
3-1-2009

Analyzing Qualitative Data about Hospitalized Children: Reflections on Bodily Expressions

Coralee McLaren
University of Toronto, cora.mclaren@utoronto.ca

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Recommended APA Citation

McLaren, C. (2009). Analyzing Qualitative Data about Hospitalized Children: Reflections on Bodily Expressions. *The Qualitative Report*, 14(1), 140-154. <https://doi.org/10.46743/2160-3715/2009.1397>

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Abstract

Although considerable energy is invested in ensuring that pediatric hospital environments are psychosocially supportive, few researchers have connected the experiences of patients to hospital architecture, a crucial interface between healthcare delivery and patient care. Seeking to uncover children's experiences within a contemporary hospital, I draw on data gathered during a photo walking tour with hospitalized children. Findings suggest that in addition to speaking, children express themselves physically by appropriating the gaze, pressing boundaries and finding alternate spaces. New methods and techniques are needed to reveal children's physical competencies and abilities to determine their environmental preferences.

Keywords

Qualitative Methods, Participatory Research, Research with Children, Hospital Architecture, Pediatric Hospital Environments, Photo Elicitation, Children's Bodies, and Dance

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Acknowledgements

The author gratefully acknowledges the time, effort, and thoughtfulness of the children and adolescents who participated in "The Paediatric Hospital Atrium: Designers' Intentions versus Children's Experiences" project (short title: "Kids in the Atrium"), which was funded by the Canadian Institutes of Health Research (cihr: frn# 74457). The Coralee McLaren 154 project also benefited greatly from the generous input of the SickKids Children Council and other members of the KITA Project team: Patricia McKeever, Anmarie Adams, David Theodore, Karen Spalding, and Ellie Goldenberg.

Analyzing Qualitative Data about Hospitalized Children: Reflections on Bodily Expressions

Coralee McLaren

University of Toronto

Although considerable energy is invested in ensuring that pediatric hospital environments are psychosocially supportive, few researchers have connected the experiences of patients to hospital architecture, a crucial interface between healthcare delivery and patient care. Seeking to uncover children's experiences within a contemporary hospital, I draw on data gathered during a photo walking tour with hospitalized children. Findings suggest that in addition to speaking, children express themselves physically by "appropriating the gaze", "pressing boundaries" and "finding alternate spaces". New methods and techniques are needed to reveal children's physical competencies and abilities to determine their environmental preferences. Key Words: Qualitative Methods, Participatory Research, Research with Children, Hospital Architecture, Pediatric Hospital Environments, Photo Elicitation, Children's Bodies, and Dance

"Can I take a picture from here?" asked a young girl as we made our way around the hospital atrium. "Of course" I said, wondering whether I had answered the question too quickly, as her request would disrupt the standardized vantage points we had so neatly designated prior to data collection. "Why do you want to take a picture from here?" I asked curiously. She reflected for a moment, and then said: "From here you can see everywhere outside, you can see the roads, you can see the sky, and you can look down to one of the entrances to the hospital. I like it because you feel free, like you are outside but you are really on the inside." Just as her words began to stir my analytical brain, I was distracted by the speed and agility with which she maneuvered her way towards the opposite end of the atrium, her IV pole and I in hot pursuit. In that moment I distanced myself as a researcher and returned to my role as a nurse to determine whether her IV site had been disturbed. No sooner had I evaluated the situation, she was off again, this time skipping and commenting spontaneously on the array of dancing pigs and butterfly catcher sculptures located high above her head, the children gathered by the fountain and food court, and the light that poured in from the windows and glass ceiling. Having felt that I had been left in her wake for the majority of the interview tour, we made our way back to her hospital room together. She and many other participants moved with a kind of playfulness and physical abandonment that made me question what it was that I had intended to learn about hospitalized children. My main objective as a research assistant had been to gather verbal and visual data on children's perceptions of the atrium lobby, but I found myself drawn in and intrigued by the dynamic changes in physicality among the children who participated in this study. It felt like I had "discovered" their bodies, much like encountering a lifeless body at the beginning of a

mystery novel (Frank, 2004). However the bodies I encountered were very much alive and brimming with activity. Drawing on Frank's idea that a good scholarly article should begin like a detective story, I will illustrate how children articulated their sense of place within a pediatric hospital not only through speech, but through the language of their physical bodies.

Background and Relevance: The Kids in the Atrium Research Project

The Kids in the Atrium Project (KITA) was conducted in 2006 at the Hospital for Sick Children (HSC / SickKids) in Toronto. In this study, children's detailed, perceptual accounts of the 1993 Atrium addition were gathered and compared to the designers' original intentions for the space. Hospital architecture is an understudied yet crucial interface between healthcare delivery and patient care. Very little is known about how pediatric hospital settings are experienced by children, especially those who are unwell. While questions pertaining to architectural design and children's well being are often voiced during the planning of children's hospitals, none have been systematically studied or evaluated after the buildings are occupied (Whitehouse, Varni, Seid, Cooper-Marcus, Ensberg, Jacobs, Mehlenbeck, 2001). To fill this significant gap in knowledge, the KITA Project was designed using a highly original interdisciplinary focus on children's agency in hospital environments, and drew upon theoretical underpinnings from architecture, humanistic geography, and participatory methods increasingly advocated by both child researchers and theorists.

A main objective of the KITA Project was to uncover children's self-identified, self-articulated place within this type of contemporary pediatric hospital (see photo A).

Photo A



The team aimed to determine how children experienced the Atrium through meticulous observations, focused interviews, and photo elicitation techniques. It was through observation that I began to notice children's physicality during the interview, and wondered whether these young patients were in fact revealing perceptions of the hospital environment through their bodies as well as their words. My attention to this form of

body talk stemmed from my prior career as a professional dancer, choreographer and children's dance teacher, where perceptions, ideas and emotions were elicited and physically communicated through the body and movement. This perspective is supported by research that suggests that children are able to express themselves more naturally in spaces that permit movement and activity, and although these kinetic conversations can be technically and analytically challenging, it has been shown that they yield more complete and naturalistic expressions of children's experiences (Irwin & Johnson, 2005).

With the principal investigators' permission, I augmented the original research questions to include children's non verbal responses to the Atrium. In this discussion, I draw on my past experiences as a dancer and on legendary choreographer Martha Graham's belief that nothing is more revealing than movement (1984) to decode children's physical conversations, and to follow an intuitive sense that these hard-to-articulate observations may be an important piece of the analytic puzzle. In addition to the original research question which asked: How do children and youth perceive the Atrium? I asked: How do children and youth physically respond to the Atrium? Focusing on this slice of the larger KITA Project is a valuable opportunity to reflectively work through some of the complex issues that arise during qualitative investigations, and to develop the skills needed to conduct a rigorous analysis and interpretation that reads like a good "detective story." This analysis may contribute to the limited knowledge and understanding we have of children and their perceptions of hospital environments, illuminate children's ability to competently express themselves both verbally and non verbally, encourage the development of new methods concerning children's perspectives of space and place, and provide insight to those who design health care spaces and deliver care children.

Literature Review

Recent research into healthcare settings in architectural history, social history, and humanistic geography focuses on the ways in which experiences of health and health care are constituted by emotional and imaginary experiences of place (Andrews, 2004; Kearns & Barnett, 2000; Parr, 2003). Hospitals constructed in the post World War II era were perceived by patients and staff as austere and angular, their interiors potentially generating feelings of placelessness (Relph, 1976). More recently geographers and architects have argued that the windowless, maze-like hallways and the unfamiliar "smellscapes" of these traditional hospitals may exacerbate children's distress and even contribute to poor health outcomes (Varni & Katz, 1997; Zeidler, 1995). Consequently, hospital designers have increasingly attempted to "de-emphasize connotations associated with institutionalized medicine... [and] normalize the place for children" (Kearns & Barnett, p. 84).

Many features of the HSC Atrium were designed in response to this need to "normalize" health care settings, and reflected a larger trend during which many building types began resembling other public spaces such as shopping malls, airports and hotel lobbies. *Zeidler Roberts Partnership Architects'* 1985 Master Plan for the HSC called for "a happy environment so that children and their families would find a place of relief, courage, and even joy" (Zeidler, 1995). Hence, features such as natural light and foliage, brightly coloured exposed elevator mechanisms, painted murals of parks, overhead

mechanical animals, a food court, toy and clothing stores, and a wishing well fountain were designed to create an environment that responds to the emotional needs of a sick child (Zeidler, 1995). In short, the design of this and other recent pediatric hospitals in Western countries is intended to provide “geographies of pleasure and indulgence (not just fear and pain)” (Parr, 2003, p. 215), and to foster a “sense of enchantment” (Kearns & Barnett, 2000, p. 84).

Recent investigations into health and place relationships have been augmented by studies that position children as knowledgeable social actors and highlight their competencies rather than their immaturity relative to adults (Christensen & James, 2000; Holloway & Valentine, 2000; Matthews, 2003). This positioning is timely as many places designed for children reflect adult values (Matthews & Limb, 1999; Rasmussen, 2004). It is important then to provide children with the opportunity to fully participate in research by using methods that allow them to reflect on and express their preferences, opinions, and emotions regarding space, place and health care. Examples of child – friendly methods include semi structured interviews, focus groups, drawings, guided tours, photographs, behaviour mapping (Driskell, 2002; Holloway & Valentine, 2000; Rasmussen, 2004), or similar techniques that do not limit children to vocabulary (Cappello, 2005). These techniques allow access to children’s worlds (Pole, Mizen & Bolton, 1999) by encouraging them to physically express themselves in non verbal, unconstrained ways, and communicate in ways they find meaningful and comfortable (Thomas & O’Kane, 2000).

Design, Sample, and Methods

The KITA Project consisted of two parts that were conducted simultaneously: Part A consisted of an analysis of architectural documents pertaining to the Atrium, and Part B gathered the views and perspectives of a stratified sample of inpatients (N=35) and outpatients (N=45). After having received approval from Research Ethics Boards at HSC and the University of Toronto, children were invited to participate in the study if they communicated in English, were between ages 5-18, and were not in physical or emotional distress (ascertained by SickKids staff or parents). Children with sight impairments that prohibited visual description and the use of the camera were excluded. Based on the language spoken at home, participant and/or parents country of birth, the sample was ethnoculturally diverse. Pilot tours were conducted with SickKid’s Children’s Council and child volunteers prior to the onset of the project to test the research equipment and process. During the study, each child participated in a semi-structured interview, followed by a walking photo-taking tour of the Atrium and a post tour interview incorporating photo elicitation techniques. Field observations were recorded following each session.

Adapting a method described by Rasmussen (2004), the RAs escorted children on a walking tour of four points in the Atrium and one point overlooking the Atrium from a floor above. Inpatients toured the same four points from the perspective of their hospital floor. From these vantage points, children were asked to take photographs of architectural and design features that interested them. These photographs were used to trigger further thought and talk on how they perceived, used and navigated the Atrium. All conversations were captured by a small, clip on microphone. It was during the shift from

the semi-structured interview to the photo tour that I serendipitously observed and recorded a dynamic change in children's physicality. Of the fifty children I interviewed, the majority moved through the space with an apparent ease, regardless of whether they used a mobility aid or were tethered to hospital equipment. There was a notable increase in their speed, agility and exploratory behaviour as they navigated the space. This "freedom" was further noted when children offered spontaneous comments during the tour, and engaged in photo taking with a similar kind of physical curiosity. This registered as an initial clue that children were speaking to me with their bodies. This clue prompted a new level of theoretical and methodological inquiry that provides the foundation and impetus for the remainder of this discussion. What follows is the analytical unraveling of these physical phenomena, and the accompanying obstacles, questions, and conceptual considerations I encountered along the way.

Boundaries, Edges, and Structures

Klaus Witz's (2007) development of Cooley's principle of 'sympathetic introspection' (1909 / 1952) provides a starting point to begin unraveling the mystery of how children may speak through their bodies during interviews. He suggests that new understandings in qualitative research take shape when we "awaken to" and "articulate" something we have perceived intuitively. In attempting to develop a more holistic understanding of individuals, an investigator "absorbs" some of what is going on in the person or social context by glimpsing his or her subjective inner world through nuances of feeling, gesture, speech and activity, and other unarticulated phenomena. This means that apparent sudden insight or understanding reflects a consciousness or self-understanding that allows the investigator to perceive not only a child's individuality, but also a "gestalt" that has a universality and validity of its own (Witz, p. 245). This approach differs from what Witz describes as "fashioning" where ideas are generated in a preexisting, more or less well-understood conceptual space and horizon.

So what was it about children's physical exploratory behaviour and abandonment in the Atrium that resonated for me and awakened my own understanding of the communication potential of movement? As a professional dancer, I recall how I persistently searched for freedom in my own movement, and how I continually challenged and pressed against the architectural barriers and edges of my own body to find new, more articulate ways of expressing myself. This structure was also built into the technique I studied, where freedom was sought within the precise and choreographed boundaries designed by Martha Graham. Could it be that these children were pressing against the architecture of their bodies in the architecture of the space? What other edges or structures are present in hospital environments, and how might children respond to them? Were children also pressing against the physical architecture of the Atrium itself? When we talk about structure and boundaries, are we in fact speaking about control? If so, what do we mean by control, and in what ways is it manifested in this particular setting? What might children be saying about "freedom" and "control" in hospitals through their bodies, their words, and their photographs? And more abstractly, does freedom only exist in relation to structure or control? In order to begin answering these questions, I will use two analytical strategies presented by Becker (1998) to articulate a

new research question, and move beyond intuition by problematizing these concepts as they emerge from the observational, verbal and visual data.

In returning to the young child's response to my question: "Why do you want to take a picture from here?" I am reminded of Becker's processes of "naming an object of interest" (in this case, control and/or freedom) and "identifying the institutional machine" that is operating and making things happen in a certain way (pp. 122;120). The young girl described the roads, the sky and the entrance to the hospital from the vantage point of a large picture window facing away from the main Atrium, and stated that she felt free when she looked out and beyond her immediate hospital surroundings, "*like you are outside but really you are on the inside*" (see photo B).

Photo B



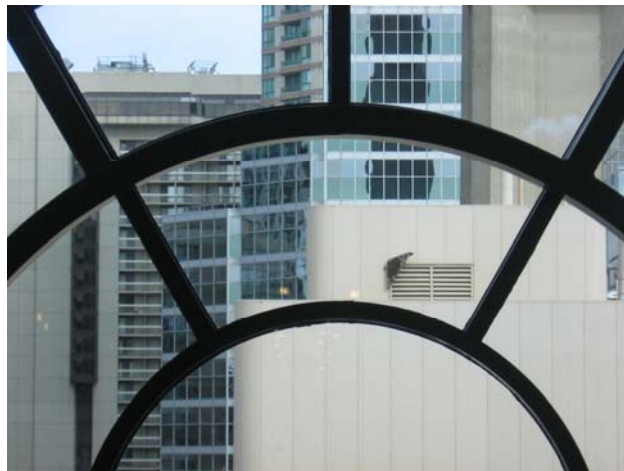
Why was this view important to her? What was she attempting to free herself from, or what was she now free to do or imagine? What did an open window and its perspective offer her? What structures, boundaries and controls could she be pressing against? The concept of control conjures up many ideas: the power to direct or determine; a relation of constraint of one entity (thing or person or group) by another; exercising authoritative control or power over; lessening the intensity of; tempering; holding in restraint. These notions of control are recognizable within hospitals. Although we did not ask the children to comment about their medical care, we can accurately predict the kind of care, treatments and medical discourse that take place in an acute care hospital which adheres to evidence based protocols. Children we interviewed were at the centre of a "medical gaze", which Michel Foucault argues is a way of establishing a regime of visibility where bodily details can be observed, regulated and controlled (Rose, 1999). Perhaps the physical, verbal and visual data collected is in fact "an answer to a question" (Becker, p. 121). What new question I am asking? Does Foucault's insight on the medical gaze provide the theoretical direction needed for further analyzing and interpreting this data? I will attempt to answer these questions by returning to the data.

Appropriating the Gaze

Anspach's (1988) analysis of medical language provides an interesting micro perspective that sheds light on what Foucault might describe as the broader operations at work within health care settings. Through a detailed analysis of the speech exchanges between professionals and patients, Anspach identified a subordination of patients' concerns, beliefs, and life world to the demands of medical discourse, and that the medical interview (which occurs on a daily basis with hospitalized children) can become "a form of repressive communication which seriously compromises the quality of patient care" (Anspach, p. 358). This highlights once again the notion of gaze, where the real object of medical intervention is not the patient, but rather a "looking past" the person to see the disease and organs (Anspach p. 372). The serious medical conditions that children present with in teaching hospitals also put them at risk of being "viewed" as potential learning material (Anspach p. 359). As articulated by Miller & Fox (2004), it is useful "to build a bridge" between a micro analysis and broader notions and ideas on power within medical discourse. This is not a form of triangulation, but rather a strategy that links the informative aspects of different perspectives "while respecting the distinctive contributions and integrity of each" (Miller & Fox, p. 35). By building this bridge, a concept begins to emerge. Illuminated in the data may be children's resistance to this form of control, and their need to take command of their surroundings and actions by appropriating the gaze. By taking control and becoming the ones that *view*, children may gain a "freedom" or power to look back at the world through picture windows and the lens of a camera:

Why did you take this picture? [this child also took a picture through the large picture window facing away from the internal features of the Atrium] (see photo C) "It's just open and it's one of the few places that you can actually see out far. I like the vantage point...it's nice to look down and see the cars going by" Would you say you come here very often? "3-4 times a day". What do you do? "I turn the bench around [away from the Atrium] and just sit and listen to my iPod and look out the window". (17 year old boy)

Photo C



Anspach herself begins to build this bridge at the conclusion of her article when she states: “The ability to “see” diseases, tissues, and organs as entities apart from patients is what Foucault calls the clinical mentality” (Anspach, p. 372). Historically this mentality began to take shape during the modern era, when governments and public powers began to develop new ways of organizing society that focused on the regulation of citizens through their conduct, capacities and propensities, manifesting in complex apparatuses that infiltrated institutions such as school, hospitals and prisons. Foucault argues that this regulation of subjective capacities continues to pervade social existence, with the child being the most obvious manifestation of an organizing apparatus that aspires to manage and control the interior or very “soul” of the citizen (Rose, 1999, p. 2). Psychologist Arnold Gesell developed techniques necessary for the disciplining of human difference through the laboratorial, “medical gaze”, targeting the child amidst a complicated arrangement, transforming him or her into a visible, observable and analyzable object within a particular scientific discourse (Rose, p. 144). Foucault also argued that particular disciplines such as medicine “make” individuals by gathering them en masse and observing them as entities both similar to and different from one another, establishing a regime of visibility where detail can be observed and regulated (Rose, p. 132). As a result, bodies are often reduced to what they have in common, measured against multiple norms, and become known through their generality. These ideas led me to another theoretical insight:

*What’s it like for you up here? [Child was taking a photograph from the 8th floor, looking down onto the main Atrium floor] (see photo D)
“Actually, it’s a bit empowering. It’s more like you’re omniscient. And you know everything that’s going on. Whereas you might not know what’s going on with your own condition, but you now know – kind of nice that way.” (16 year old girl)*

Photo D



Gaining power by resisting the medical gaze returns us to the bodies of these young patients with a curiosity about how this resistance takes its form and shape in other pieces of the data. With this curiosity, a new question is asked: “In what ways do children

maintain or gain a sense of physical freedom and control within the context of a hospital?”

Pressing Boundaries

A return to the physical bodies that provided the impetus for approaching the data like a “detective story” sent me back to where Goffman describes “the action is” (as cited in Frank, 2004, p. 434), or the place of incongruity. How else might I understand the gap between how slowly and cautiously I expected these ill children to move and their exuberant activity? Field notes describe children moving with speed and ease, eagerness and recklessness, and with an unusual ability to maneuver and navigate their bodies through what was a very busy and complicated public space. Martha Graham might interpret this as the living in an affirmation of life that energizes the spectator into a keen awareness (Graham, 1984). Perhaps the clue in this interpretation is the affirmation of life, which given an illness event is likely something children strive to recapture. Watching children physically use their bodies and environment in their everyday, illness-free lives illustrates an affirmation of life through sheer physical vitality, and through the sharing of a physical language that connects them to others. Decoding this language of the body through theoretical frameworks invites us to imaginatively break away from the confines of mundane reality (Alasuutari, 1996, p. 374). It appears then that theory seems to be as much a device for telling a story as it is the instigation to observe in certain ways (Frank, 2004, p. 436).

It seemed that a game had begun (which I have entitled “Pressing Boundaries”) when children broke away during the photo tour and embarked on a speedy and curious exploration of the space. Daring me to keep up, I continually tried to “economize” the event by steering them (and their medical devices) onto a linear route, and encouraging the most efficient pathway to our various vantage points. Inevitably we would arrive, however much more circuitously than I had anticipated. Along these rather “non-economical” routes (Jackson, 1995) I was often asked, “*Can I take a picture from here?*” which resulted in children turning away from Zeidler’s (1995) fantasy “elsewhere” (Hopkins, 1990), and took photographs of things such as the floor beneath them, an unassuming bench, an architectural detail, the glass ceiling above, and for one child - an image of his casted foot elevated in front of him as he rested in a wheelchair. It was as if these children were pressing against the rules of my game by finding ways to exert their control and freedom to move, choose and re-centre their gaze on things that had relevance and meaning for them. It appeared that they were attempting to break free from the adult centered ideals (Balen, Blyth, Calabretto, Fraser, Horrocks, & Manby, 2006; Rasmussen, 2004) manifested in the design, research and operation of this hospital, and press against a kind of environment that fosters enchantment, but primarily aims to protect and contain ill, vulnerable children. What appeared enchanting for these children was the opportunity to choose and imaginatively explore the more subtle, hidden aspects of their immediate world, and to exert a power over the hospital (and me) that allowed them to control and direct their attention (paradoxically) to features less distracting or indulgent, such as areas of openness and natural light, and places that afforded a view that moved them beyond the containment of the hospital:

[Another child took a photograph of the glass - enclosed elevators] (see photo E) *Why did you choose the elevators? “I like them. Just the shape and the colour and how they’re open as opposed to enclosed in a shaft. And...uhh...how there’s so many windows. And then, it’s just really interesting that you can see them. Wide open”. What is it about them being ‘wide open’ that you like? “To be able to see everything that’s going on around you as opposed to just being able to see, like, the pictures in the elevator...it works. It’s good”.* (14 year old boy)

Photo E



As Nightingale stated: “It is a curious thing to observe how almost all patients lie or make their way towards an open window...” (as cited in Skretkiewicz, 1992, p. 115), and even more fascinating that children so easily identified (when given the opportunity to do so) the spaces and places that are universally recognized as conducive to the healing process.

Finding Alternate Spaces

Children are able to “forge a place for themselves” by demonstrating that they are speaking, knowing and experiencing subjects actively involved in the social worlds they live in, and are interactive agents who engage with people, ideologies and institutions (Prout, 2000, p. 7). While “children can be seen as shaped and constrained by the circumstances of their lives”, they also shape them and are enabled by them when they find ways to creatively manage, negotiate and extend the possibilities (Prout, p. 7). Moreover, it is emphasized that the body of a child is a place of contestation. Rhetorics of children’s safety in schools (and hospitals) displace attention from the body as a site of disciplinary and regulatory regimes (Prout, 2000). In attempting to produce docile bodies, those in power are met with resistance from children who sometimes “subtly pitch activities to subvert this aim” (Prout, p. 9). “Mr. Aesthetics” was a young boy who demonstrated a form of resistance (and simultaneously a form of control) when he described the Atrium space as “chaotic, cluttered and in need of organization”, and took a photograph of a single bench facing away from the Atrium to illustrate an alternate “spot” he had found and often visited in the Atrium. His aesthetic sensitivity was further

revealed when he spoke not only of his sense of spatial organization, but of his perception of colour:

“You can just tell by the colours...do you see the bright yellow, the green, the bright pink, and the cow...it’s really tacky and kiddish. I think the environment should be organized and clean, more simple - maybe simple plants would be perfect”. Why did you take this picture of this bench? “All you need is someone there reading – I thought it showed that it was clean, organized, comfortable, really simple” (see photo F). (13 year old boy)

Photo F



Gibson’s theory of affordances (Kyttä, 2002) may provide insight into children’s ability to find alternate spaces. In Gibson’s view, people and animals do not construct the world that they live in, but are attuned to the invariants of information in the environment. Social rules and practices regulate which affordances can be utilized or shaped, and when, where, and how this done. It is also possible that the social context restricts the utilization and shaping of affordances. For example, a little boy may independently perceive the potential affordance of climbing but before utilizing this possibility, his parents may either encourage him to be brave and climb, or tell him not to climb because he may spoil his clothes (Kyttä, p. 109). When reflecting on the stimulating design of the HSC Atrium, the aesthetics may restrict children to certain experiences, and do not “afford” children a variety of other possibilities (or the power to choose some other activity) other than an immersion into fantasy. Young patients like Mr. Aesthetics clearly articulated objects and alternative areas that afforded him tranquility, and continually searched for hiding places and secret nooks devoid of fantasy like creatures and images. Massumi might describe these places as zones of indeterminacy or cracks in the environment that can be “filled with potential unpredictable bodily responses that unhinge habit, and break the stimulus – response circuit by providing a new milieu within which the body to move” (Massumi, 1992, p. 98). Mr. Aesthetics most certainly found such a place.

In being reflexive during this process of analysis and interpretation, I am aware that by introducing and applying various theoretical perspectives to the data, different

forms of children's action and activity become pronounced. It is not that various theories change the research question or direction of the inquiry, but rather they illuminate different components of children's activity within this hospital setting. By watching, pressing, and searching, children are in fact demonstrating their sophisticated and creative ability to manage, negotiate and forge a place for themselves during hospitalization. Since this extending of possibilities clearly resonates in the data, further analysis is needed to determine and make more visible children's understandings of what is environmentally essential for recovery, and uncover the multiple ways they exert freedom and control within the context of a hospital setting.

Conclusion

To summarize, the small methodological steps I took towards unraveling the complexity of one slice of a larger qualitative inquiry began with treating an intuition like a clue to an analytic puzzle. New questions were generated and brought to the data, and the object of interest was identified. In approaching the data as an answer to a question, a broader research question emerged which shifted the analysis towards a more sociological inquiry. Using the technique of bridging, (Miller & Fox, 2004), various theoretical concepts were applied and linked in a way that respected the distinctive contributions and integrity of each. This methodological strategy was particularly enlightening for me as I realized that what I was observing and interpreting was children's activities, however different *forms* of activity were illuminated through the use of various theoretical perspectives. Eventually these forms distinguished themselves as mechanisms for exerting a sense of freedom and control. Challenges ahead include the complexity of analyzing the vast amount of data collected from 80 participants, and determining which theory or theories fit the larger data set in the most creative and insightful way. Contradictions in the data must also be addressed, as children spoke about and took photographs of the main, fantasy – like features of the Atrium. Finally, further discussion around the methodology of photo elicitation is needed, as I discovered that it was not only the final viewing of the photographs that elicited further thought – it was the act of taking pictures that resulted in insightful textual and visual responses.

Although this paper focused on the methodological process of analyzing and interpreting data, an analysis is beginning to take shape. Children's need to exert control during hospitalization is revealed in this study through their ability to appropriate the medical gaze, press against sociological and architectural boundaries, and find alternate spaces. Drawing on children's self identified, self articulated place within contemporary pediatric hospitals, further evaluation is needed to identify what aspects of hospital designs are effective/not effective in meeting the needs of children coping with illness. At this point in the analysis, it appears that extended and open views from various windows are responsive to children's needs. Lacking are the opportunities for children to choose activities and find places that afford something different than a fantasy elsewhere. Tranquil and hidden getaways may offer children a sense of control that resist adult-centered ideals, and allow them to creatively manage, negotiate and forge places for themselves.

As I come to the end of this discussion, I am aware that these beginning insights about hospitalized children are not necessarily new. The complex relationship between

freedom and control has been at the root of many qualitative, sociological inquiries, however as I “put into prose what everyone knows” (Frank, 2004, p. 437), and begin to fill that gap between what we know and articulating it from different theoretical perspectives, I am encouraged by the prospect of decoding hard-to-articulate observations. Unfortunately, the metaphor of detective fiction begins to break down at this point because the genre of mystery requires a solution at the end (Frank, p. 439). However, “if this lack of closure leaves us feeling ineffectual and powerless in the face of complexity, we can also feel that we have gained a power to look hard at this complexity and not be turned to stone” (Frank, p. 439). While being both humbled and empowered by this notion, I will continue to take interpretive chances that address this complexity, and search for new ways of seeing what children might be saying through their bodies’ physical conversations.

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Author Note

The author gratefully acknowledges the time, effort, and thoughtfulness of the children and adolescents who participated in "The Paediatric Hospital Atrium: Designers' Intentions versus Children's Experiences" project (short title: "Kids in the Atrium"), which was funded by the Canadian Institutes of Health Research (cihr: frn# 74457). The

project also benefited greatly from the generous input of the SickKids Children Council and other members of the KITA Project team: Patricia McKeever, Annmarie Adams, David Theodore, Karen Spalding, and Ellie Goldenberg.

Coralee McLaren is an RN and PhD Student at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, Ontario; E-mail: cora.mclaren@utoronto.ca

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Article Citation

McLaren, C. (2009). Analyzing qualitative data about hospitalized children: Reflections on bodily expressions. *The Qualitative Report*, 14(1), 140-154. Retrieved from <http://www.nova.edu/ssss/QR/QR14-1/mclaren.pdf>
