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Focus Groups in Health Research

Exploring the Meanings of Health and Illness

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Abstract

Focus group method is becoming increasingly popular among qualitative researchers. After introducing focus group method and briefly overviewing its use in health research, this article shows that the distinctive (and under-used) feature of focus group method is its generation of interactive data. Illustrating my argument with examples from health-related focus group research (including my own data on breast cancer), I argue that this feature makes focus groups an ideal method for gaining access to research participants' own meanings. Interactive data result in enhanced disclosure, improved access to participants' own language and concepts, better understanding of participants' own agendas, the production of more elaborated accounts, and the opportunity to observe the co-construction of meaning in action. Focus groups are, then, an ideal method for exploring people's own meanings and understandings of health and illness.

Keywords

breast cancer, co-construction, focus group, interaction, meaning

SEVEN WOMEN, linked by a shared diagnosis of breast cancer, meet over coffee one evening. Their conversation ranges across 'finding the lump', cone biopsies, a friend's death from breast cancer, the insensitivity of medical professionals, the experience of radiotherapy, partners' reactions to mastectomy scars, and the merits—or otherwise—of 'stick-on nipples'. They tell stories, crack jokes, argue, support one another, and talk over each other. This is a typical focus group scenario, drawn from my own research. A focus group is, at its simplest, 'an informal discussion among selected individuals about specific topics' (Beck, Trombetta, & Share, 1986, p. 73). Focus group research generally involves organizing and running a series of small, focused group discussions, like the one described above, and analysing the resulting data using a range of conventional qualitative techniques. The method has become popular among qualitative researchers in recent years, with, for example, over 100 focus group articles published in 1994 alone (Morgan, 1996).

The invention of what are now called focus groups is usually attributed to sociologist Robert Merton, who, together with colleagues Patricia Kendall and Marjorie Fiske, developed a group approach (the 'focused group-interview') for studying audience responses to radio programmes (Merton & Kendall, 1946; Merton, Fiske, & Kendall, 1956). Although focus groups have been in use as a research tool for more than half a century, relatively few studies were published before the late 1970s, and most of these were in the field of business and marketing (see Goldman & McDonald, 1987, for a review). The contemporary 'resurgence of interest' (Lunt & Livingstone, 1996, p. 79) in focus groups has meant expansion well beyond this field: the method is now 'gaining some popularity among social scientists' (Fontana & Frey, 1994, p. 364), with much current research concentrated in the fields of health (e.g. Harrison & Barlow, 1995), communication/media studies (e.g. Lunt & Livingstone, 1996) and education (e.g. Vaughn, Schumm, & Sinagub, 1996).

Health researchers pioneered the use of focus groups in social action research, particularly family planning and preventive health education (e.g. Folch-Lyon, de la Macorra, & Schearer, 1981; Schearer, 1981; Suyono, Piet, Stirling, &

Ross, 1981), and research on health-related topics continues to be a major area of focus group research today. Much of this research, however, has been conducted within nursing, social policy and sociology. Within psychology, focus groups have been less widely used, and the method rarely appears in psychological research methods texts, even in those devoted to qualitative methods (although for recent exceptions see Millward [1995] and Vaughn et al. [1996]). This may be partly because, as Harrison and Barlow (1995, p. 11) suggest, psychologists have been concerned that focus groups 'did not fit the positivist criteria extant in the dominant research paradigm'. I will take it for granted that I do not need, in this context, either to establish a case for qualitative over quantitative methods, or to differentiate the particular sets of technical, epistemological and political issues associated with qualitative and quantitative methods respectively (see Bryman, 1988). Rather, I will consider the particular advantages of focus group method per se for qualitative researchers, particularly for those (e.g. phenomenological, experiential or narrative researchers) concerned to elicit participants' own meanings and understandings of health and illness.

Centrally, focus group method involves one or more group discussions, in which participants focus collectively upon a topic or issue, most commonly presented to them (either verbally or in written form) as a set of questions; although sometimes as a film, a collection of advertisements, cards to sort, a game to play, or a vignette to discuss. Focus group participants (usually 6–8) may be pre-existing clusters of people (such as family members, friends or work colleagues) or they may be drawn together specifically for the research. An increasingly common use of focus groups is to bring together 'a group of people who have experienced the same problem, such as residents of a deteriorating neighbourhood or women in a sexist organization' (Rubin & Rubin, 1995, p. 139). Discussions between group participants, usually audiotaped (sometimes videotaped) and transcribed, constitute the data, and conventional techniques of qualitative analysis are then employed. This most commonly entails some variety of content analysis or thematic analysis (sometimes computer-assisted with the use of programs such as NUD.IST or THE ETHNO-

GRAPH) as typically employed in analysing other forms of qualitative data, such as that generated in one-to-one interviews. Additionally, some researchers have used rhetorical, discursive and conversation analytic techniques (e.g. Agar & Macdonald, 1995; Myers, 1998).

There is an extensive methodological literature on the practical details of conducting focus groups (e.g. Barbour & Kitzinger, 1998; Krueger, 1994; Morgan, 1988, 1993; Stewart & Shamdasani, 1990; Vaughn et al., 1996), so I will not rehearse such details here. A useful brief introduction to the method is provided by Kitzinger (1995), while a recent 'state of the art' review may be found in Morgan (1996). As many of these commentators on focus group method emphasize, the method is distinctive not for its mode of analysis, but rather for its data collection procedures. Crucially, focus groups are characterized by the interaction of group participants *with each other* as well as with the researcher/moderator, and it is the collection of this kind of interactive data that distinguishes the focus group from the one-to-one interview (cf. Kitzinger, 1994a; Morgan, 1988), as well as from procedures which use multiple participants but do not permit interactive discussions (cf. Stewart & Shamdasani, 1990). I will return later to some of the implications of the interactive nature of focus group data.

From across a wide range of perspectives, particularly those sometimes referred to as 'anti-positivist' (Murray, 1997, p. 9),¹ as well as some versions of cognitive psychology and some research on health beliefs and attitudes, increasing interest is being directed toward participants' *own meanings* of health and illness: 'the patient's view' (Armstrong, 1984). Such meanings are seen as essential in understanding, for example, coping behaviour, psychosocial well-being and adaptation to negative life events, as well as offering important insights into people's phenomenological lifeworlds (cf. Fife, 1994). For those researchers with an interest in accessing participants' own meanings—either as a research topic in their own right, or as an adjunct to other more conventional (or positivist) approaches—focus groups offer a valuable way forward.

After briefly overviewing the main uses of focus groups in health research, I advance the key argument of this article: that focus groups

are an ideal method for gaining access to participants' own meanings. Illustrating my argument with examples from health-related research (including my own current work on breast cancer), I consider the specific mechanisms through which focus groups facilitate access to participants' own meanings. I conclude by discussing the potential of focus group method for future research on participants' own meanings of health and illness.

Overviewing focus groups in health research

Before expanding on the particular value of focus groups in eliciting people's own meanings and understandings of health and illness, I will outline the range of different topics and approaches currently used in health related focus group research. An extensive range of topics central to health and illness has been studied using focus groups. Such topics include: the experience of specific disorders and diseases;² reproductive issues;³ violence and abuse;⁴ living with chronic illness or disability;⁵ health care practices and procedures;⁶ health-related behaviours;⁷ and broader factors that mediate health and illness.⁸ A wide variety of participants has also been involved in focus group studies on health-related issues, ranging from Australian schoolchildren (Houghton, Durkin, & Carroll, 1995) to old people in residential care in England (Chapman & Johnson, 1995), and from former LSD users (Agar & Macdonald, 1995) to rural Chinese women (Wong, Li, Burris, & Xiang, 1995).⁹ Focus groups are an appropriate method for addressing a broad range of research questions across a variety of health-related domains, and they are suitable for use with diverse populations of research participants. Focus groups have been used in five main theoretical and/or practical ways in health-related research, each of which will be discussed briefly below.

Studies of lifeworlds and health beliefs

There is a tradition of health-related research that uses focus groups to explore people's own meanings of health and illness. Some of this work seeks to develop in-depth understandings of individuals' lifeworlds, e.g. women's experiences post-partum (DiMatteo, Kahn, & Berry,

1993), the experience of living in a nursing home (Brody, 1990), or the experience of living with multiple sclerosis (Lyons & Meade, 1993). Other studies broadly in this tradition seek to develop more specific understandings of individuals' health beliefs or models, e.g. about HIV/AIDS (Irwin et al., 1991), heart attacks (Morgan & Spanish, 1985) or nutrition (Crockett, Heller, Merkel, & Peterson, 1990). As Hoppe, Wells, Wilsdon, Gilmore, & Morrison (1994, p. 118) point out, focus groups are 'a useful method for learning about the vocabulary and thinking patterns of a population within its social context'. In addition, as a relatively naturalistic method, which enables relatively spontaneous interaction between people, focus groups increase the likelihood of 'gaining deeper insights than might arise with individual structured interviews or questionnaires' (Ritchie, Herscovitch, & Norfor, 1994, p. 97). Focus groups have been used to study, for example, the knowledge and beliefs of elementary schoolchildren about AIDS (Hoppe et al., 1994), the beliefs of blue collar workers about coronary risk behaviours (Ritchie et al., 1994) and the traditional beliefs of Black women in relation to breast cancer (Duke, Godon-Sosby, Reynolds, & Gram, 1994) and AIDS (Flaskerud & Rush, 1989).

Assessment of health status and health care needs

Focus group research has also been used to obtain an index or measurement of individuals' states of health, or health care needs, including assessments of 'quality of life', e.g. in relation to breast cancer (Wyatt, Kurtz, & Lyken, 1993) or asthma (Hyland, Finnis, & Irvine, 1991). Other such indices derived from focus group research include individuals' satisfaction with their health status or with health care services on offer to them, such as general practice (Murray, Tapson, Turnbull, McCallum, & Little, 1994) or community health services (Collins, Stommel, King, & Given, 1991). In some of these studies, focus groups are used on a stand-alone basis to assess individuals' needs or attitudes. In others, they are used as an initial data-gathering tool to inform the later development of surveys (O'Brien, 1993) or scales (Hyland et al., 1991). One major advantage of this, as O'Brien (1993) notes, in reporting the

use of focus groups to develop an instrument to survey the social relationships of gay and bisexual men at risk for AIDS, is that focus groups enable the investigator to identify concepts and practices central to the respondents, and so to construct more appropriate survey items. Further, using material derived from focus groups, the investigator can design a questionnaire using respondents' own words or phrases, thereby enhancing their understanding of the research questions. Focus groups may also be used as an exploratory technique to generate hypotheses meriting further qualitative or quantitative investigation.

Health education and health promotion

There is a great deal of focus group research focused around health education and health promotion. Key areas where focus groups have been used include: the US National High Blood Pressure Education Program (cf. Basch, 1987); uptake of cervical screening facilities, particularly among ethnic minority women (Dignan et al., 1990; Naish, Brown, & Denton, 1994); prevention of teenage pregnancy (Kisker, 1985; Okonofua, 1995); and sex education, particularly the promotion of safer sex in the context of HIV/AIDS (Kline, Kline, & Oken, 1992; Lupton & Tulloch, 1996). Used in the context of health education, focus groups are particularly useful for identifying obstacles or objections that prevent or discourage individuals from (say) using contraception or practising safer sex. There is also a substantial body of focus group work on individuals' understanding of, and responses to, health-related media messages (e.g. Aitken, Leather, & O'Hagan, 1986; Freimuth & Greenberg, 1986; Kitzinger, 1990; Philo et al., 1994). Health education messages have often been proposed, or modified, on the basis of focus group research which has assessed their likely effectiveness. For example, following focus group research in which men spoke of their sense of responsibility, the message 'protector of the family' was designed to encourage condom use (Kline et al., 1992, p. 455); and another focus group study on compliance in taking medication led to the extension of the health promotion message 'Do It For Them' to include 'doing it for oneself' (Basch, 1987, p. 424).

Participatory and social action research

Focus groups have been used extensively in planning and developing health-related social action programmes. Examples of such programmes include: smoking prevention (Heimann-Raitan, Hanson, & Peregoy, 1985); work-site nutrition (Mullis & Lansing, 1986); malaria and child survival (Glik, Gordon, Ward, Kouame, & Guessan, 1988); and—notably—family planning (Folch-Lyon et al., 1981; Knodel, Havanon, & Pramualratana, 1984; Suyono, Piet, Stirling, & Ross, 1981). Some focus group researchers (e.g. Plaut, Lannais, & Trevor, 1993) suggest that the method is particularly useful for accessing the views of those who have been under-represented in, or poorly served by, traditional research. Others suggest that focus groups can be used radically in participatory or action research 'to empower and to foster social change' (Johnson, 1996, p. 536). For example, Jean Orr's (1992) project on well woman clinics encouraged participants to view their problems as deriving from social structure rather than personal inadequacy and offered 'support to members in changing aspects of their lives' (p. 32) via the community health movement. Similarly, Annie George (1996), conducting participatory research on sexuality with poor women in Bombay, ran focus groups in collaboration with an NGO aiming to help separated or deserted women in regularizing their legal status. 'The focus group meetings', she says, 'were a means in the process of analysing the various forces which were bottlenecks, in their search for greater autonomy' (p. 128). Other examples of the use of focus groups in feminist action research on health issues may be found in Brems and Griffiths (1993) and de Koning and Martin (1996).

Evaluation and marketing of products and services

This tradition of focus group research draws on the early development of the method in the context of business and marketing in a number of ways. First, focus groups are used as a means to evaluate the success of health promotion, disease prevention, early intervention or social action programmes (see Basch, 1987, for a review). Basch argues for the value of focus groups in both 'formative' evaluation (i.e. monitoring pro-

grammes during their development and use) and 'summative' evaluation (i.e. making final judgements about their worth). Second, focus groups are used in service evaluation and public relations exercises. Typically, health care 'consumers' are asked to give their views on the services available to them; more rarely, providers are asked to reflect on consumer views, or on their relations with consumers. Examples include the evaluation of mental health services (Richter, Bottenberg, & Roberto, 1991), abortion services (Flexner, McLaughlin, & Littlefield, 1977), public health care in the community (Loevy & O'Brien, 1994) and hospital administration (Hisrich & Peters, 1982). Third, focus groups are used to facilitate the marketing of health care services and products. Focus group studies have been used, for example, to increase the acceptability of contraceptive implants (Zimmerman et al., 1990) and to maximize the impact of television advertisements for spermicidal foaming tablets (Freimuth & Greenberg, 1986).

Having outlined these five broad traditions of health-related focus group research, in the following section I will highlight the use of focus groups in developing understandings of participants' own meanings.

Exploring the meanings of health and illness

Focus groups are an ideal method for the study of people's own meanings of health and illness. As Williams and Popay (1994, p. 123) suggest, 'understanding the nature of lay knowledge requires an approach to data collection that is, in a sense, egalitarian, and most certainly phenomenologically open'. Focus groups satisfy both these criteria, and newcomers to focus groups often comment favourably on both the quantity and the richness or depth of the data the method generates in comparison with other methods. For example, Nigel Fielding (1993) has described how, as an experienced one-to-one interviewer, he had initially seen group discussions as 'too difficult to bother with', but he was 'rapidly converted' to the value of focus groups through their use in a project on domestic violence:

A group of women from a local refuge were [sic] invited and eight of them came. ... We

found that the women were prepared to share information of remarkable emotional intensity, about harrowing experiences we regarded as deeply private and which we had not thought we would be able to address ... It seemed that, because they all shared the experience of having been abused by their partners, once one respondent launched a line of discussion the others were more than willing to join in. We were certain that we would not have got the amount and depth of data using one-to-one interviews ... (Fielding, 1993, p. 142)

Focus groups, then, produce more—and better—data than researchers, even experienced qualitative researchers, typically expect.

The words and phrases used to describe that which is elicited in focus groups vary across research topics and with the theoretical bent of the researcher. Some researchers, like Fielding, say that what participants' talk provides is information about their experiences; other researchers use terms like 'understandings', 'ethno-concepts', 'lay representations', 'common-sense beliefs', 'folk theories', or 'models'. In this article, I am using the term 'participants' own meanings' as a catch-all phrase to encompass the crucial component of all these descriptors: that they are the understandings, concepts, representations, beliefs, etc., as developed and expressed *by the participants*. These understandings, concepts, and so on, are not derived from academic theory or from medical models; rather they reflect and embody the meanings attributed by the participants themselves to their own experience. My argument in this article is that focus groups are an especially good method for eliciting participants' own meanings, and that this makes them invaluable to all those researchers for whom the study of participants' own meanings is of central relevance.

In this section, I highlight the ways in which focus groups facilitate access to research participants' own meanings. As I will show, this accrues directly from the distinctive feature of focus groups, i.e. that data are produced in interactions between group members. I consider here the specific mechanisms through which focus groups elicit participants' own meanings: by enhancing disclosure; by providing access to participants' own language and concepts; by

enabling participants to follow their own agendas; by encouraging the production of elaborated accounts; and by providing an opportunity to observe the co-construction of meaning in action.

Enhancing disclosure

Contrary to the common assumption that people will be inhibited by the presence of other group members, the group context facilitates openness and disclosure. Focus group participants often assist the researcher by asking questions of each other (perhaps more searching than those the researcher might have dared ask), by contradicting and disagreeing with each other (in a manner which, coming from the researcher, might have seemed authoritarian) and by pointing to apparent contradictions in each other's accounts (often in a manner that an empathetic and sensitive researcher might feel to be inappropriate coming from him or her). The effect of these questions, disagreements and challenges from other group members is generally to produce enhanced disclosure, as people answer questions, resolve disagreements and defend their views against attack.

This enhanced disclosure is especially evident when sensitive issues are under discussion. Many focus group researchers report that when research participants share common experiences—in particular, painful or emotionally intense experiences (such as domestic violence, a stigmatizing illness or a sudden bereavement)—individuals typically offer considerable detail about such aspects of their lives, particularly when their contributions are reinforced and their concerns legitimated by other group members (Zeller, 1993). It is commonly found that the less inhibited members of the group break the ice for shyer participants, and that one person's revelation of 'discrediting' information encourages others to disclose similar experiences. According to Kissling (1996), for example, it is easier for young people to talk freely about menstruation in a group context than in a one-to-one interview with an adult researcher: the 'solidarity among friends' seems to 'decrease their discomfort with the topic'. Similarly, Kitzinger (1994a, p. 111) cites data in which interaction between female focus group members enables one of them to talk about oral sex, and she describes this as an example of the

facilitation of the expression of difficult or taboo experiences in a group context.

In particular, social desirability may be less of a problem in focus groups than in one-to-one interviews. Several researchers have noted that, compared with interviews, group discussions tend to generate the expression of more 'socially undesirable' opinions and emotions. In a focus group study of lovers of people with AIDS, for example, the researchers found that there were more angry and emotional comments about their treatment by the medical profession than are generally found in individual interviews (Geis, Fuller, & Rush, 1986). Similarly, researchers have found that women whose babies are delivered healthy are generally unwilling to express dissatisfaction, in one-to-one interviews, with the practices and procedures of childbirth. In focus groups, by contrast, the 'supportive environment' of other women also talking about their birth experiences facilitates women's ability to be critical of the management of the birth process (DiMatteo et al., 1993). In sum, then, contrary to the commonly accepted view that intimate or sensitive information is best elicited in a one-to-one context, it seems that focus groups typically facilitate disclosure.¹⁰

Providing access to participants' own language and concepts

Researchers often carry out research on people very different from themselves, across differences of age, culture, race/ethnicity, (dis)ability, and so on (cf. Wilkinson & Kitzing, 1996). Some familiarity with the language habitually used by research participants is important both for effective communication and for the development of an adequate understanding of their experiences and beliefs. Like interviews, focus groups enable the researcher to listen to people talking. However, in focus groups, the research participants talk primarily *to each other* rather than to the researcher, and they talk in a way that is much closer to everyday conversation than is a one-to-one interview. They are not primarily concerned with providing explanations to a researcher who is 'Other' to them, as is often the case in interviews. The relatively free flow of discussion and debate between members of a focus group offers an excellent opportunity for hearing 'the language and vernacular used by respondents' (Bers, 1987, p. 27). Focus group

researchers have seen the method as providing an opportunity for 'listening to local voices' (Murray et al., 1994), for learning the participants' own language instead of imposing the researchers' language upon them (Freimuth & Greenberg, 1986; Mays et al., 1992) and for gaining an insight into participants' conceptual worlds, on their own terms (Broom & Dozier, 1990).

Listening in on focus group discussions—or 'structured eavesdropping' (Powney, 1988)—enables the researcher to become familiar with the way research participants habitually talk, the particular idioms, terminology and vocabulary they typically use, the ways in which they joke, tell stories, construct arguments, and so on. In listening to participants talk in the social context of a focus group, the researcher is able to observe a (sub)cultural argot in use. Focus group interactions reveal not only shared ways of talking, but shared experiences, and shared ways of making sense of these experiences. The researcher is offered an insight into the commonly held assumptions, concepts and meanings which constitute and inform participants' talk about their experiences.

In particular, focus groups can enable researchers 'to observe people who may be very different from themselves' (Bers, 1987, p. 26). Such respondents may use very different language from that of the researcher to describe their experiences or convey their opinions. For example, few researchers are likely to use, or perhaps even be familiar with, the terms 'muff diver' and 'muffling', to refer (pejoratively) to the practice of oral sex. These terms were used spontaneously by ex-prisoners talking among themselves, when asked in a focus group to assess the extent to which lesbians are at risk of AIDS:

- E1: They're faggots aren't they, everyone of them
 E2: No, they are faggotesses!
 E3: They're quite a lot at risk
 [All shouting at once]
 Researcher: They are quite a lot at risk?
 Several voices: Aye
 Researcher: Why?
 E2: They're faggotesses
 E3: Muff divers [oral sex]
 E4: Licking pussycat

- E3:** Licking all sorts mind, you never know what's been in there
- E7:** They might have had sex with a guy before
- E?:** Muffing dogs
- E?:** Muffing snakes. (Kitzinger, 1990, p. 328)

Note that the focus group members do not offer a 'translation' of their language for the researcher: it is she who provides the explanation, '[oral sex]', for the reader. This exchange provides a graphic example of the ex-prisoners' vocabulary and humour, and offers an insight into a shared conceptual world which is very different from that of the researcher (and probably from that of most readers). In sum, then, focus groups provide an opportunity to learn participants' own language and to develop some understanding of their conceptual worlds.

Enabling participants to follow their own agendas

Simply by virtue of the number of participants simultaneously involved in the research interaction, focus groups inevitably reduce the researcher's power and control, making focus groups a relatively 'egalitarian' method. (It is this feature of focus groups that has proved especially attractive to feminist researchers: cf. Wilkinson [1998a, 1998b].) Compared with a one-to-one interview, it is much harder for the researcher to impose her or his own agenda in the group context. Note, for example, the difficulty experienced by the researcher in the focus group extract quoted above: the ex-prisoners' badinage about implausible sexual practices is very much *their* agenda, rather than hers (even though it may inform her understanding). As focus group researchers have pointed out, the researcher's influence is 'diffused by the very fact of being in a group rather than a one-to-one situation' (Frey & Fontana, 1993, p. 26) and focus groups place 'control over [the] interaction in the hands of the participants rather than the researcher' (Morgan, 1988, p. 18). Indeed, reduced researcher influence is seen as a *problem* in much of the focus group literature, which typically offers the researcher a range of techniques for constraining participants and reasserting control (e.g. Krueger, 1994; Stewart & Shamdasani, 1990; Vaughn et al., 1996).

However, reduced researcher influence can be seen as a *benefit* of focus group research for researchers who are primarily interested in participants' own meanings, and who encourage participant-directed interaction, rather than constraining it. Reduced researcher control gives focus group participants much greater opportunity to set the research agenda, and to 'develop the themes most important to them' (Cooper, Diamond, & High, 1993). These may diverge from those identified by the researcher and participants may challenge, or even undermine, the researcher, insisting on their own interpretations and agendas being heard in place of the formal requirements of the research project. For example, one researcher changed her analytic focus to include social class as well as gender after the insistence of young women in her focus groups in talking about this issue (Frazer, 1988).

One particular benefit of focus group participants' increased role in setting the research agenda is to provide researchers with new information or to draw their attention to previously neglected or unnoticed phenomena. For example, researchers running a focus group with former LSD-using adolescents uncovered the possible use of Robitussin (a strong cough medicine) as a substitute for LSD. In characterizing this discovery as a new piece of the contemporary drug puzzle, they comment:

this is one place where focus groups shine. Through group interaction, we learn that something we hadn't noticed before is a significant issue for drug-experienced young people. ... From the way the group takes up the topic, it is clear that something significant is going on, something significant to them. A new piece of territory is revealed. (Agar & Macdonald, 1995, p. 80)

In sum, then, reduced researcher influence in focus groups enables participants to have more control over the research agenda, which in turn may generate unexpected insights.

Encouraging the production of elaborated accounts

Focus group interactions also encourage individuals to develop and elaborate their accounts in response to both *agreement* and *disagreement* from other group members. For example, bolstered by the support of others, one or more

group members may enthusiastically extend, elaborate or embroider an initially sketchy account. In the following extract, focus group participants who share the experience of multiple sclerosis collaborate to provide the researcher with an elaborately detailed account of what living with the illness means to them:

S: Another thing that has changed is my appearance. The way that I dress ... some fads that come out like shoes. Well, you have to. I know myself and I notice other people. I've been checking underneath the table ... flat shoes! High heels are no way ...

S: High heels are gone!

S: And just like our clothes. We go and instead of messing around with those little, little, tiny buttons where you're all thumbs—pull on stuff. Something easy to get on and get it off. And another thing—jewelry ... the neck pieces ... I can't get the clasp done

S: Some earrings I can't get. The one's [sic] now that you have to get through the hole? Like the loop thingy

S: And another thing—hairdos. Like we can't go and sit there with a curling iron, not anymore. You'd burn your scalp half to death and your fingers

S: So, it's wash and go

S: Yeah, and forget about putting makeup on. Try to put on mascara and you get it in the eyeball. (Lyons & Meade, 1993, cited in Lyons et al., 1995, pp. 24–25; formatting amended to highlight changes of speaker; individual speakers undifferentiated in original)

Through the consensual piling up of fine detail—the height of shoe heels, the size of buttons, the fastening mechanisms of jewelry and the dangers of beauty appliances—these women not only provide information about the functional limitations of multiple sclerosis, but also convey a consensual sense of what it is like to live with multiple sclerosis on a mundane and daily basis. Their jointly elaborated account offers the researcher a far more detailed and in-depth insight into their shared lifeworld—and direct evidence that it *is* a shared lifeworld—than could one-to-one interviews. While focus

group researchers commonly emphasize the role of *disagreement* between participants in encouraging the elaboration of accounts, *agreement* can also have this effect.

However, as focus group researcher Jenny Kitzinger (1994b, pp. 170–171) points out, participants do not just agree with each other: 'they also misunderstand one another, question one another, try to persuade each other of the justice of their own point of view and sometimes they vehemently disagree'. These challenges and disagreements between participants are also effective in provoking the development and elaboration of accounts. In the British-based AIDS Media Research Project, which ran focus groups based on pre-existing social groups (e.g. colleagues, friends), participants often challenged each other on contradictions between what they *claimed* to believe and how they actually behaved, e.g. 'how about that time you didn't use a glove while taking blood from a patient?', 'what about the other night when you went off with that boy at the disco?' (Kitzinger, 1994a, p. 105). Challenges like these, in forcing people to defend and justify their actions or beliefs, often lead to the production of more elaborated accounts. This process can be seen in another AIDS-related study with Australian schoolchildren. In the following extract, three 14-year-olds are discussing the likelihood of contracting AIDS through being tattooed:

Child 1: Unlikely to get AIDS

Child 2: AIDS is possible if you share needles

Child 1: Yes, but you would have to share the needles very quickly 'cause AIDS virus is volatile and dies within seconds when it gets out of the body

Child 2: Yes, but still possible

Child 3: Yes, but you wouldn't just tattoo someone and then just switch over very quickly. The only thing possible, not in professional tattooing studios, but in any amateur or backyard tattoo and they are doing friends or something like that, there would be a chance—they just use compasses. (Houghton et al., 1995, p. 977)

Here, Child 1 initially offers the kind of risk assessment ('unlikely') that could have been recorded via a rating scale or in a structured interview. Child 2's challenge (suggesting a circumstance in which contracting AIDS through tattooing is more likely) prompts the first speaker to defend her original assertion and to offer additional information about her understanding of the AIDS virus. This elaboration of her viewpoint is very much a product of the group context. Child 2's subsequent defence of her position (as 'still possible') enables Child 3 to enter the discussion, developing the argument in terms of different risks in different contexts.

In sum, one important benefit of focus groups is that interaction between participants results in the production, by individual group members, of more elaborated accounts of their beliefs and lifeworlds.

Providing an opportunity to observe the co-construction of meaning in action

Finally, focus groups are an ideal approach for researchers interested in exploring participants' own meanings, because they offer a unique opportunity to observe the co-construction of meaning in action. People's health beliefs, their ideas about what causes a disease or what cures an illness, the meanings they attribute to different parts of their bodies or to different medical procedures are not generated by individuals in splendid isolation. Such beliefs are forged and shaped in everyday social contexts: in discussions between family members in the home; in conversations with others at school or in the workplace; in exchanges with medical professionals or members of self-help groups. People build their ideas, beliefs, understandings and world views *in interaction* with others, in a *social context*: as Radley and Billig (1996, p. 223) say, 'thinking is a socially shared activity'. I am using the term 'co-construction of meaning' to refer to the interactive processes through which individuals collaboratively construct their meanings of health and illness in a social context. A focus group is itself a social context: its participants are members of a social group in interaction, and it is this social interaction among participants that constitutes the primary data.

Focus groups are not, of course, entirely

naturalistic, and a researcher running a focus group (unlike a researcher engaged in participant observation) is not witnessing a naturally occurring event, in the sense that focus groups constitute part of a research enterprise and are not part of participants' everyday social contexts. Such everyday social contexts are not, however, always easily accessible to the researcher. For example, although Morgan and Spanish (1984), in studying how people collectively make sense of heart attacks, would have liked to observe 'informal discussions of friends' and acquaintances' heart attacks', such discussions are, of course, relatively rare events. By using focus groups rather than participant observation of naturally occurring discussions, they were able to collect far more data. And although, as they point out, the focus group discussions 'lacked the "Oh my God, not Harry" quality of a lunch table group first hearing about one of their number's heart attack' (Morgan and Spanish, 1984, pp. 258–259), these data do nevertheless share many of the features of ordinary social interaction. Focus group data reflect everyday social processes of communication, such as arguing, joking, boasting, teasing, persuasion, challenge and disagreement. Focus groups may, like those run by Robin Jarrett (1993, p. 194), have 'the feel of rap sessions with friends'. Crucially, then, focus groups offer an opportunity for researchers to observe how people interactively construct the meanings attributed to health and illness: how opinions are formed, expressed, defended and (sometimes) modified within the context of discussion and debate with others.

We have already seen that focus group interactions can enhance disclosure and yield elaborated accounts through participants' support for, or challenge of, each other's views. But there is more than this. In a focus group, people are confronted with the need to make collective sense of their individual experiences and beliefs. This collective sense-making involves sharing information, pooling experiences and comparing and contrasting them, negotiating divergent ideas and experiences, expressing agreement as well as disagreement with other participants, asking questions that challenge or which seek clarification, and providing answers that elaborate, justify or defend the speaker's views. It is also sometimes possible to observe people shift-

ing their views in the course of focus group discussion: augmenting and strengthening their ideas based on complementary input from other group members, incorporating discrepant information, or simply changing their minds. All of these processes are key aspects of the co-construction of meaning.

I will now illustrate how the co-construction of meaning can be explored through focus group research, using two specific examples of women talking about their breast cancer. I have drawn on my own data here not only because it is apposite, but also because published reports of focus group studies rarely include the kind of detailed, interactive data extract necessary for this kind of analysis. I also hope to make a substantive contribution to the breast cancer literature.¹¹

In the first example, three focus group participants interact: Anne had a mastectomy a year before; Carol had a lumpectomy some weeks ago; and Barbara, who arrives for the focus group looking tense and nervous, had her mastectomy only a few days before. Within about 10 minutes of the start of the focus group, Anne asks Barbara whether she is wearing a prosthesis, and Barbara explains that, because her mastectomy is so recent, she has 'only a little soft comfie' (a lambswool puff, typically given to women until the scar heals sufficiently for them to be fitted for a silicone prosthesis). Anne responds by reflecting on the difference in size between 'your bosom' and 'my bosom', and then offers to show Barbara (who has never seen a prosthesis before) what hers looks like. As Barbara hesitates, Anne reaches inside her bra, pulls out her prosthesis, and passes it around the table:

- Anne: Would you like to see my prosthesis? The *size* of it?
 Barbara: [laughs] Well, mine's only really tiny [laughs]
 Anne: Excuse me [pulls out breast prosthesis and passes it around the table] Feel the weight
 Carol: [gasps]
 Anne: You don't, you don't feel it though, once it's
 Carol: My friend's, though, isn't as, it doesn't seem as *heavy* as that
 Anne: [to Barbara] Pick it up. Look at it

Barbara: No, I've had—

Carol: [cuts in] It's *very heavy*

Several: [raucous laughter, voices indistinct]

Carol: It's ra—[collapses into laughter]

Several: [more laughter]

Carol: It's *rather heavy*, isn't it?

Anne: You can imagine *my* scar

Barbara: Do you want to see my scar?

Several: [more laughter and clamorous voices overlapping]

Look at *my* scar. Look at my scar

[more raucous laughter, voices indistinct]

Barbara: [Picks up prosthesis] My goodness, it feels so nice. It even feels warm [laughs].

Various features of this brief interaction (it lasts only a few minutes of a focus group totalling over 2 hours in all) point to the advantages of focus groups in studying the co-construction of meaning. Anne, Barbara and Carol are sharing information in a relatively naturalistic way: it is possible to imagine that similar interactions might take place, for example, in a self-help group discussion, or among friends. Through this sharing of information, Barbara's ideas about her post-mastectomy experience are being actively constructed. She is learning not only what a prosthesis looks and feels like, but also a socially acceptable attitude to it (and to the mastectomy scar¹²): that it is something that can be shown to and discussed explicitly with others, something about which women with breast cancer can laugh, joke (and even brag!). She is also being socialized into the conventional belief that a prosthesis (however small) is an essential part of post-mastectomy life: this group is typical in that prostheses are taken for granted.¹³ The possibility of *not* wearing one is rarely discussed in my focus groups, and then only as an oddity.

Barbara's attitude to prostheses can be observed changing over the course of this interaction. At the beginning of the extract, she deflects Anne's question about whether or not she would like to see the prosthesis (perhaps she doesn't take the question seriously; in any event, she sounds embarrassed and awkward). The group interaction then shifts to Anne and Carol, who compare and contrast prostheses they have

known, while Barbara sits stunned, unable to look at or to touch the prosthesis, although Anne specifically encourages her to do so: 'No...', she says. Various other group members juggle the prosthesis from hand to hand, crack jokes (sadly, inaudible on tape), talk excitedly over each other, and laugh together. Finally, Barbara relaxes and joins in, holding the prosthesis and saying with surprise and laughter in her voice, 'My goodness, it feels so nice'. For researchers interested in people's own understandings of health-related issues, this extract offers the opportunity to observe the co-construction of the *meaning* of a prosthesis. It shows how Barbara, in the social context provided by the focus group, responds to the collaborative construction of a prosthesis as something to be joked about publicly, and begins to incorporate this benign image into her own understandings.

My second example of the co-construction of meanings in a focus group also involves interactions between three women with breast cancer. Doris and Fiona are both pub landladies (although Doris has recently retired). They arrived early, met each other for the first time, and discovered their shared occupation while waiting for the other participants. During this pre-focus group conversation, they developed a joint theory about the possible role of their work in causing their breast cancer. Specifically, Doris and Fiona co-constructed the explanation that 'pulling' (drawing beer from a cask by means of a hand-pump, which is quite a strenuous activity) was to blame. Immediately prior to the following extract, I ask the focus group participants if they have any ideas what might have caused their breast cancer. Doris turns to Fiona and says, 'Like you I wondered if it was with *pulling*'. The other participants look blank, so I explain that Doris and Fiona were talking earlier about whether being pub landladies could have contributed in some way. Edith is very quick to catch on (asking a clarificatory question which I as researcher would certainly not have thought to ask):

Edith: Is it at the side where ... ?

Doris: Mine's at the side where [indistinct]

Fiona: Where you pulled

Doris: Yes

Fiona: And mine's the same side, and I've got two friends who are both pub landladies down south

Doris: And then

Fiona: And they're sisters and both of them have got breast cancer, both on the same side as they pull beer

Doris: And then there's the atmosphere of the smoke in the [stutters] in the pub

Fiona: Well I, I'm not, I don't know, I'm not so sure about that one

Doris: Well, I think I lean to that more in, what do they call him? The artist, Roy Castle

Fiona: Oh Roy Castle, yeah, with passive smoking.

Doris and Fiona respond to Edith's question by pooling their similar experiences: Fiona even completes Doris's sentence for her, in expounding their joint theory. Fiona then offers additional information: she has two friends who are also pub landladies, and they too have breast cancer on the same side as they pull beer. This strengthens their joint theory still further: with the evidence of four pub landladies all with breast cancer on the same side as they pull beer, who could doubt that pulling beer is a contributory factor? However, Doris then offers an alternative or additional contributory factor for breast cancer in pub landladies: 'the atmosphere of the smoke in the pub'.

There are several possibilities open to Fiona at this point: she can *reject* this new information out of hand in favour of the 'pulling' theory (in which case she will need to defend pulling as the stronger contender, perhaps offering more evidence to support pulling or to refute the 'smoky atmosphere' theory); she can elaborate the pulling theory to incorporate smoky atmosphere as an *additional* possible cause; she can engage with the new information as offering a possible *alternative* theory (perhaps exploring the parameters and implications of a smoky atmosphere, or challenging Doris to provide examples or additional evidence of its effects); or she can simply *accept* the smoky atmosphere as a better explanation for breast cancer. In the event, her hesitant and qualified response ('Well I, I'm not, I don't know, I'm not so sure about that one') implies disagreement or, at the very least, uncertainty. Fiona's apparent disagreement leads Doris to marshal supporting evidence for the smoky atmosphere theory, in the form of a recent television documentary featuring a

celebrity with cancer. Fiona has seen the documentary too, and in her response to Doris, we see a possible beginning of a shift in her views (or at least a willingness to engage seriously with the smoky atmosphere theory): she recognizes and names (as passive smoking) the phenomenon that Doris has identified.

These two examples have illustrated, then, how focus groups offer the researcher the opportunity directly to observe the process of the co-construction of meaning in action. In a focus group, contributions to the discussion are made for a purpose, e.g. to amuse, inform, illustrate or explain something to the other participants. Although focus groups also have an affinity with narrative and storytelling methods (see Bruner, 1991; Howard, 1991; Murray, 1997)¹⁴ within the context of a focus group, a narrated story is never just a stand-alone. In contrast to narrative approaches, which typically isolate material from the social context of its production, a story told in a focus group provides a stimulus for others also to tell their stories for comparative or contrastive purposes, and so provides an impetus for the development of shared knowledge within a group: stories told in focus groups facilitate 'the translation of common knowledge displayed by individuals into shared knowledge ... elaborated consensually by the group' (Hughes & DuMont, 1993, p. 794).

In sum, in this section I have identified and illustrated five ways in which focus groups are of particular value for researchers interested in exploring people's own meanings of health and illness. Focus groups facilitate access to individuals' own meanings by enhancing disclosure, by highlighting participants' own language and concepts, by enabling participants to follow their own agendas, by facilitating the production of elaborated accounts, and by enabling the researcher to observe the co-construction of meaning in action.

Conclusion

As I have shown, then, focus groups are an ideal method for eliciting people's own meanings and understandings of health and illness. This makes the method well suited to those researchers concerned with 'the patient's view', or who are approaching health-related research from theo-

retical perspectives in which meanings, folk theories, lay representations, common-sense beliefs, and so on are crucial. Given this apparently good fit between focus group method and the aims of phenomenological, experiential or narrative researchers, it is surprising to find how rare it is for such researchers to see focus groups as an appropriate method. For example, Williams and Popay (1994), who claim that methods that elicit 'the nature of lay knowledge' should be 'egalitarian' and 'phenomenologically open', highlight the use of unstructured interviews (not focus groups) in achieving this goal. For health researchers emphasizing a crucial concern with eliciting 'meanings', the one-to-one interview is most often the method of choice (e.g. Conrad, 1985; O'Connor, Wicker, & Germino, 1990; Williams & Wood, 1986). Others have used written accounts (e.g. Robinson, 1990), or even questionnaires (e.g. Harding & O'Looney, 1984) and scales (e.g. Fife, 1995): the use of focus groups is not common.

Moreover, it is also surprising that to find that in a great deal of published focus group research, the interaction between participants, i.e. precisely that feature of focus groups which makes them such a good method for eliciting meanings, is neither reported nor analysed. In expounding the *theory* informing focus group method, researchers typically emphasize interaction between participants as a distinctive characteristic of the method: writing in the journal *Qualitative Health Research*, Carey and Smith (1994, p. 125) state clearly that 'researchers who use focus groups and who do not attend to the impact of the group setting will incompletely or inappropriately analyze their data'. *In practice*, however, focus group researchers typically neglect this very feature. Both an earlier review of 40 focus group studies (Kitzinger, 1994a) and my own review of over 200 studies for this and another article (Wilkinson, 1998b), reveal that it is rare to find reports that concentrate on the analysis of group interactions and, indeed, very few that include any data extracts showing participants' interactions. Focus group data are most commonly presented as if they were one-to-one interview data. Consequently, it should be noted that in writing this article I have deliberately sought out and presented these rare published examples of interactive data, and my presentation of focus group data in this article is

therefore not typical of the way in which these data are normally reported: indeed, I have often drawn attention to interactional features that are not commented upon by the authors themselves. Further, I have had to rely upon my own data in illustrating the process of the co-construction of meaning, in order to have sufficient information about interactive features. There is a pressing need to develop focus group research in order to benefit more fully from the interactive nature of its data.

Finally, it should be noted that focus group method is flexible in terms of the analytic frameworks within which it can be used. It is possible, as I have shown, to use focus group method within a traditional essentialist framework (such as in some versions of cognitive psychology and some types of research on health beliefs and attitudes). It is also possible to use focus groups within the alternative (social constructionist) framework offered by the 'turn to language' in health psychology (e.g. Radley & Billig, 1996). For those health researchers working within an essentialist framework, focus groups offer a valuable way of studying 'the individual in social context' (Goldman, 1962; Rubin & Rubin, 1995, p. 95) and provide insights both into the content of cognitions and into the processes through which such cognitions are formed and modified. For those health researchers working within a social constructionist framework,¹⁵ focus group data offer a route to studying the construction and negotiation of health-related talk, the social functions served by different accounts or discourses, and the ways in which aspects of health and illness are produced and perpetuated through talk.¹⁶ In this article, I have shown that focus group method can be used flexibly across a wide range of health-related research contexts, to address a wide range of research questions central to the study of health and illness. I have argued that the method is of particular value to those researchers (e.g. phenomenological, experiential or narrative researchers) interested in exploring individuals' own meanings of health and illness because focus group interactions facilitate access to such meanings. Health researchers were pioneers in the early use of focus groups and we have continued to make extensive use of the method in our research. If we are able fully to exploit the analytic potential of group inter-

action, in exploring the meanings of health and illness, focus group method offers health researchers a major opportunity for the future.

Notes

1. These 'antipositivist' perspectives include: (auto) biography, ethnomethodology, experiential research, grounded theory, life histories and life-worlds, narratology, phenomenology, social representations, symbolic interactionism, and other approaches.
2. These include: HIV/AIDS (e.g. Brown, 1993; Flaskerud & Rush, 1989; Geis et al., 1986; Hoppe et al., 1994; Irwin et al., 1991; Kline et al., 1992; Lampon, 1995; Lupton & Tulloch, 1996; Nymathi & Shuler, 1990; Rogler, Cortes, & Malgady, 1994; Vera, Reese, Paikoff, & Jarrett, 1996); asthma (Hyland et al., 1991); high blood pressure (Basch, 1987); breast cancer (Duke et al., 1994; Wyatt et al., 1993); diabetes (Crabtree, Yanoshik, Miller, & O'Connor, 1993); heart attacks (Morgan & Spanish, 1984, 1985; Ritchie et al., 1994); tropical diseases (Khan & Manderson, 1992); and body image and eating disorders (Grogan & Wainwright, 1996).
3. For example: menstruation (Kissling, 1996; Lovering, 1995); contraception (Cooper et al., 1993; Folch-Lyon et al., 1981; Knodel et al., 1984); and pregnancy and childbirth (DiMatteo et al., 1993; Okonofua, 1995).
4. For example: child sexual abuse (Barringer, 1992); domestic violence (Brown et al., 1993; Fielding, 1993); and sexual aggression (Norris, Nurius, & Dimeff, 1996).
5. These include: multiple sclerosis (Lyons & Meade, 1993); restricted mobility following fractures or falls (Quine & Cameron, 1995); and young children with disabilities (Brotherson, 1994).
6. For example: cervical screening (Dignan et al., 1990; McKie, 1996; Naish et al., 1994); communication within hospice teams (Zimmerman & Applegate, 1992); mental health services (Richter et al., 1991); midwifery practice (Jaffre & Prual, 1994); and community care and self-help groups (Loevy & O'Brien, 1994; Orr, 1992).
7. For example: diet and nutrition (Crockett et al., 1990; Mullis & Lansing, 1986); drug use (Agar & Macdonald, 1995); drinking (Beck, Summons, & Hanson-Matthews, 1987); driving and road safety (Basch, DeCicco, & Malfetti, 1989); smoking (Aitken et al., 1986; Heimann-Ratain et al., 1985); and stress and coping (Hamon & Thiessen, 1990; Mates & Allison, 1992).
8. These include: environmental assessment (Bur-

- gess, Limb, & Harrison, 1988); job satisfaction (e.g. Frey & Carns, 1988); racism at school and work (Hughes & DuMont, 1993); poverty (e.g. George, 1996; Jarrett, 1994); social class (Walkerdine, 1996); and unemployment (Willott & Griffin, 1997).
9. Other examples include: urban American children (Vera et al., 1996); adolescents in rural Nigeria (Okonofua, 1995); sexually active black male teenagers (Nix, Pasteur, & Servance, 1988); New York Puerto Ricans (Rogler et al., 1994); black gay men (Mays et al., 1992); African-American single mothers (Jarrett, 1994); Hispanic women, especially I.V. drug users (Kline et al., 1992); 'difficult to-reach, high-risk families' in an inner city (Lengua et al., 1992); poor women in Bombay (George, 1996); immigrant/refugee women (Espin, 1995); older rural Americans (Crockett et al., 1990); urban Indonesians (Suyono et al., 1981); physicians (Brown et al., 1993); and midwives (Jaffre & Prual, 1994).
 10. For discussion of some of the factors influencing self-disclosure in focus groups (e.g. group composition, relationships among participants, moderator style), see Krueger (1994) and Zeller (1993).
 11. I see this work as contributing in particular to qualitative studies of breast cancer, particularly those informed by a feminist perspective, e.g. Cannon (1989), Datan (1989), Kasper (1995), Morris (1983), Rosser (1981), Tait (1990), Winnow (1992); see also Wilkinson & Kitzinger (1993).
 12. Anne and the other focus group members laugh and brag about mastectomy scars in a similar manner to their joking about prostheses. Note that by the end of this extract, Barbara is also able to join in with this joking: she echoes Anne's initial question 'Would you like to see my prosthesis?' with a playful 'Do you want to see my scar?'
 13. Later, the group discusses swimming as post-mastectomy exercise, and Barbara is involved in an exchange of information about exactly what 'you put in your bathing costume' to make a post-mastectomy breast 'look like the other one'.
 14. Indeed, some narrative researchers have started to use focus groups (e.g. DiMatteo et al., 1993; Espin, 1995).
 15. Within a social constructionist (or discursive) framework, however, focus group data are considered to be just as constructed—albeit differently as (say) responses to a questionnaire or measurements on a scale. Viewed within this framework, the method offers access to 'the patterns of talk and interaction through which the members of any group constitute a shared reality' (DeVault, 1990, p. 97)—and not to any under-

lying cognitions or cognitive processes. The analytic focus is on the talk and conversational interaction itself, and *only* on this (e.g. Potter and Wetherell, 1987).

16. For further examples of this approach see, for example, Antaki (1994), Edwards (1997), Edwards & Potter (1992), Potter (1996), and Wilkinson & Kitzinger (1995). For research that applies social constructionist, discourse analytic or conversation analytic techniques to the analysis of focus group data, see, for example, Agar & Macdonald (1995), Frith & Kitzinger (1998), Myers (1998) and Wetherell & Edley (1997).

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