



## “Why did I try to kill myself?”: A narrative context analysis of Marianne’s story

Rita Kristin Klausen PhD Student, Researcher

**To cite this article:** Rita Kristin Klausen PhD Student, Researcher (2016) “Why did I try to kill myself?”: A narrative context analysis of Marianne’s story, *Social Work in Mental Health*, 14:3, 260-270, DOI: [10.1080/15332985.2015.1005274](https://doi.org/10.1080/15332985.2015.1005274)

**To link to this article:** <http://dx.doi.org/10.1080/15332985.2015.1005274>



Accepted author version posted online: 22 Jan 2015.  
Published online: 22 Jan 2015.



Submit your article to this journal [↗](#)



Article views: 235



View related articles [↗](#)



View Crossmark data [↗](#)

## “Why did I try to kill myself?": A narrative context analysis of Marianne's story

Rita Kristin Klausen, PhD Student, Researcher

Center for Care Science, Department of Health and Care Sciences, The Arctic University of Norway UiT, Tromsø, Norway

### ABSTRACT

This article is based on one case study, drawn from a larger qualitative study of 30 mental health service users (MHSUs) in three Norwegian community mental health centers. The meaning of context is analyzed from a meeting with Marianne, a 31-year-old mother of three children diagnosed with bipolar disorder three years before the interview. Faced with dominant narratives that define mothers diagnosed with a mental illness in negative terms, Marianne provided a personal story that created a contextualized understanding of being a mother and an MHSU. Critical analyses of case studies play a valuable role in illness narrative research by giving another voice to otherwise silenced marginalized groups that are primarily described in terms of biomedical characteristics. Using a performative narrative perspective within a social constructionist approach, the present study developed a concept of “good mothering” as a relational term that is explored through a dialog with the MHSU.

### KEYWORDS

Mothers diagnosed with a mental illness; case study; personal performative narrative; context analysis

The purpose of this article is to present a context analysis of Marianne's story and to investigate her personal performative narrative in three contextual spheres, as inspired by Zilber, Tuval-Mashiach, and Liebllich (2008). The study from which this interview emerged included interviews with 30 mental health service users (MHSUs) at three Norwegian community mental health centers (CMHCs). The MHSUs had experienced considerable changes in their lives as a result of mental illness. Most of them had been admitted to a psychiatric hospital unit for acute care. During the interviews, many issues surfaced; one issue concerned being a mother and experiencing mental distress. There were 10 mothers among the participants in the study. Many women with diagnosed with mental illness are mothers, and their mothering role exists in constant tension with their diagnosis. Marianne, a 31-year-old woman, had been diagnosed with bipolar disorder only three years prior to the interview. She had been suicidal over multiple years, and she described two suicide attempts. Her first acute admission to a psychiatric hospital was connected to the first suicide attempt. Each research interview in the current

study represented an interactional context for storytelling (De Fina, 2009; Mishler, 1986; Riessman, 2008). All of the interviews reflected and were shaped by the relationship between the interlocutors (De Fina, 2009). Marianne's story was unique in its description of the suffering connected to the suicide attempts and how the suffering affected the whole family.

In this article, I explore context in relation to Marianne's performative narrative. One of the main aims of qualitative research is to learn about people's lives in the context in which they live (Tuval-Mashiach, 2014). I connect Marianne's personal story to the intersubjective level, a larger social sphere and a cultural metanarrative sphere. By performing a context analysis, I hope to demonstrate that mothering is a relational concept that occurs in the interaction and dialogue. By moving the focus away from the dominant narratives of mentally ill mothers and toward mothering as a relational term, I hope to inspire health professionals to open a dialogue with the contextual embedding of illness narratives (Klausen, Haugsgjerd & Lorem, 2013). First, Marianne's story is defined as a personal performative narrative. Before presenting the contextual frame, I focus on the dominant narrative of mothers diagnosed with a mental illness. Next, I analyze Marianne's story in three contextual spheres. Then, I relate these spheres to the concept of mothering as a relational term, underlining the importance of working with the family as a system during a crisis.

### **The personal performative narrative**

Life stories are socially situated actions and provide the individual with a sense of identity (Karlsson, 2006). A personal story is always a representation of a lived experience and is subject to change and reinterpretation (Gilbert, 2002). To perform personal narratives both defines and redefines body and voice: "the personal gives body to narrative, and narrative gives voice to experience" (Langellier, 1998, p. 207). I focus on the narrative as a personal performative event, and the interview with Marianne serves as a contextual frame (Klausen et al., 2013). I define my research within a social constructionist approach, and within this frame, knowledge is understood as something people do together (Burr, 2003). Marianne's personal story was created through collaboration between the researcher (me) and Ellen, the contact person from the CMHC. Personal stories develop in conversation with real and imagined audiences (Gilbert, 2002). In the current case, the imagined audience can be considered as Marianne's family and network, you (as readers) and the health professionals who work with this MHSU group. Marianne's personal story was equally directed to Ellen, the imagined audience and me as the researcher.

I began all of the interviews with the open question, "Can you tell me what brought you to psychiatric services?" This open question was designed to

elicit a narrative account (Thornhill, Clare, & May, 2004). Marianne informed me that her doctor referred her to the psychiatric hospital for acute admission. Then, after a couple of days, she was transferred to the CMHC. When I asked her how her family and network felt about her admission, she stated, “They were fantastic ... it was ... I don’t know, it was a relief for all those around me. That I finally realized ... (whispering) that I needed help.”

This interaction focused attention on how Marianne built her narrative and the performative work from which she wanted the dialogue to emerge (Phoenix, 2008). At the same time, it was characterized by the story of her experience and her understanding of experiences, actions, situation-bound elements and cultural thought forms (Pérez Prieto, 2006). The dialogue stresses the performative nature of interviews, while the performance underlines narrative as both a making and a doing (Peterson & Langellier, 2006). To approach the narrative as a performance, a theory that equally considers the context and the text is required (Langellier, 1999).

Marianne’s experience of illness has a knowledge value that is related to the topic of family- and network-based approaches within mental health treatment. The cultural context of motherhood within mental health care has been dominated by a diagnostic- and medicine-oriented approach toward MHSUs, with the treatment of the individual’s disease as the main focus (Fox, 2012). This orientation is related to what I refer to as the dominant narrative of mothers diagnosed with a mental illness.

### **The dominant narrative of mothers diagnosed with a mental illness**

Many women with severe mental illness are mothers (Diaz-Caneja & Johnson, 2004). As mothers, they are typically considered to be responsible for the health and wellbeing of their children. Furthermore, in the public forum, they are judged on their perceived mothering skills (Malacrida, 2009; Power, Jackson, Weaver and Carter, 2011). When I interviewed Marianne, she told about the relief of finally getting a diagnosis. Her husband and her parents had been in despair for a long time and had not understood what was going on with her. Women with mental health needs have been characterized as poor parents (Fox, 2012). The role of caregiver is a master status for modern adult women, but mothers with an illness may have a more complicated relationship with ideal motherhood than do other mothers (Malacrida, 2009). Marianne says during the interview that it is not easy for an eight-year-old to have a mentally ill mother. She wishes her children had somebody to talk with about all of the things they do not understand. Western norms view the ideal mother as a woman who mothers naturally, is always present to care for her baby and performs this mothering selflessly (Choi, Henshaw, Baker, & Tree, 2005). Most Western women recognize the

narrative of “good mothering” regardless of their country, ethnicity, class, age, or sexual orientation (Sevón, 2011). The long history and scientific authority behind the narrative of “good mothering” affect how mothers interpret their lives (Sevón, 2011). According to Diaz-Caneja and Johnson (2004), women reported that the label of “mother” was valued and respected by both society and themselves, whereas “mental health patient” was a label of social exclusion (Fox, 2012). Marianne tells about her everyday life during the interview; some days she experiences as very meaningful, while other days are just empty and meaningless.

Mothers diagnosed with a mental illness encounter a triple burden of discrimination. In addition to the diagnosis of mental illness, gender and motherhood seem stigmatizing to these women, who are already in exposed positions because of their illness and its challenges. Women diagnosed with a mental illness have reported that one painful aspect of living with their diagnosis is the loss of personal identity due to the label of being mentally ill (Scheyett & McCarthy 2006). Today, mothers must reconcile societal expectations that they can be good mothers while simultaneously meeting the expectation that they will fulfill their roles as members of society (Tardy 2000). Marianne describes in the interview how the diagnosis affects her everyday life. She says that she has been so active that it has made her sick; she has not been able to stop herself. At parent meetings today, she does not dare to sign up for different tasks because she is afraid that she will find herself doing so much that she will tire of it. These women are betwixt and between, so to speak. The burdens of being a woman, a mother and an MHSU can be rather difficult to handle in a small community. Marianne told about the first time she went to a psychologist in the community: “She actually told me that she would never give me comfort if I cried, and she would never hold me in her arms.” Marianne said she could not see the psychologist as a fellow human afterward. Feelings of guilt and failure are common because an identity as a mentally ill person is not compatible with these women’s own ideas about being a good mother (Vallido, Wilkes, Carter, & Jackson, 2010). These different roles can be difficult to combine. Furthermore, during admission in a CHMC, there are often few opportunities to function as a mother.

## **A contextual frame**

Context enters this story in a complex choreography and moves on several levels. The context exists in the spaces between narrator and listener, between telling and setting, between reader and text and between history and culture (Riessman, 2008). Considering the interview with Marianne from a performative perspective emphasizes that stories are created in the moment and exist in a vital and vibrant setting (Klausen et al., 2013). The narrative

activities that occur within the interview situation also articulate aspects of the wider social context (De Fina, 2008, p. 421). Identifying context is not a simple task because there seems to be no limit to the relevant contexts (Zilber et al., 2008, p. 1048). One must decide, as a researcher, what should be excluded or included in a context analysis of stories. By focusing on external contexts (which, in contrast to internal contexts, are connected to relations within languages), I concentrate on how the world is constructed and experienced by the storyteller. I wish to explore how Marianne experienced and situated the context or the background against which her life unfolded (Zilber et al., 2008, p. 1049). Zilber et al. (2008) introduced the following three relevant spheres of context: the immediate intersubjective relations in which the narrative is produced, the collective social field in which one's life and story evolve and the broad cultural metanarratives that underlie and give sense to a particular story. In the following analysis, I employ these spheres to describe the interview situation. Each sphere is further described throughout the analysis of Marianne's story.

### Marianne's story

Before the interview, Marianne was contacted by a contact person at the CMHC and agreed to speak with "this researcher from Tromsø." We met earlier on the same day as the interview in the shop where Marianne worked part time. Ellen wanted me to meet Marianne before the interview; perhaps Ellen believed that this meeting would help Marianne prepare for the interview. It was a short, pleasant meeting, and Marianne reassured us that she would come to our appointment later. Ellen was also present during the interview. Marianne and Ellen had known each other for a long time, which was typical in this small community. We drank coffee, and Ellen knitted while Marianne and I spoke. I asked Marianne whether she felt that her diagnosis was correct and whether it reflected how she felt sometimes. Then, she told the story as presented.

I've struggled since adolescence, and when I had my first [child],<sup>1</sup> I was only 19 when I started to fight ... I got a natal depression, and it was like, it has never been good, and it turned out I was bipolar then. And if the pregnancy triggered it, I don't know. So that I do not know ... no, I'm so glad that I got a diagnosis, that "*I am not just like that*", my mom and my family were going like "oh, what is it?"; "why is she like that?", and today they dare to say it to me. Those around me have been in despair, my husband has been in despair. It's a wonder that I have a husband. That he has endured (laughs); it's a miracle. It is a TERRIBLE disease to have, it is. I think my stay there [at the CMHC] was to get me on my feet. I had

---

<sup>1</sup> The transcription of the recordings followed the following principles: ... indicates a pause of two to three seconds, () indicates an explanation from the interviewer related to expressed emotions, (...) indicates that some text from the interview was excluded and [] indicates a clarifying comment from the interviewer.

nothing, there was no talk about what I'd done, or what kind of past I had, it was not, it was just . . . focus was that I was going to *get myself back on my feet*. I did go quite often to the psychologist, but when I think back, we just talked *bamboo* (laughs). When I talk with my friends, I can talk for hours, I just get it out and it's *all* about the two years before I got sick and until the hospitalization. But it was never talked about in there [at the CMHC]. It was all talk of the past; *so far way*. Like childhood. I had a very great need, it's probably very individual, but I had at least a great need to talk about what had happened, *why did I try to kill myself?* What just happened? I was not asked once if I needed to talk about it. I don't know if they [the mental health professionals] wouldn't talk about it? I don't know. But no one asked. . . . I wanted someone to ask, I could compare it to a birth. After having borne a child, you have a conversation afterwards [with health professionals]. About the birth. IT. When I think about it now, I would have liked it. With just that thing here [the suicide attempt]. Only to be able to speak, be allowed to talk and, YES, about exactly those things [the suicide attempts]. (. . .) I feel I was not heard in relation to the kids [either]. They [the mental health professionals] ignored it a long time in there [at the CMHC]. "No, you only think about yourself", "think of yourself", but as a mother, it is not possible. No matter how sick you are . . .

The researcher participates in the creation of stories and decides what to present in the stories (Blix, Hamran, & Normann 2012). Marianne's story has been transformed into a coherent narrative based on the interview with her. This process involves the construction of a more comprehensive, condensed narration. The main content has been shortened, but the words are those of Marianne. In the interview with Marianne, she told a story about her suicide attempts and her opinion about the way that she was treated in the CMHC. I relate her story to the three contexts of Zilber et al. (2008).

## Analyzing contexts

### *Intersubjective relations*

The immediate relationship and interaction that occur in the interview represent a context-sphere in which the storyteller's identity is linked to the story at that moment (Zilber et al., 2008, p. 1051). On the intersubjective level, Marianne broached the topics of the birth of her first child, her mother, her family, and her husband early in the conversation. She described her diagnosis as a relief for all of them. This description can be viewed as a lead for interpretation (Zilber et al., 2008, p. 1056). We can see how Marianne interprets the narrative; the diagnosis can be understood as a turning point. Knowing the context of the interview, Marianne wanted to talk about the diagnosis as a positive change for herself and her network. Marianne's narrative was intense, yet very concrete. She knew what aspects she wanted to highlight and illuminate. Her storytelling was, in fact, painful. It was difficult to grasp her feelings of helplessness at some points because she

emerged as such a strong and determined woman during the interview. Marianne infused her storytelling with an alternative story of good mothering. It can be argued that the only thing missing from the story is the actual presence of the voices in her network, those of her children and her husband.

### ***The social field***

The social field is related to the sociohistorical context in which life is lived. When narrating their lives, people situate their stories within certain social structures and historical events. Their choice of a relevant social field is meaningful and may be interpreted to indicate what they consider as relevant or important for their identity (Zilber et al., 2008, p. 1053). The social sphere refers to personal constructions of the public collective sphere, and Marianne situated her story within certain social structures (Zilber et al., 2008, p. 1053). Losses occur in social networks, and the personal story of a loss fills a social purpose (Gilbert, 2002). Marianne nearly lost her life. This subject was very painful and difficult to discuss, both for Marianne and the surrounding professionals.

When Marianne talked about her suffering after the suicide attempts, she referred to a common and well-established practice in Norwegian maternity wards. After a birth, a midwife (or a nurse) has a conversation with the mother about how she experienced giving birth. This conversation is thought to help alleviate any possible suffering that the new mothers experience and promote their health (Nygård, Nåden, & Foss, 2011). The midwife asks the patient how she experienced the birth and whether there were any difficult moments. If there were difficult moments, the midwife asks (first) whether the patient wishes to talk about them, what the patient relates them to, and whether she (or any other health professionals) can help the patient. Postpartum care is of crucial importance to the woman (Frei & Mander, 2011, p. 722). When Marianne brought this issue into the conversation, Ellen and I both understood the reference, as we had also experienced these conversations after giving birth. Ellen and Marianne each have three children, and I have two. “The caring relationship between a woman and a care provider influences satisfaction with received care. It determines the extent to which women feel in control” (Frei & Mander, 2011, p. 716). I remember the strength behind this particular portion of the interview. Marianne deeply desired to talk about her suicide attempts. She was a mother of three small children at the time, and all of the individuals who she interacted with merely wanted her “back on her feet.” She wanted to talk, she asked herself “*How could this happen?*” She also wanted another individual to pose the same question to her. When Marianne discussed her suffering in this context, she consequently talked about her family, particularly her children, in relation to the mental health system and the clinicians at the facility where she was

receiving treatment. She addressed her story to the professionals in the psychiatric field. Her entire family was in need of help; she was not experiencing a life crisis alone.

### ***Cultural metanarratives***

Master narratives enjoy a more or less unchallenged status, and they are framed by the culture in which individuals live (Andrews, 2002). Andrews underlines that when marginalized women (in this case, mothers diagnosed with a mental illness) offer a different model of mothering, they may be regarded as deviant or even sometimes pathological (Andrews, 2002, p. 10). The women in the current study are often defined as a marginalized group, and a biomedical perspective on their diagnosis has dominated the discussion (Chernomas, Clarke, & Chisholm, 2000). The experience of motherhood is socially constructed (Andrews, 2004), and the construction of the mothering role is a complex and dynamic process. How does Marianne's story fit into the dominant narrative of mothers diagnosed with a mental illness?

Marianne lives within a system of meaning that characterizes her suffering as individual. The dominant culture in psychiatry does not recognize "the importance of including the family in the treatment plan and discharge planning process" (Engquist, Ahlin, Ferszt, & Nilsson 2011). Marianne addressed this system throughout her personal story by highlighting the importance of including the entire family in an MHSU's treatment. She also resisted the dominant narrative of mothers diagnosed with a mental illness. She was a highly responsible mother who wanted her husband and children to receive help. She spoke openly and insisted on the importance of viewing the family as a system in crisis. "The shift from holding up a dominant worldview to which we expect all perspectives to correspond, to acknowledging the coexistence of multiple, diverse views may be a necessary precondition for encouraging people with mental illness<sup>2</sup> to compose and share their narratives, and for these narratives to be respected, not only as valid and useful tools for research, but as a foundation for recovery as well" (Roe & Davidson, 2005, p. 91).

By experiencing Marianne's personal performative narrative attempts to understand her own experience, one can understand the concept of mothering in a more relational sense. The term "relational" emphasizes that individuals voice systems of meanings in their meaning-making process. Meaning is created through the interaction of competing discourses (Harrigan & Miller-Ott, 2013). Motherhood is a complex term that is connected to several discourses, including the dominant discourse of mothers diagnosed with a mental illness and the discourse of good mothering. Marianne interwove her

---

<sup>2</sup> The term "schizophrenia" in the original quote was replaced with "mental illness" by the author of this article.

story with many discourses, all within contexts surrounding her meaning-making process. Through a relational dialogue with Marianne and her family, several of these discourses came to the surface and became “less dangerous” for her family and health professionals.

## Closing remarks

Through a context analysis of Marianne’s personal narrative, this article addresses the need for a more family- and network-based approach to community mental health care. One of the core principles of mental health care rehabilitation is “to optimize individuals’ successful outcomes in the community in their roles of choice” (Mowbray, Nicholson, & Bellamy, 2003, p. 104). Community mental health services seldom focus on the needs of women as spouses, mothers, and family members (Mowbray, Oyserman, Saunders, & Rueda-Riedle, 1998). I agree with David, Styron, and Davidson (2011) who argued that collaboration among various providers, including staff at various service agencies involved with the mother, teachers, and mental health professionals, “could result in an increasingly open dialogue about women’s parenting needs and desires, as well as much-needed discussion of these concerns in the context of children’s emotional and physical needs” (p. 148). Marianne is in need of health professionals who can include the family in the recovery process and she wants her children to understand her illness. She considers it important for her children to receive the help required for them to not blame themselves in any way. If Marianne’s mental health providers had included her social network in her treatment, they would have recognized that the family as a system had been affected by Marianne’s mental distress. In this scenario, neither Marianne’s nor her family members’ experience of the disease would be ignored.

## Ethics

It was ensured that professional help was available to all of the participants in this study if needed after the interviews were conducted.

The project was approved by the Ethics Committee of the Fifth Region of Norway in 2011.

## References

- Andrews, M. (2002). Memories of mother: Counter-narratives of early maternal influence. *Narrative Inquiry*, 12(1), 7–27. doi:10.1075/ni.12.1.04and
- Andrews, M. (2004). Memories of mother. Counter-narratives of early maternal influence. In M. Bamberg & M. Andrews (Eds.), *Considering counter-narratives. Narrating, resisting, making sense* (pp. 7–26). Amsterdam, the Netherlands: John Benjamins Company.

- Blix, B.H., Hamran, T., & Normann, H.K. (2012). Indigenous life stories as narratives of health and resistance: A dialogical narrative analysis. *CJNR (Canadian Journal of Nursing Research)*, 44(2), 64–85.
- Burr, V. (2003). *Social constructionism*. East Sussex, UK: Routledge Psychology Press.
- Chernomas, W.M., Clarke, D.E., & Chisholm, F.A. (2000). Perspectives of women living with schizophrenia. *Psychiatric Services*, 51(12), 1517–1521. doi:10.1176/appi.ps.51.12.1517
- Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: Performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology*, 23(2), 167–180. doi:10.1080/02646830500129487
- David, D.H., Styron, T., & Davidson, L. (2011). Supported parenting to meet the needs and concerns of mothers with severe mental illness. *American Journal of Psychiatric Rehabilitation*, 14(2), 137–153. doi:10.1080/15487768.2011.569668
- De Fina, A. (2008). Who tells which story and why? Micro and macro contexts in narrative. *Text & Talk—An Interdisciplinary Journal of Language, Discourse Communication Studies*, 28(3), 421–442.
- De Fina, A. (2009). Narratives in interview—The case of accounts: For an interactional approach to narrative genres. *Narrative Inquiry*, 19(2), 233–258. doi:10.1075/ni.19.2.03def
- Diaz-Caneja, A., & Johnson, S. (2004). The views and experiences of severely mentally ill mothers—A qualitative study. *Social Psychiatry and Psychiatric Epidemiology*, 39(6), 472–482. doi:10.1007/s00127-004-0772-2
- Engquist, I., Ahlin, A., Ferszt, G., & Nilsson, K. (2011). Comprehensive treatment of women with postpartum psychosis across health care systems from Swedish psychiatrists' perspectives. *Qualitative Report*, 16(1), 66–83.
- Fox, J.R. (2012). Best practice in maternity and mental health services? A service user's perspective. *Schizophrenia Bulletin*, 38(4), 651–656. doi:10.1093/schbul/sbs035
- Frei, I.A., & Mander, R. (2011). The relationship between first-time mothers and care providers in the early postnatal phase: An ethnographic study in a Swiss postnatal unit. *Midwifery*, 27(5), 716–722.
- Gilbert, K.R. (2002). Taking a narrative approach to grief research: Finding meaning in stories. *Death Studies*, 26(3), 223–239. doi:10.1080/07481180211274
- Harrigan, M.M., & Miller-Ott, A.E. (2013). The multivocality of meaning making: An exploration of the discourses college-aged daughters voice in talk about their mothers. *Journal of Family Communication*, 13(2), 114–131. doi:10.1080/15267431.2013.768249
- Karlsson, M. (2006). *Föräldraidentiteter i livsberättelser [Parental identities in life stories]*. (Doctoral thesis, Uppsala University, Uppsala, Sweden). Retrieved from <http://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-7085>
- Klausen, R. K., Haugsgjerd, S., & Lorem, G. F. (2013). “The lady in the coffin”—Delusions and hearing voices: A narrative performance of insight. *Qualitative Inquiry*, 19 (6), 431–440.
- Langellier, K. (1998). Voiceless bodies, bodiless voices: The future of personal narrative performance. In S. Dailey (Ed.), *The future of performance studies: Visions and revisions* (pp. 207–213). Annandale, VA: National Communication Association.
- Langellier, K. M. (1999). Personal narrative, performance, performativity: Two or three things I know for sure. *Text and Performance Quarterly*, 19(2), 125–144. doi:10.1080/10462939909366255
- Malacrida, C. (2009). Performing motherhood in a disablist world: Dilemmas of motherhood, femininity and disability. *International Journal of Qualitative Studies in Education*, 22(1), 99–117. doi:10.1080/09518390802581927
- Mishler, E. G. (1986). *Research interviewing. Context and narrative*. London, UK: Harvard University Press.

- Mowbray, C.T., Nicholson, J., & Bellamy, C.D. (2003). Psychosocial rehabilitation service needs of women. *Psychiatric Rehabilitation Journal*, 27(2), 104–113. doi:10.2975/27.2003.104.113
- Mowbray, C.T., Oyserman, D., Saunders, D., & Rueda-Riedle, A. (1998). Women with severe mental disorders: Issues and service needs. In B. Labotsky-Levin, A. Blanche, & A. Jennings (Eds.), *Women's mental health services: A public health perspective* (pp. 175–200). Thousand Oaks, CA: Sage.
- Nygård, I.J., Nåden, D., & Foss, B. (2011). Hvordan kan samtale bidra til å lindre lidelse og fremme helse hos kvinner Med fødselsdepresjon? [How can conversation contribute to alleviate suffering and regain health in women with postnatal depression?]. *Vård i Norden*, 31(1). Retrieved from <http://hdl.handle.net/10642/1093>
- Pérez Prieto, H. (2006). *Historien Om Råven och Andra Berättelser.Om. Klasskamrater och Skolan På en Liten ort—Ur Ett Skol- och Livsberättelseperspektiv* [The story about the fox and other stories. About classmates and school in a small town- from a school and life story perspective]. Karlstad, Sweden: Karlstad University Studies.
- Peterson, E.E., & Langellier, K.M. (2006). The performance turn in narrative studies. *Narrative Inquiry*, 16(1), 173–180. doi:10.1075/ni.16.1.22pet
- Phoenix, A. (2008). Analysing narrative contexts. In M. Andrews, C. Squire, & M. Tamboukou (Eds.), *Doing narrative research* (pp. 64–77). Thousand Oaks, CA: Sage Publications.
- Power, T., Jackson, D., Weaver, R., & Carter, B. (2011). Social support for mothers in illness: A multifaceted phenomenon. *Contemporary Nurse*, 40(1), 27–40.
- Riessman, C.K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage Publications.
- Roe, D., & Davidson, L. (2005). Self and narrative in schizophrenia: Time to author a new story. *Medical Humanities*, 31(2), 89–94. doi:10.1136/jmh.2005.000214
- Scheyett, A.M., & McCarthy, E. (2006). Women and men with mental illnesses: Voicing different service needs. *Affilia*, 21(4), 407–418. doi:10.1177/0886109906292114
- Sevón, E. (2011). “My life has changed, but his life hasn’t”: Making sense of the gendering of parenthood during the transition to motherhood. *Feminism & Psychology*, 22(1), 60–80.
- Tardy, R.W. (2000). “But I am a good mom”: The social construction of motherhood through health care conversations. *Journal of Contemporary Ethnography*, 29(4), 433–473. doi:10.1177/089124100129023963
- Thornhill, H., Clare, L., & May, R. (2004). Escape, enlightenment and endurance. *Anthropology & Medicine*, 11(2), 181–199. doi:10.1080/13648470410001678677
- Tuval-Mashiach, R. (2014). Life stories in context: Using the three-sphere context model to analyze Amos’s narrative. *Narrative Works*, 4(1), 125–145.
- Vallido, T., Wilkes, L., Carter, B., & Jackson, D. (2010). Mothering disrupted by illness: A narrative synthesis of qualitative research. *Journal of Advanced Nursing*, 66, 1435–1445. doi:10.1111/j.1365-2648.2010.05350.x
- Zilber, T.B., Tuval-Mashiach, R., & Lieblich, A. (2008). The embedded narrative: Navigating through multiple contexts. *Qualitative Inquiry*, 14(6), 1047–1069. doi:10.1177/1077800408321616