty, with periods of intensive care-giving required for each other, reduced social support, and Daniel increasingly troubled. For the Johnsons, early social work support for Carol and Phil was followed by a three year gap, during which their disabilities worsened, Phil's mental health plummeted and both were unemployed, caring for each other with little social support and struggling financially. Social work resumed for Carol when her mental health and disability worsened, but not for Phil, whose own health had also deteriorated, including the return of alcohol/drug problems and a serious accident.

There seems little doubt that these narratives bring to light insufficiencies in the provision of social work support to families in need. This may be unsurprising given the increased rationing of social services in the UK since the 1990s. But these insights are important because they help us to interrogate further our quantitative findings; they encourage us to be cautious in our interpretations about the outcomes of social work use. Both families' narratives bring to life how social work use is part of a much bigger, more complex and in each case distinctive story. While on balance it may be true that both families fared worse over time, their trajectories were not linear and their changing outcomes did not obviously follow their patterns of social work use. One tentative suggestion might be that the mismatch between their patterns of need and service use may have contributed to, rather than alleviated, their troubles. More pessimistically, it is plausible that social work intervention itself may have been ineffective in strengthening these families, or even reinforced their vulnerability. More optimistically, social work use may have prevented still worse outcomes.

At this point, however, the insights our analysis can offer become more limited. It remains true that the BHPS and the other cohort studies we have used can tell us more than has previously been told about parents and children who use routine social work, compared to similar others who do not. But still they tell us too little about social work use itself. We are left guessing about the nature, quality, intensity or duration of the social work these families received. We assume it was voluntary and triggered by parental ill-health; we might also reasonably assume it was social workers who helped secure the welfare benefits that brought some financial relief. But we do not know, for example, whether Ann Cox received sustained support over a three year period to help with the challenges of disability and parenting, or just short-term support in adjusting to her return home from hospital, followed by episodic advice about welfare benefits or other support services. Likewise for the Johnsons, we cannot tell why social work ceased during a period of intensive need, why it then restarted, and in what form. If we knew this, the narratives would be still richer, and the insights they afford more powerful.

Conclusion

Our final question looks forward: Is it worthwhile to develop and use this method further? We believe it is. Our efforts so far have been modest – for example we have not yet compared the life histories of 'outlier' families who improved following social work with those who fared poorly. Inevitably, longitudinal quantitative data do not offer the depth or the actors' own subjectivities that longitudinal qualitative studies, if they existed, could add. Other limitations are distinctive to our particular study. These are shortcomings of data not method – a result of the deficits of social work information within UK panel/cohort surveys and their limited linkage to administrative data. Frustrations apart, we are nonetheless struck by the insights that emerge when the lives of families who use social work are reconstructed through a person-centred methodology brought to quantitative longitudinal data. Their stories expose key questions we must ask when interpreting the bigger picture.

Both within and beyond the social work field, the potential benefits of developing this methodology seem convincing. There have been impressive advances in qualitative longitudinal research in recent years (Holland, Thomson & Henderson, 2006) along with initiatives to increase the mix of qualitative with quantitative longitudinal enquiry. The latter include conducting in-depth research with sub-sets of panel samples (an example in social

work is Biehal and colleagues, 2014-16) and designing separate small-scale qualitative studies to complement panel/cohort surveys (for example the Economic and Social Research Council Timescapes programme, 2007-12). These are very welcome developments. But quantitatively derived life histories offer something distinct and, we believe, add value. While longstanding qualitative or mixed methods longitudinal studies remain relatively rare, there exists in the UK, USA and Europe an impressive array of quantitative longitudinal panel/cohort studies following the lives of individuals, families and households over time. Embedded within them is largely untapped narrative potential that may enrich our understanding of how lives unfold. The quantitative life history narrative method offers a chance to realise this potential.

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