

Qualitative Methods *for* Health Research



5th
Edition

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 **Sage**



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Preface to the Fifth Edition

Two major shifts have prompted many of the changes in this fifth edition. The first is the global protests that followed in the wake of the murder of George Floyd in Minneapolis, USA, in May 2020. These sparked a long-overdue reckoning with racism and the enduring effects of colonialism in many social fields, including health research. In terms of methodology, debates around decolonizing the curriculum prompted debate around decentring northern assumptions around knowledge, and how it is made and legitimized. This debate led us to reflect on some of the claims in previous editions about the ‘principles’ of methodology, and whether these claims sufficiently acknowledged the specificities of their emergence. This is not a text on decolonizing methods, but we have now pointed to some of the literature that does address this, and we have at various points pulled back what were (in previous editions) rather universalizing claims about methodological principles largely forged in the histories of colonial social science.

The second shift was the reconfiguration of work – including research work – in many countries as COVID-19 pandemic restrictions were introduced. In a short timeframe, researchers often had to rethink their methods, pivoting to new topics as the pandemic threw up urgent questions that needed answering, but also revising planned data generation approaches, as those requiring co-presence become impossible in many settings. Moving to digital methods was not a revolution: various forms of online ethnography and interviewing were already common, and they were addressed in a chapter in previous editions. However, the restrictions on co-presence did incentivize a proliferation of commentary and reflection on the affordances of digital methods as they became a routine choice, rather than one that needed defending. We have now therefore integrated issues of online research throughout the text, given their ubiquity across many designs, and removed the specific chapter on digital research.

Other changes include a new stand-alone chapter on methods for synthesizing qualitative research, and the recruitment of a new co-author with expertise in this area. This reflects the increased interest in including qualitative empirical studies in systematic reviews. We have also refreshed some of the material on theory, to help orient readers who may be relatively unfamiliar with theoretical approaches from the social sciences.

In terms of aims and structure, this fifth edition is otherwise similar to earlier editions. Our aim remains that of producing a text that predominantly meets the needs of our postgraduate students, who typically have considerable professional experience in health, but little prior knowledge of the social sciences. This book is intended primarily for these public health, primary care, health promotion and nursing students, and practitioners and managers who need to commission, use or conduct qualitative research. The second audience is social science researchers who may need pointers to some of the specific contexts of applied health research, where they

may be working in fields in which their colleagues may be less familiar with qualitative social science disciplines. The aims are to introduce these readers to some of the debates in qualitative methodology, to demonstrate the uses of qualitative designs and methods of data generation in a wide range of health research projects, to suggest ways of improving their own research practice and to improve their skills in communicating qualitative research in interdisciplinary settings.

Although qualitative research is now firmly part of the canon of 'evidence-based practice', it is often undertaken in institutional contexts (medical schools, health authorities, hospitals) in which the assumed model of research may still be clinical, rather than social. Many of our colleagues and students still report challenges in explaining qualitative approaches to funders, ethical review bodies, or collaborators. Communicating the value of methods in the interdisciplinary and intersectoral spaces of health research does still demand a particular range of skills from the researcher, including the ability to explain rationales for sampling or analysis approaches to a wide range of partners and potential research users, and an understanding of why the most common conflicts over issues such as research design may occur. Despite the greater legitimacy that qualitative methods now have across the health sciences, qualitative researchers may still find themselves working alongside those who may have very little experience of qualitative methods. Our general focus in this edition has, then, continued to be on how to acquire competence in not just using and appraising qualitative research, but also in integrating qualitative research when working in applied and interdisciplinary settings.

We draw on examples from research from countries including the UK, South Africa, the USA, Uzbekistan, India, Tanzania, Lao PDR, and Moldova, as well as examples from digital and global spaces. These examples span classics of methodological literature, such as studies of psychiatric hospitals from the 1970s, through to recent studies illustrating novel applications of methods. We also include a wide range of literature from the decades in between – in part a deliberate resistance to only including findings from the last few years. We have been aided in the task of finding good examples of qualitative health research by our current and past colleagues and students from the London School of Hygiene and Tropical Medicine, King's College London, and the University of Exeter, and we have used examples from their research liberally to illustrate key points.

An incentive for writing this book was to bridge a gap that is sometimes apparent between pragmatic field guides that aim to provide 'toolboxes' for novice researchers and the more theoretical introductions to methodology that may appear to have little relevance to researchers working in applied areas. A key argument of this book is that good-quality applied qualitative work has to be theoretically informed: doing policy-orientated studies is no excuse for poor design, or inadequate attention to methodology. Indeed, we argue that methodological rigour is even more important in applied work, given the real risk that your findings may well influence policy or practice. If your aim is to have an impact on practice, it is worth getting the findings 'right' as far as you are able. However, it is not always obvious to practitioners how 'getting it right' is to be done, particularly if faced with the constraints of short-term funding or inadequate training in social science methods. We hope this book will help more practically minded researchers to see the value of attending to theoretical issues, both for producing more useful findings and for unpacking some of the debates they will inevitably have about the validity, generalizability and implications of their findings.

The structure of the book remains straightforward. The chapters in Part I deal with methodological principles, theory, research designs and ethics. They introduce key terms used in methodology, the principles of qualitative approaches, and debates around these. Those in Part II discuss common strategies for producing or collecting qualitative data: individual interviews, group interviews, ethnography, and using secondary sources. These chapters provide overviews of these methods and suggestions for improving research practice, with a focus on applied health research. The chapters in Part III deal with the management and analysis of qualitative data, taking the reader through thematic analysis and introducing some approaches to more detailed analysis. Part IV covers issues raised by doing qualitative research in practice. This includes chapters on mixed-method designs and interdisciplinary research; on reading and appraising qualitative research; on synthesizing qualitative evidence; and on writing and knowledge exchange.

There is no perfect order for the chapters in a methods textbook: to design a study, you need some insight into what different data generation methods can do; but to understand debates about interviewing relies on some knowledge of research design. We are aware that few readers will read a methods textbook from cover to cover: most will dip in for the chapters that are relevant to them at particular times in their research careers. We have planned the chapters in roughly the order you might need them if undertaking your first study, such as a student dissertation. Novice students might like to start with Chapters 1, 2 and 3, then skim-read chapters in Part II and Chapter 9 to start. They can then return in more detail to the most relevant chapters when they have finalized their research question and decided on a data collection strategy. For those readers who are dipping in, we have included a glossary of key terms if you missed the first use.

Each chapter includes two case studies. These are summaries of published qualitative research to illustrate the use of qualitative methods in practice, with questions for reflection on how you might use similar methods yourself, and what the strengths and limitations of different methodological strategies would be for your setting and topic. We would encourage you to read the originals of these wherever possible, both for the full details of how the research was done, but also as examples of how to write up qualitative research. Each chapter also has suggestions for exercises for developing your own craft skills in research.

Finally, we would like to acknowledge the input of our past and current colleagues and students, particularly those from the London School of Hygiene and Tropical Medicine who participated in the long-running Qualitative Analysis workshop, for lively discussions, critique and comments on methodology. We have drawn widely on all their experiences, both published and unpublished. We would like to pay particular thanks to the following people, for their formal and informal contributions to this and previous editions of the book: Lucía Guerrero Rivière, Benjamin Hanckel, Sarah Bernays, Alizon Draper, Emma Garnett, Fay Dennis, Philip Corran, Sarah Milton, Sara Cooper, Ruth Willis, Louisa Polak, Patricia Kingori, Simon Lewin, Gillian Hundt, Geraldine Barrett, Catherine Montgomery, Alvaro Alonso-Garbayo, Jacqueline Fitzgerald and Simon Carter. Their research insights, experiences and suggestions have fed into various chapters (though perhaps often in ways they might be robustly critical of).

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Developing Qualitative Analysis

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Chapter Summary

Moving analysis beyond describing or summarizing the content of data is a challenge for many researchers. However, to ensure that qualitative analysis is likely to be useful for policy and practice, a sound analysis of ‘what is going on’ is needed. This chapter reviews some strategies for developing skills in qualitative analysis, including drawing on discourse analysis, grounded theory and narrative approaches to data. The focus remains on language data, as interviews remain the most common source of data in applied health research, although we note the importance of also attending to action and materiality. Well-analysed data should be conceptually generalizable beyond the empirical case, and this chapter discusses approaches to generalizability.

Introduction

The previous chapter introduced thematic content analysis as an approach which ranges from fairly descriptive summaries of data to more sophisticated analyses, in which the researcher

moves beyond simply categorizing and coding the content of data to thinking about how the codes relate to each other and asking more complex questions. In this chapter, we explore ways of enhancing more analytic approaches. If we return to the example in Box 9.3, which included some descriptive codes for focus group data, we can see that these codes essentially summarized the *content* of what the women said about the problems they faced in living with glaucoma. These codes, relating to the topics people speak about, and the vocabulary and concepts they use, are sometimes called ‘manifest’ or semantic codes. However, our analysis can move beyond simply summarizing ‘what was said about what phenomena’. We can instead, for instance, ask questions such as: ‘What makes it possible for these beliefs to be held, or these experiences to be recounted as salient?’. That is, the aim of analysis can be oriented to understanding and (in some styles) explaining the world, not just reporting it. This requires not just looking at *what* was said, but analysing data for what are sometimes called ‘latent’ codes, or the underlying meanings that make it possible for particular utterances to be made, in that place, and with particular consequences. This level of analysis requires moving away from just focusing on the content of language, even with interview data, and attending to structures, material things, contexts, and practices. This more analytical approach is vital for applied as well as critical health research. If our analysis is intended to make recommendations for practice, or to inform policy, simply reproducing accounts is rarely sufficient. If we are aiming to change practice, for instance, we need a solid understanding of why current practices are the way they are. If the aim is to contribute to policy formation or implementation, we need more than a descriptive account of the topics people talk about in interviews: we need some way of understanding how these shed light on why current policy is the way it is, and why this works or doesn’t. These all require insight into both the more tacit knowledge that people draw on (as this is often a more fundamental driver of what is going on) and the ways in which this knowledge is located in broader cultural, social, historical and political contexts.

Rigour is not Enough

Addressing the elements of transparency, reliability and validity discussed in the last chapter will help produce credible analysis that is less likely to leave a sceptical reader asking: ‘How do I know this is not just your subjective interpretation?’. These criteria are also essential for writing for wider audiences. To produce useful and transferable insights, though, requires a social science imagination as well as technical skills. However thorough the analysis, if it remains at the level of superficially attaching ‘codes’ derived from interviewees’ own accounts, with little attempt to integrate these into existing theory, or to look for connections within the data, the findings will look ‘under-analysed’. As we suggested in Chapter 9, this may be sufficient to generate hypotheses for a new programme of work, or to represent the views of participants whose voices are rarely heard.

Some have argued that the kinds of thematic approaches described in the last chapter, based on coding transcripts or other sources, simply mimic positivist and reductive approaches,

in treating words or research products as if they can be reified as ‘data’ which somehow exist outside the research process itself. Elizabeth St. Pierre and Alecia Jackson (2014), for instance, drawing on the post-materialist approaches we introduced in Chapter 2, question how ‘coding’ in general can persist in the light of the many post-positivist critiques in qualitative enquiry that have questioned any stable, unified reality that could possibly be encapsulated by language. In their introduction to a collection of papers on ‘analysis post coding’, they focus on analyses (or interpretations) that are informed more by the critical humanities than the social sciences: pluralistic analytic approaches which foreground instability, hybridity and assemblages, rather than the commonalities and stabilities that are often the focus of more procedural approaches to coding and formal thematic analysis.

These critiques have certainly resonated with many qualitative health researchers – and a number of case studies in this book draw on theories of post-humanism and post-materialism. Fay Dennis’s analysis, for example, reported in Case Study 5.2 on body mapping, draws on what she describes as a methodology for going ‘below and beyond’ abstractions that seek to *represent* drug-using bodies. Thus, in acknowledging that researchers and methodologies co-create the world, rather than study it, her analytic aims are to attend to new stories that might enable different futures, rather than to represent her participants’ accounts in any simplistic way (Dennis, 2020).

However, those working in applied health fields will generally have to attend to some of the more ‘procedural’ aspects of analysis, at least for pragmatic reasons of presenting findings that are credible for colleagues from other traditions. They will also be working with practitioners and policy actors who are, largely, well aware of the messy hybridity of the worlds they work in: to an extent, a qualitative analysis that does nothing other than document this messiness, and point to the contingencies of enactments may add little that can be used, in a practical sense, to what they already know. We would argue, then, that a pragmatic approach should also attend to commonalities, understanding and explanation. This does not mean, though, that we have to stop at simply ‘coding’ themes: indeed, some health-related journals actively encourage more critical and theoretically informed qualitative contributions (see, e.g. Mykhalovskiy et al., 2018). Our approach in this chapter is in a pragmatic middle ground, advocating for a critical, reflexive approach that does not shy away from representation, even if acknowledging that such representation is inevitably partial, positioned and part of the world it is studying. This is what Joan Eakin and Brenda Gladstone (2020) call a ‘value-adding’ analysis. They trenchantly critique much existing published qualitative health research for adding little new to knowledge, because the data are under-analysed. The legitimacy of qualitative research in health, they suggest, has come at a cost of over-emphasizing the procedural elements of analysis, as they are those that look more ‘scientific’: repeatable, formulaic and easy to describe. Thematic analysis, argue Eakin and Gladstone, all too often simply reproduces what is already known, with researchers searching for routine themes and summarizing what was found in interviews. To ‘add value’ relies on craft traditions of enquiry as well as the more procedural. These should be creative and critical, and have capacity to generate new knowledge, reconceptualize our understanding of the topic, and rethink our research questions.

It is perhaps impossible to be prescriptive about how to achieve this, but there are a number of ways of increasing the depth of your data analysis, and this chapter outlines some strategies for moving beyond a simple or 'representational' content analysis. We discuss here three broad traditions – discourse analysis, grounded theory and narrative analysis – and then point to some ways that researchers can draw on these strategies in pragmatic ways to improve their own analysis. These descriptions of analytical styles are intended to be summaries of the main features, not definitive guides to the debates within each approach, or the diversity of ways in which each has been used in qualitative health research.

Discourse Analysis

Discourse analysis focuses on discourse itself as the analytical target, rather than the content of what is discussed by interviewees, or described in documents. We have already introduced the principles of taking talk as the 'topic' of analysis rather than simply the method of data generation in Chapter 5, when we looked at the role of language in interviewing. There are a range of approaches that are called 'discourse analysis', but the starting point for most is the recognition that speech or textual acts cannot be read as straightforward indicators of some reality, whether that reality is a participant's view, a policy objective or a rationale for action. This is because all language has functions beyond those that are apparent in the content of speech acts. Any statement, in an interview or focus group, may also be doing work such as justifying the speaker's opinion, deflecting possible criticism, blaming others or creating commonalities. When we are communicating, we use these functions at different times and in different contexts, so the 'content' of our views will not necessarily be consistent across settings, or even across the same interview. This was illustrated in Case Study 1.1, in which Catherine Will and Kate Weiner (2014) looked at the different, sometimes contradictory, repertoires that their participants drew on to account for their health practices.

In qualitative analysis, it is therefore problematic to analyse the content of data to unpack phenomena such as 'views' as if they were properties of individuals, as the evidence we have (what is said) is not simply about, say, eating healthily, but about how those 'views' are deployed in social interaction. Approaches to discourse analysis that focus on interaction take account of the various functions utterances are performing, as these are considered vital for understanding what is going on (Gilbert and Mulkay, 1984). These functions may not be the ultimate object of the analysis, but we cannot interpret talk (or texts) if we do not first have a clear idea of what particular speech acts are aiming to do and are achieving. Following Gilbert and Mulkay's (1984) approach, Wetherell and Potter (1988) describe the aim of discourse analysis as uncovering the 'interpretive repertoires' that can help us understand the variability in what is said about the phenomena of interest. It is an approach, they say, which is 'intended to do justice to the subtlety and complexity of lay explanations as they are deployed in natural contexts' (1988: 183).

To take an example, here is an extract from an interview with a married couple who are talking about calling an ambulance for a health emergency:

- Claire: [...] we called the ambulance out twice and it goes against my grain that I don't want to be, you know, like Peter and the Wolf.
- Walter: But you don't get a choice if you are in pain you cannot question that, because you don't get a second chance.
- Claire: Well, it is that little puffer [inhaler for medication] – if you take it twice you need to call, and I am embarrassed to ring up, you know, I just think that I am not ill enough. (quoted in Polak and Green, 2016: 1644)

A thematic content analysis might focus on issues such as triggers to calling the ambulance, or reluctance to call the ambulance. If we were approaching this short text as discourse, though, we can first see some 'functions' of the utterances of Claire and Walter. Claire can be seen doing some work in the extract to make clear that she 'knows' that it might be considered inappropriate to use the emergency services too readily. This draws on a trope from a traditional story in which a boy erroneously warns about a wolf coming so many times that his neighbours do not believe him when a wolf does finally appear. She acknowledges that 'it goes against the grain', and that her behaviour risks being seen as an example of 'the boy who cried wolf' (although she uses the name of an opera, 'Peter and the Wolf' instead). Walter bolsters Claire's justification of calling the ambulance by suggesting that there was 'no choice', and she goes on to support their case of making 'appropriate' use of emergency services in her citation of medical advice to call if she needed to use an inhaler (which she calls a 'puffer') twice. In this simple example, we can see something of the interpretive repertoires that Walter and Claire draw on to account for their health service use: the moral value of not making a fuss; the potential moral opprobrium of being an 'over-user' of emergency services; the use of medical advice to legitimate health actions.

These repertoires are not evident in the semantic content of the data: neither Walter nor Claire explicitly state that they are concerned about the moral threat of seeming to be 'inappropriate' users of health care. Neither are they necessarily conscious: it is not usually possible to ask respondents what their aims were in phrasing utterances in particular ways, or choosing particular words or concepts to describe experiences, and indeed most of us, most of the time, use such repertoires without strategic or purposive intent. In everyday conversation, we draw on repertoires by using our tacit, largely taken-for-granted, knowledge of the functions and consequences of our language use. Discourse analysis is directed towards making these explicit. Wetherell and Potter (1988) describe the process as one of generating hypotheses about what particular repertoires do: what consequences they have. We saw an example of this in Case Study 2.1, which used discourse analysis to look at the consequences of particular kinds of discourse in medical consultations.

Clearly, how particular repertoires are used is context dependent, and discourse analysis does require some cultural as well as linguistic fluency, and knowledge of the setting. In the extract above, Claire and Walter's account draws on their experiences in a publicly funded health care system in which there may be strong moral prohibitions against 'over-using' the system: the tropes they draw on may not be apparent in talk about health care use in, say,

a privately funded system. Similarly, Claire uses a reference to 'Peter and the Wolf', assuming that the listener will know this refers to a familiar folk story about the 'boy who cried wolf' and its moral message (that to raise alarm inappropriately risks being ignored when there is a real emergency), rather than the opera, with a different story.

Many of the case studies in this book describe studies in which the analysis used, or drew on, elements of discourse analysis. Two good examples are Case Study 1.1, in which Catherine Will and Kate Weiner directed their analysis at not the content of people's accounts of heart health, but at *how* particular repertoires were deployed; and Case Study 2.1, which drew on discourse analysis to look in detail at medical consultations. However, most qualitative analysis pays some attention to these elements of discourse, as it is impossible to understand what data are about without understanding what participants are doing with language when they use it.

Grounded Theory

Grounded theory is an approach to qualitative data analysis that was developed by two American sociologists, Barney Glaser and Anselm Strauss (Glaser and Strauss, 1967; Strauss, 1987). They aimed to operationalize the procedures that informed much qualitative analysis, but which were never written down. They argued that you could unpack the rules researchers use to, as they put it, 'discover theory from data' and that, with practice, most people could learn to use them. So it was in some ways an attempt to demystify the craft processes of qualitative analysis, and to provide a set of what they called 'rules of thumb' to help develop theory that was grounded in empirical data. Although this suggests an inductive method of research, in which theory is built up from empirical observations (rather than deductive, in which theories are 'tested' against the data), Glaser and Strauss argue that the strength of grounded theory approaches lies in the cyclical process of collecting data, analysing it, developing a provisional coding scheme, using this to suggest further sampling, more analysis, checking out emerging theory and so on, until a point of 'saturation' is reached, when no new constructs are emerging. Charmaz (2012) has described this cyclical process as an 'abductive' approach, which relies on explicitly testing the range of plausible explanations that emerge until the point when you have a rich, dense theoretical account – but one that is completely grounded in empirical data. It is thus both inductive, and deductive, moving back and forth between emerging theory and data. Because grounded theory moves from inductive to deductive modes, and back and forth between theory and data, it ideally relies on theoretical sampling (see Chapter 3). The cases to include should be dictated by the emerging data, and data analysis will suggest further cases to investigate. The other key principle (and why this is also known as the '**constant comparative method**') is 'constant comparison', and the notion that interpretation of data moves forward through comparing indicators (codes), cases and data sets. Thus, analysis is driven by questioning how phenomena are similar and different, drawing on the logic of analytic induction to build up credible arguments about what is going on.

Open Coding

One key element of grounded theory analysis is the emphasis on intense coding of early data. Unlike the coding we described in the last chapter, which is oriented to summarizing the dataset around key themes, the first steps in grounded theory coding are generative, and aim to expand initial interpretations of the data. This is a creative process of analysis in itself, rather than a task to facilitate later analysis. A first step entails *open coding*, a line-by-line analysis of, say, a transcript, which attempts to open up or ‘fracture’ the data. This forces you to take a step back and open up all potential avenues of enquiry. In taking a small part of early data, phrase by phrase, and asking the general question ‘What’s going on here?’, the idea is to generate as many potential codes as possible. It doesn’t matter if these are ‘wrong’ at this stage, as grounded theory involves going back to the data to check these emerging ideas, and refining the concepts and ‘theories’ about them throughout the research process. By ‘codes’ Glaser and Strauss do not mean merely descriptive summaries of the data, but more conceptual labels, which identify what general phenomenon is indicated by the instance, or extract of talk, being analysed. To go back to the example from the last chapter, we could take the first few lines only, now reproduced in Box 10.1.

Box 10.1

Grounded Theory Coding

Data	Codes derived from open coding
1. Ann: The problem is that we all look, well	Being misjudged as able-bodied
2. well normal. It’s not like	
3. we’re carrying white sticks or anything	
4. Bertha: No, and if you’re being guided,	Rejecting disability aids
5. you could just be	Passing as normal
6. with a friend or something	Being misjudged as able-bodied

If we interrogate lines 1–6 of this transcript for the possible answers to ‘What is going on here?’ some potential questions one might ask of these data are: How does Ann constitute ‘looking normal’? Why does she say this is a problem? What signs of ‘normality’ are there in everyday appearances? Why would a white stick undermine this appearance of normality? Why would ‘being guided’ undermine an appearance of normality? How is being guided different to being ‘with a friend’? Asking this barrage of questions intensively around the lines of data helps generate some useful early ideas about the data, and lines of enquiry to follow. Even from these few lines, we might develop some initial concepts, including:

- Creating an appearance of normality (how people behave normally, how they assess it in others).
- Communicating disability (how 'being disabled' is signalled to others).

Each of these initial concepts is subjected to further questions, in order to explore its *properties* and its *dimensions*. Properties are attributes, or characteristics. In the example above, the properties of 'communicating disability' might include behaving in remarkable ways, looking unusual, using mobility aids. Dimensions are the continua along which these properties can be arranged. For instance, one concept in the study of glaucoma was 'noticing the onset of sight problems'. The dimensions of this include: rate of onset (sudden, gradual) and expectedness (expected, unexpected).

Open coding can quickly generate a long list of concepts, which can then be categorized into a more sophisticated scheme by gathering together those that appear to relate to similar phenomena. It is important not to get stuck at this stage with identifying a 'true' reading of the text. The aim of open coding is not that this is the final interpretation of the data, but that it generates some abstract enough concepts that capture the actions, strategies and meanings that are going to be useful. This ensures that you are not closing off potential avenues of analysis too early.

One key strategy is to look for phrasing that suggests relationships between concepts. These include causal relationships ('because ...'); time order relationships ('then', 'after'); similarities ('same as a ...'); differences between phenomena ('It's not like ...'). These can help build up typologies, and move towards connections between codes. Another is to use comparisons early on. These can come from the data, but also from your own experience, other literature or asking hypothetical questions about the data, such as 'when wouldn't this happen?'

In Vivo Codes

One set of codes to look for are what Glaser and Strauss call *in vivo codes* – the kinds that participants use themselves to divide up the world. In the short extract from a focus group reproduced in Box 9.3, there are a number of in vivo codes suggested. The phrase of 'looking normal' is one, and we could look through the transcripts for what it categorizes: what examples are given of people who don't 'look normal'? Another is at lines 9–10; that of 'people who don't know', which could be contrasted with 'sister', and perhaps other examples of 'people who do know' in the transcripts.

Examples of in vivo codes can be found in most data, and are useful first steps in exploring how respondents see their social worlds. A common one in many medical settings is the way in which professionals classify their patients or clients into categories such as 'good patients', 'interesting patients' and other, less complimentary categories. One classic example is from Roger Jeffrey's (1979) study of 'normal rubbish' as an in vivo category used by staff in an accident and emergency department to describe the patients they did not find interesting or deserving. These in vivo codes are useful as first steps in categorizing the data, though

the analysis has to go further than simply noting them. In Jeffrey's study, he unpacked the criteria by which staff categorized patients, and linked these to normative ideas about legitimacy in sickness. Those described as 'normal rubbish' by staff were patients who breached normative expectations of the sick role by, for instance, being seen as responsible for their own injuries or illnesses, or by seeking help in inappropriate ways.

The Importance of Naming Codes

All codes should be labelled, at least provisionally, as the process of naming them is part of the work of thinking about what they are: What is the concept that this particular code relates to? What connects the different instances (extracts) that are coded in this way? This helps move the analysis from a rather descriptive level, where the researcher is summarizing the topics referred to in the data, to a more analytical level, which is focused on the phenomena themselves. Note above that the codes 'creating an appearance of normality' and 'communicating disability' contain verbs as well as nouns. Forcing yourself to include a verb in the code name helps ensure that you are not just summarizing the content of the data (i.e. the topic of the utterance) but really thinking about what is happening in a more abstract way. As Kathy Charmaz puts it:

I also advise researchers to code in gerunds, the noun form of verbs, to the extent possible. Gerunds build action right into the codes. Hence, coding in gerunds allows us to see processes that otherwise might remain invisible. Most researchers code for topics and themes. Grounded theorists code for actions and meanings. (Charmaz, 2012: 5)

Thus, using gerunds (in English the '-ing' ending added to nouns, e.g. 'assessing', or 'naming') enables us to move beyond labelling extracts in terms of the content of talk (such as 'problems'), and towards coding for what is going on (actions), such as describing problems, coping with problems, or disavowing problems.

Axial and Selective Coding

Initial open coding is a first step, but can be returned to at any point when the data analysis becomes 'stuck'. However, it is obviously too intensive to apply to the whole data set. Once a provisional coding scheme has been developed, grounded theory analysis can move to the next stage: *axial coding*, in which the fractured data are 'put back together again'. Here, the analysis moves on to looking for relationships between categories. For the glaucoma study example, this might include looking at the following questions: How does suddenness of onset of symptoms relate to problems of daily living? Is there a relationship between 'passing' as normal and attitudes to eye disease? One strategy for axial coding is developing a coding paradigm, which entails a set of questions about each code. These are: What conditions give

rise to the category? What is its context? What are the interactional strategies by which it is handled and what are the consequences of those strategies? For example, for the category 'passing as normal', we might therefore develop the following:

- Conditions: feeling that 'blindness' is stigmatizing
- Context: being in public, being with strangers
- Interactional strategies: not using white sticks, not going out alone
- Consequences: strain of managing, embarrassment.

Finally, more *selective coding*, where the aim is to move towards more abstract and analytical and theoretically-informed concepts, is the stage at which the core categories emerge. Core categories are those that are related to most other categories and explain most of what is going on.

Memos

In addition to advocating that data collection and analysis should continue simultaneously, rather than sequentially, grounded theory also encourages writing throughout the process. These ongoing written records are called 'memos', defined as 'the written forms of our abstract thinking about the data' (Strauss and Corbin, 1990: 198). Writing memos is an essential part of the analysis, rather than something begun towards the end of a project. Memos will include operational notes about data collection, but also theoretical memos, which are an essential step in the development of analytical ideas. Theoretical memos include initial ideas about the data, emerging hypotheses about relationships between codes and the properties of codes, and detailed notes later in the analysis on how the axial and selective coding is developing.

Kathy Charmaz, discussing the importance of memos in her work (Charmaz, 2006), describes them as a 'pivotal intermediate step between coding and writing' (2006: 72). Memos allow the researcher to stop and think about the data and move beyond descriptive 'codes' to thinking about how codes can become categories for analysis, and they alert the researcher to gaps in the data and the points where comparisons can be made. Crucially, she suggests, memos keep the researcher writing, which is an essential element in the analysis itself.

Deviant Cases

Key to analysis in grounded theory is the constant attempt to challenge developing theoretical insights. As initial hypotheses emerge, the researcher tests these against new data, and refines the analysis. A close attention to **deviant cases** is crucial to this process, in which the researcher both deliberately includes data with which to test the emerging theory (through theoretical sampling) and pays close attention to exceptions within the data set. The exceptions can add credibility to the emerging analysis, if your theory can predict why they are an exception, or force you to adjust your emerging theory. Examples of using deviant cases to develop the analysis are illustrated in Case Studies 9.1 and 10.1.

Methodological Developments in Grounded Theory

It should be noted that 'grounded theory' has evolved into various different strands, which incorporate other approaches, and put different stresses on the relative levels of induction and deduction (Morse et al., 2021). Above, we cited Kathy Charmaz, whose work developing what she termed 'constructivist' grounded theory, has moved grounded theory away from some of the more positivist tendencies that were (some argued) embedded in classic forms, which aimed to uncover a social reality that was assumed to be there. Another development, situational analysis (Clarke, 2003), building on some of the post-human strands of critique, is detailed below. Whilst a detailed overview of divergence and convergence between strands of grounded theory is beyond our scope (see Heath and Cowley (2004) for a brief overview) it might be useful to flag that there are disagreements, which do generate debate on the 'right way' to do grounded theory, and also to point to a few developments in grounded theory methods that have fed into health research.

In its classic forms, grounded theory prioritized theoretical naivety heading into data generation and analysis. In other words, analysts should be open to whichever conceptual framework or theory will fit the data best. This is often misinterpreted as a suggestion to have no background knowledge whatsoever of the phenomenon under investigation, or of what previous researchers have said on the subject. However, in some cases, it is necessary or appropriate to use a starting framework; for example, an evaluation of an intervention with an explanatory theory underpinning it. In this instance, grounded theory approaches can be implemented in what Heath and Cowley (2004) call the 'emergent fit mode', rather than in the 'discovery mode'. In the emergent fit mode, generation and analysis of data are used to extend, contradict, or add nuance to a starting framework, both to add to what is known and to make the starting concepts specific to the phenomenon under investigation.

Another variant of grounded theory is dimensional analysis, which treats grounded theory tools as ways to structure a 'natural analysis' that reflects how people tell stories about their experiences (Kools et al., 1996). Developed by Schatzman (1991), dimensional analysis focuses less on identifying a basic social process and more on storytelling with the generated data. An important addition to the analysis is the idea of perspective, alongside distinguishing between context, condition, process, consequence and outcome, as a way of understanding how stories about social phenomena are structured. This can be useful particularly in contexts where analysts do not wish to assume that data can be analysed using the 'view from nowhere'.

A Pragmatic Approach: Drawing on Elements of a Grounded Theory in Analysis

'Grounded theory' is perhaps one of the most abused phrases in the qualitative health literature. Too often claims to have used a grounded theory approach precede what emerges as rather superficial thematic content analysis. An analysis that has used grounded theory

should provide a detailed, saturated account of the data and how social processes unfold within the phenomena investigated, rather than a list of 'key themes'. It should be possible to read the account to see how any variation within the data set has been used comparatively to develop the analysis, and how deviant cases have contributed to a credible and thorough account of the data. Saturation does not just mean 'no new themes' came out of the fifteenth interview, but that the analysis was saturated.

To do 'grounded theory', and reach this point of theoretical saturation is time-consuming and much health research is constrained by practical issues. One constraint is on the possibility of theoretical sampling, given the limited flexibility sponsors will allow in collecting more data, or different data, as the analysis develops. A second is of course timescale. Most commissioned projects have tight deadlines, which preclude continuing to the point of saturation. Indeed, it is doubtful whether a completely saturated analysis is a possibility in theory, let alone practice. As the above brief discussion of developments in grounded theory methods suggested, there are also contested versions of what grounded theory is. Nonetheless, the principles and some of the approaches of grounded theory have been invaluable to health researchers, and even if funding and resources do not allow the researchers to develop a saturated grounded theory, there are many elements of the grounded theory approach that are useful for any analysis. Open coding, for instance, can be an insightful way of bringing fresh ideas to your analysis, and ensuring that you have developed some 'analytical distance'. Another strategy in policy-facing projects, where data generation and analysis phases are often separated, is to analyse your data with attention to maximum diversity in the early stages of the analysis. This, in a sense, orders your data sources so as to remain open to deviant cases and the kinds of 'testing' of emerging findings that theoretical sampling would suggest. Case Study 10.1 is an example of using elements of the grounded theory approach, in the study on glaucoma which we have used to illustrate elements of coding. This illustrates how a thematic approach can be extended using these strategies.

— Case Study 10.1 —

Using Elements of the Constant Comparative Method in a Study of Living with Glaucoma

Source: Green, J., Siddall, H. and Murdoch, I. (2002) 'Learning to live with glaucoma: A qualitative study of diagnosis and the impact of sight loss', *Social Science and Medicine*, 55: 257–67.

This study used individual and group interviews to explore the experiences of people with a diagnosis of glaucoma, an eye disease characterized by a gradual loss of visual acuity. The aims were to inform health promotion by identifying triggers and barriers to self-referral with eye problems, and to explore the relationship between 'medical' definitions of disability and people's experiences of sight problems.

Interviews took a narrative approach, asking interviewees to tell the story of how they first noticed eye problems, how they came to be referred for treatment and how symptoms and treatment regimes affected their everyday lives. Interviews were recorded and transcribed, and some participants also provided written notes on their experiences. Although this was not a 'grounded theory' study, some of the elements of the grounded theory approach were used to aid data analysis. One was the use of 'open coding' of early data to generate categories. This enabled the range of concepts used by participants to be identified, and to extend the analysis so the research question could better be understood in terms of 'grounded' theory, that is, ideas from the data themselves. For instance, one research aim was to identify 'triggers for self-referral'. Although the data could be 'coded' for triggers (such as noticing blurred vision, noticing 'missing' patches in the field of vision), detailed analysis of the data, and of the contexts of these reported symptoms, suggested that these were 'post hoc' descriptions of triggers, and at the time the early 'signs' of glaucoma are indistinguishable from the everyday eye problems many expect as a result of tiredness or ageing.

A second element of grounded theory used was theoretical sampling. One emerging theory in the data analysis was that a worry about 'dependence' was a concern for some in the sample, but this did not seem to be an issue for an older married man, who relied on his wife for extensive help in everyday tasks anyway. The researchers then deliberately sampled older patients and looked in detail at cases with a range of family support, to check emerging relationships between family support and concepts of dependence and independence.

Close attention to deviant cases helped develop the analysis. One example was the findings on attitudes to blindness. The majority of participants utilized one of two images of 'blind people' – either the 'victim' who was to be pitied, because they were dependent on others, or the 'hero', who manages to perform extraordinary feats despite their disability. Not surprisingly, neither was a very appealing image, and consequently most respondents did not identify as 'blind people'. Although (for them) this brought benefits such as passing as normal and resisting the felt stigma of being labelled as blind, it had considerable costs as a strategy. For some, it meant they had no access to the material benefits to which they would have been entitled as registered blind people. A 'deviant case' was one man who had a less 'stigmatized' image of what blindness meant. He had diabetes, and because he had already come to terms with an identity including 'disease', could see that 'being blind' did not have to be incompatible with 'leading a normal life'.

Locating the empirical findings from this study within wider theoretical literature on disability and living with chronic illness helped to make sense of the data. There is a large literature on issues such as 'independence' and 'stigma' and these were used to help make sense of the accounts of people with glaucoma.

The constant comparative approach, then, helped develop initial categories for coding, helped inform sampling, and provided a framework for looking at relationships between categories.

(Continued)

Reflective Questions

Think back over the case study you have just read. Can you recall the elements of grounded theory used in the analysis?

Feedback

The analysis used open coding to derive the finding that the more straightforward codes representing 'triggers' and 'barriers' are in fact post hoc descriptions: an important finding for health promotion. The analysis also looked for deviant cases. This led to further investigation of the experience of older people (theoretical sampling) and subsequent refining of the meaning of the conceptual categories of 'dependence' and 'independence' for people living with glaucoma.

Narrative Analysis

Like discourse analysis and grounded theory, the term 'narrative analysis' is used in practice to describe some very different approaches to data analysis. What narrative approaches share is a focus on the ways in which we make sense of the world through stories. Narratives have long been recognized in both medicine (Frank, 1997; Greenhalgh and Hurwitz, 1998; Charon, 2006) and social science (Chamberlayne et al., 2000; Andrews et al., 2008; Riessman, 2008) as important ways through which we understand illness in the context of our lives, and through which healers come to understand, and provide therapeutic interaction for, their patients. Charon (2006) also suggests that a focus on narratives in health and medicine acts as a counterpoint to what many experience as the growing bureaucratization of health care in many countries. Accounting for the explosion of interest in narrative in the social sciences, Catherine Kohler Riessman (2008) suggests a number of contributing factors, including the legacy of 'identity politics' movements such as those of feminism, post-colonialism and gender identity, in which the personal experience was politicized and thus became a legitimate object of social scrutiny, and the cultural Western preoccupation with identity in modern times, which has prioritized the notion of a reflexive self that can account for one's own biography. Broader cultural shifts mirror these developments, with, for instance, the rise of interest in such genres as personal memoirs.

Riessman (2008) suggests three ways in which the term 'narrative' can be used to describe styles of analysis:

- Analysis orientated to the practice of story-telling, that is, how narrators organize events in an order that is intended to be meaningful for a given audience
- Narrative data (stories) as the topic for analysis
- Narrative as a method for analysing qualitative data.

Exploring the Stories People Tell

In terms of 'narrative as data', biographical research, for instance, focuses on the stories people tell of their own lives and the relationships between their life histories (the experiences they have had) and their life stories (how these are presented in the present). The study of chronic illness in particular has generated a large qualitative research output drawing on narratives, much of it focusing on the ways in which a diagnosis of chronic illness can act as a 'biographical disruption' (Bury, 1982), in that sufferers have to reassess the story they tell of their past, present and future in order to make sense of the misfortune that has happened. In terms of the first of Riessman's approaches, analysis orientated to the practice of story-telling, we can focus on the structure of stories. One structural method widely used in narrative analysis has its roots in early work from Labov and Waletzky (1967), which has been 'rediscovered' in recent years by narrative analysts (Riessman, 2008). Labov and Waletzky suggested that narratives are stories told in chronological sequence that typically contain six structural elements, shown in Box 10.2

Box 10.2

Typical Structural Elements of a Narrative

An *abstract*, which summarizes the story.

('Did I tell you about the doctor misdiagnosing coeliac disease as irritable bowel syndrome?')

Background information setting the context, cast list and so on to orientate the listener.

('I'd been feeling so ill for ages, and my partner was getting really worried')

The *complicating action* (such as 'Then I collapsed' or 'I was completely lost') and subsequent events ('I called an ambulance').

('Then one day I cancelled a holiday, because I said I just was too tired. That's when my partner insisted I saw a new doctor, and she made an appointment')

The *resolution* of what happened at the end of the sequence of events.

('The doctor at the new clinic was fantastic; he tested me for coeliac')

(Continued)

The *evaluation*, or moral, of the story.

(‘It just shows you should always seek a second opinion’)

A *coda* finishing it off (‘So that’s my story’) (see, e.g., Wengraf 2001: 115–16).

(‘I’m just relieved to finally have a diagnosis’)

How far the structure illustrated in Box 10.2 does typify all stories told is debated. If narrators miss out a section, should we still call it a narrative? Are we imposing structure on data if we look explicitly for these elements? And how are structures like this universal, in terms of describing how all stories are told, in all cultures? At a pragmatic level, Labov and Waletzky’s elements do capture a form many listeners and readers will be familiar with, in that we recognize when we are being told a story, and when it has got to the end.

Analytically, it can be useful to look at how stories are told in interviews, and at when they do or don’t get told, or at what kind of narrative structures interviewees use to present their accounts. In a study of people who had self-harmed in the past, but have now stopped self-harming, for instance, Sinclair and Green (2005) used narrative analysis in the second of Riessman’s senses, to analyse the kinds of stories interviewees told to help make sense of their data. They used Arthur Frank’s (1997) typology of narratives to look at the different ways that people accounted for their past self-harm. Frank suggested there are three types of narrative that are typical of illness stories: ‘quest’ narratives, narratives of ‘resolution’ and ‘chaotic’ narratives. In the study of those who had self-harmed, younger interviewees, when talking about the time in their life when they were self-harming, told their stories in dislocated ways, with many pauses and disjointed chronologies. These sections of narrative did not easily fit the structure of a typical narrative in Box 10.2, but rather reflected their chaotic lives at the time being recalled in the interviews. When discussing their lives in the present, the narrative style shifted, with descriptions of a clear break (such as leaving the family home, or having a baby) followed by increasing steps to autonomy, and a sense of purpose to their lives. These were characterized as ‘chaos’ and ‘quest’ narratives, respectively.

Looking at how we can use stories as the topic of analysis, Nick Caddick and colleagues (2015) draw on narrative analysis in their study of combat veterans with post-traumatic stress disorder who were involved in a surfing club run by a charity. They were particularly interested in discourses of masculinity, and how these could be health promoting or health damaging: narrative analysis enabled them to explore these questions, because (as they put it): ‘The stories people tell of their lives are shaped by culturally appropriate ways of doing gender’ (2015: 98). Stories therefore allow a ‘way in’ to what would otherwise be tacit knowledge about how gender is ‘done’, and how this might be good or bad for health. They are also a subject for analysis in their own right, as stories we tell may be more or less useful for fostering health. Thus, the researchers looked at what kind of stories were told, and where, and how they circulated within groups. For these men, who shared a military history in

which stories of fighting and bravery were prized, there were opportunities to draw on positive stories about masculinity for promoting mental health. In this example, the narrative analysis is not so much on the structures of stories, but more on the nature of discourse.

Narrative analysis, then, does not describe a particular approach to qualitative analysis, but is usually used to suggest that either the topic of interest is stories and how they get told, or that narrative structures are used as an analytical device to help make sense of the data. Narratives can be analysed from a number of epistemological traditions, from life histories which stay close to the story as told by the narrator, through to more interpretative traditions (see Denzin, 1989a) and those drawing on discourse analysis. Case Study 8.2, for instance, summarized a narrative analysis of policy documents, and Case Study 10.2 in this chapter makes sense of accounts of injecting drug use in terms of narratives.

While being attentive to narratives as topics of analysis is useful, some have cautioned against an overly 'romantic' approach which privileges narrative data as if they contained some more authentic accounts of reality, or narrative analysis as if it can provide normative explanations ('these are the stories which should be told'). Atkinson (1997), for instance, notes that the patient story may well get prioritized in sociology, particularly in the study of chronic illness, but that the modern medical clinic is also a rich site of narrative production, in which the clinician's ability to 'tell the patient's story' is key to transforming the patient into a 'case'. However, he notes that focusing on such narrative performances without due analytical care, or at the exclusion of other forms of meaning production, risks simply taking the 'narrative turn' in culture at face value, rather than subjecting it to the same scrutiny we should bring to bear on any cultural construct. This entails locating narrative discourse in the social sphere: ensuring that we ask what shared cultural resources are drawn upon to tell a story, or for that story to be legitimate. It also entails looking at narratives as only one, rather than the primary form, of social representation. 'We cannot afford', argues Atkinson (1997: 341) 'to be seduced by the cultural conventions we seek to study.' Clearly there are limits to how far a focus on structural elements can account for issues such as the partial and contested ways in which stories get told in practice, and the ways in which story-telling might be socially patterned, in that different people tell different kinds of stories (Patterson, 2008).

Case Study 10.2

Narratives of Injecting Drug Use and Social Transformation in Moldova

Sources: Rhodes, T., Bivol, S., Scutelnicu, O., Hunt, N., Bernays, S. and Busza, J. (2011) 'Narrating the social relations of initiating injecting drug use: Transition in self and society', *International Journal of Drug Policy*, 22: 445–54.

(Continued)

Rhodes, T. and Bivol, S. (2012) "'Back then" and "nowadays": Social transition narratives in accounts of injecting drug use in an East European setting', *Social Science and Medicine*, 74: 425–33.

Moldova is a former Soviet republic that has experienced increased rates of injecting drug use since the breakup of the Soviet Union in 1991. Injecting drug use is associated with risks for HIV and other public health harms, so accounting for how and why people start to inject, and why rates may be high in countries such as Moldova is important. Tim Rhodes and colleagues used narrative theory to explore the accounts of 42 people with experience of injecting drugs in one city in Moldova, with an aim of exploring individual narratives of drug use, broader narratives of social transformation and the links between these two.

Data were generated through semi-structured interviews of individuals recruited by a team of outreach workers who then used 'chain sampling' to contact others, until they had a sample which was purposively chosen to include a range of genders, locations, injecting histories and drug use patterns. Interview topics included how the interviewee became initiated into drug use and their drug use career. The analysis of data (which was transcribed in full, and then translated into English) drew on narrative theories within the symbolic interactionist tradition. That is, the research team assumed that the accounts generated in interviews were part of the interactive accomplishment of 'the self', and the interview itself was part of the negotiation and presentation of a self in context.

Narratives, in this perspective, are seen as 'moments in the discursive production of the becoming self' (Rhodes et al., 2011: 446); a personal resource for making sense of a life (particularly of difficulties) and a resource for coping with that life. Such narratives are also, though, told in context: they both draw on available cultural scripts which make some stories more legitimate or meaningful, and also contribute to those broader 'meta-narratives' of social life. Thus, a focus on narrative in this study offered a way to make sense of the interactions between structure and agency: personal and societal narratives can be seen as part of the reciprocal processes of 'structuration'. Structuration is a theory about the process by which social structures are (re)created and reproduced.

This approach to analysis enabled the researchers to go beyond a thematic analysis of the accounts of those with experience of injecting drugs focused on the individual level factors that affected their use of drugs, and beyond traditional approaches to 'narratives of transition', focused on drug use simply as a way of coping with difficult external circumstances such as economic upheaval. Instead, they were able to make links between these two levels. At the social level, interviewees drew on a common meta-narrative of transition, in which drug use in general was mapped to a chronology of two periods: 'back then', generally referring to the period just after the breakup of the Soviet Union in 1991, and 'nowadays', referring to the period from 2005 (interviews were conducted in 2009).

'Back then', in the stories of the interviewees, the drug most commonly injected was home grown poppies: cheap, easily available and typically injected in groups. 'Nowadays' the patterns of drug use were described as very different. Poppy cultivation was more tightly controlled, and a more commercialized market had emerged, with fewer people dealing drugs, and new drugs including heroin available which

were typically more expensive and difficult to get hold of. With increased police surveillance, using drugs had become more likely to be criminalized. It was also more likely to be an individualized practice, in which drugs were bought by each individual user buying from low-level dealers rather than direct from suppliers and taken alone rather than in groups. Stories of initiation – how users first injected a drug – were stories of how the interviewee came across drug use, and (typically) had some agency in the decision to inject within particular social networks. Telling this story in the present, looking back at the beginning of an injecting career, people who used drugs were reflexive about their own personal transitions, from non-user who held users in low esteem, to someone who habitually used drugs. They also narrated that story in terms of the broader one about social and economic transitions between ‘back then’ and ‘nowadays’. These were framed as generational shifts that reflected social change, with the interviewees referencing the many differences in social values that had occurred in the context of a society moving from Soviet times, through a period when old certainties had been fractured and towards an unknown future which had both positive and negative elements. Thus, interviewees contrasted their early drug taking, which was presented as a choice, and something pleasurable and ‘cool’ within their social networks, to that of contemporary initiates to drug use, who were presented as more knowledgeable about the potential risks of injecting and having the benefit of seeing the effects of drug use on the ‘lost generation’. These narratives then position new initiates as having different relationships to drugs. The younger generation, growing up after Soviet breakup, are seen as suffering from a breakdown of social relations, and a weakening of social coherence in the face of widening economic inequality and uncertainty.

Analysing interviewee accounts of using drugs in terms of narratives therefore allows an exploration of the data that both accounts for individual explanations of ‘what is going on’ and a more sociological explanation of changing behaviour at a time of transition. The ‘transition narratives’ told by the interviewees in this study relate to change in both the narrator and society, as they account for a career in terms of shifting drug markets, patterns of social relations and cultural norms. These narrators draw on available cultural scripts of social transition to make sense of individual problems, and thus link personal biographies to collective social experiences.

Reflective Questions

This study, by using a narrative method of analysis, makes a theoretical link between the stories told in the interviews and the wider social structure. Can you think of other studies you might conduct where this kind of linkage could be made?

Feedback

You might for example be interested in linking the narrative accounts of the experiences of health workers or patients to wider aspects of social or political change. Any link (or lack of one) would then need to be located in some kind of *theoretical* explanation for these apparent changes.

In health research, then, narratives can be the topic of analysis, but can also be an analytical device, used to help understand what is going on in the data. We can use narratives in this way because we assume that much of the *meaning* of a narrative lies in the unconscious structures, conventions and norms that speakers use to tell their stories. The ways in which accounts are given, in interviews or other settings, follow cultural rules of meaning-sharing, and paying close attention to *how* these are used provides us with some access to the social meanings of utterances.

Beyond Talk and Text

The discussion so far has centred on how to deal with qualitative data in the form of talk and text. Strategies from discourse analysis, grounded theory and narrative analysis can be applied to other kinds of data, such as images, and, as we noted in the introduction, most approaches to analysis also entail attending to other forms of data: sensory data, actions, emotions, or material things. We turn now to the methodological issues raised by analysis of non-language data.

Analysing Visual Data

An example of analysis of visual data was presented in Case Study 8.2: Gonzalez-Polledo and Tarr's (2016) use of narrative analysis to look at pictures posted to social media. However, they also pointed to some of the limitations of using narrative approaches here: it is not clear, for instance, how far we can treat data such as photographs, drawings or other material objects in the same way as oral or written stories. Gonzalez-Polledo and Tarr also drew on elements of semiotic analysis – the study of signs – to look at how the pictures communicated particular messages. Semiotic analysis can explore how images 'do their work', through attention to such aspects as framing, point of view and co-occurrences. One example of using discourse or semiotic analysis to look at images was referred to in Chapter 8: that of Francis Ray White's (2013) analysis of the images of 'devolution' often used in articles and books about obesity. Taking a familiar image of human evolution, in which human figures are presented in a line, with gradually less ape-like and more human features, graphics used in obesity articles often end this with figures depicting a 'devolved' human, looking fatter and less healthy, and perhaps ending in a figure resembling a pig. White looks in detail at what these images of devolution do and don't include, and what assumptions are built into the supposedly humorous use of a familiar trope. The images, for instance, are generally of white men, suggesting a particular preoccupation with masculinity and civilization, and they position the overweight body as abject and laughable.

Situational Analysis

In line with the post-human and post-materialist approaches introduced in Chapter 2, there has been a growing interest in approaches to analysis that move beyond the

assumption that 'social processes' are the key subject. Adele Clarke (2003), for instance, suggests that the 'postmodern' turn has destabilized the traditional subjects of qualitative enquiry, such as patterns, regularities and narratives should not be assumed. Instead, the focus is more likely to be on partialities, contingencies, contestations and complexity. If the traditional outcomes of qualitative analysis might have been relatively stable explanations of 'what is going on', these might serve a postmodern sensibility less well: we need to have methods for analysis that can capture multiple 'goings on' and instabilities. We also need ways of incorporating a greater range of actors than just the 'social'. As we noted in Chapter 7, contemporary ethnography may well be exploring the life of 'things' as much as people, and attempting to set aside assumptions about what is in the realm of the 'social'. In terms of how we approach analysing these diverse sources, Clarke (2003) proposed 'situational analysis' as a development in grounded theory that can accommodate these challenges from postmodern theory by taking 'situations' rather than social processes as the focus of analysis. She uses a cartographical metaphor to develop an approach to analysis that generates 'situational maps' to describe the range of actors (both human and non-human, material and discursive) within the situation of concern. This should include all the actors who matter, in that they affect something or make a difference, from the point of view of those within the situation and the researcher. Thus, if we were researching a laboratory that is developing new drugs for malaria, a situational map might include: mosquitoes, cages, lab assistants, principal investigators, drugs, freezers, the funding organization, international policies on malaria, blood, syringes, the university, the concept of antimicrobial resistance, and so on. This should be as inclusive as possible at the beginning, so as not to preclude elements which are taken for granted in the setting, but which do make a difference. The next step is a relational analysis, to explore the relationships between elements in the map: thinking through for each pair of elements by asking what the nature of the relationship between them is. This starts revealing who/what matters to whom/what, and also, importantly, what doesn't. Here, the absences and lack of connection are as important as the connections. As in traditional grounded theory, analytical memos are written about the process: the maps are not end points of analysis, but a tool for exploring what is going on. Clarke uses Janet Shim's work on inequalities in heart disease (which we described in Case Study 2.2) as her exemplar, noting that Shim's relational analysis allowed her to see the absence of any discourses around social class around heart disease in the USA; a clue as to why there might be such a focus on racial disparities.

Action and Materiality

In ethnographic methods, the focus of analysis is on what people do, and how they interact with the material and non-human world, as well as what they say and how they interact with the social world. Even in studies that are interview based, where the dataset is language data, we need to be aware that language does not exist in a vacuum: the meanings and consequences of words are embedded in practices and 'being in the world'. For Eakin and

Gladstone (2020) this means treating ‘everything as data’ in critical analysis – that is, an awareness of the situatedness of accounts, and the clues to what is going on that come from things, actions and interactions. There are often richer data on these from ‘mobile’ interviews such as the walk-alongs we described in Chapter 5, but even an interview on zoom or in a sterile office repays reflection on materiality. Howlett (2022) for instance, reflects on the differences she found when interviewing professionals on Zoom during the COVID-19 pandemic, and prior to that in person: whereas in person, her participants were relatively formal and kept to strict time, on Zoom, often in their own homes, they dressed more casually, and attended to non-work aspects of their identity, as pets or other household members came into view.

Some Strategies for Thinking More Analytically

Discourse analysis, grounded theory and narrative analysis all, then, offer ways of thinking about your data that move beyond the simply descriptive, and to start to answer the question ‘what is going on here’ in ways that are likely to be more useful for policy and practice. It is not always practical to do a full grounded theory, or a narrative analysis, unless undertaking a PhD, say, when there may be the time and resources to sample to saturation, or develop the detailed kind of work needed for a situational analysis. However, we would argue that the techniques and sensibilities that these approaches bring can be usefully employed within more applied work, to move our thematic content analysis in directions that are likely to be valid and conceptually generalizable. They are also useful for those points when both novice and more experienced researchers can find themselves ‘stuck’ with their data analysis, unable to think outside their own pre-existing assumptions or to move beyond summarizing the content of the accounts they have generated. Some general suggestions for ensuring that you have developed a more analytical grasp of your data are to:

- Read and discuss widely: not just within your own topic and discipline, but from other disciplines, to look for connections and transferable concepts.
- Ask constantly about the context of the data: think about them in terms of historical, political, social and cultural contexts.
- Return frequently to the theoretical assumptions embedded in your research question (see Chapter 2): challenge them; think about how different assumptions might provide a fresh look at what is going on.

Drawing on the literature and on the experiences of colleagues working together on data analysis, we suggest some more specific strategies for using these approaches, and for moving forward when data analysis becomes repetitive, or it is difficult to see anything ‘new’. This is not an exhaustive list, and these strategies will not always be useful, but they may generate fresh insights for your own data.

Sharing Analysis with Colleagues

Interrogate your data with colleagues, as other people will have a different reading of your data, and may challenge your common-sense accounts of what is going on. Equally, helping others with their data analysis can help encourage a more imaginative approach to your own.

Detailed 'open coding', as above, or simply sharing data excerpts with others is an invaluable method for ensuring that the assumptions you bring to your data have not closed off other avenues of enquiry. As an example, here is a quote from one young man from the study described in Case Study 11.2, on young people's travel, describing his journey to school:

In the mornings, I wake up at about eight and my dad takes me [by car] a couple of metres down the road, it's only about 200m down the road. And then from then I go and get the bus to school. And then there's only a few metres from where I get off the bus to go to school. (Cited in Jones et al., 2012: 607)

The study from which this extract came concerned the use of public transport and health, and the research team were focused on such issues as how using cars and buses reduced the amount of exercise young people undertook. This extract was shared with colleagues to illustrate the ways in which young people went to great lengths to avoid walking. However, reading this for the first time, and from outside the framework of 'physical activity', one discussant noted that they read this as an example of how the young man might be sharing valuable time in a busy life with his father: perhaps this brief car journey was a rare opportunity to be alone with a parent. Other members of the group with teenage children noted that driving them was often a point to have conversations that might be difficult at other times and places. Simply bringing fresh insights from those outside the research team's public health framing helped shift the researchers' assumptions about the links between transport and health: choosing a mode of transport may affect 'health' in broader ways than simply reducing physical exercise, by, for instance, fostering communication with parents and thus mental well-being.

Being Alert to In Vivo Metaphors

Above, we noted the importance in grounded theory of identifying in vivo codes, or the ways in which participants categorize their social worlds. Looking for the metaphors people use can also be a clue to seeing what is taken for granted in their accounts, in that the metaphors used can suggest underlying assumptions that are difficult to make explicit. Here, for example, we can compare two extracts from a study of general practitioners, which included single-handed practitioners, who worked alone in their practices, and partners, working together with others in larger practices. Both extracts had been 'cut and pasted' (see Chapter 10) under the theme 'Describing the Practice Locality':

Extract 1: ... on the walkways of the Birdsley Estate, you're on your own, you may as well be on the North Pole (Partner)

Extract 2: This is my little parish, my community (Single-handed). (Cited in Green, 1996: 90)

These two metaphors for the (similar) local areas within which these doctors worked ('the North Pole' and 'parish') evoke rather different assumptions about the relationship the doctor has to that locality: as an outsider in a hostile environment in the first, and as a rather patrician 'priest' perhaps in the second. It is not that these necessarily describe the 'truth' of two different ways of relating to the community, and we would obviously have to look at these brief extracts in context to be able to say anything about what they reveal about the views of doctors. We also cannot extrapolate anything general about 'partners' or 'single-handed' doctors from two extracts. The point is that these contrasting metaphors can suggest avenues for further enquiry, in looking at differences in the ways doctors with different patterns of practice think about their position in their community. Being alive to the more symbolic ways in which participants describe their worlds is a useful way of learning about the connections they make that might be difficult to describe explicitly in interviews.

Reflecting on the Interactive Context of Accounts

Looking for metaphors shows the value of 'fracturing' data to look at what might not be noticed until we look across cases by theme. It is also necessary to look within cases to account carefully for the interactive context within which utterances are made. As we noted above, drawing on discourse analysis entails a close reading of what work particular utterances do. A good example comes from Sue Wilkinson and Celia Kitzinger (2000), who look at the ways in which one particular phrase – 'feeling positive' – was used in their focus groups with women who had experienced breast cancer. They suggest that much of the research that underpins the concept of 'feeling positive' is flawed because it takes little account of the ways in which people talk about 'feeling positive' in everyday settings. Using examples from their focus groups, they show how, when participants talk about 'feeling positive', it would be a mistake to read this as merely indicating some underlying mental state. Instead, they point to the ways in which the term is actually used interactively in the focus group talk. First, it is used as an idiom – an ordinary saying that is used in a formulaic way to summarize 'what everyone thinks' and to keep a conversation moving along. Phrases such as 'you've got to think positive' are ways of generating agreement in general in discussions. They are difficult to disagree with, and may be used at points where the speaker is seeking support and affirmation from others. Second, they note that if particular attention is paid to what participants are 'thinking positively' about, it is clear that it is not having cancer, but about other things in life or the possibility of recovery. Third, comments about 'thinking positive' are often made just after participants speak about difficult issues, such as feeling devastated by the diagnosis. The comment is thus used conversationally to enable participants to discuss emotional or

difficult issues, which would be awkward to do in a group unless followed by a routine positive comment.

Some tactics for developing a sensitivity to the interactive context include:

- looking carefully at when and how particular kinds of claims are made (or not) and what the interactive consequences are: for instance, do they generate agreement or dissent, or are they ignored?
- Comparing what is said at different points of the interview or across interactive contexts, such as informal conversation and formal interviews
- Reflexivity about the role of the researcher and research framing in co-creating particular discourses.

Searching for Anomalies

The importance of 'deviant cases' in grounded theory was discussed above, but looking more broadly for anomalies is one strategy advocated by Eakin and Gladstone (2020) in their suggestions for 'value-adding' analyses. Anomalies include data that do not fit with emerging theories, but also findings that seem strange or unexpected. For Eakin and Gladstone, reading for anomalies helps make the familiar 'strange', to prompt analysis of what might otherwise be taken for granted.

Cassandra Phoenix and Noreen Orr (2017) advocate the benefits of attending to 'exceptions' as well as commonalities in the data, and for bringing multiple analytical strategies to bear to elucidate nuances and bring new knowledge. They take the example from their narrative enquiry in the field of physical activity and healthy ageing. This is, they argue, a field with a rich tradition of qualitative enquiry, but one that now suffers from the problems Eakin and Gladstone (2020) identified with much applied work: generally, thematic analyses produce little new, merely reproducing lists of barriers to exercise at older age. By attending to exceptions, rather than dismissing them as outliers not contributing to main storylines, Phoenix and Orr show how their understanding was enhanced. Anomalies included narratives of health damaging behaviours alongside the more dominant ones of healthy living, which helped attune the researchers to ideas of balance and how their respondents used quantification to create a coherent narrative (in, for instance, balancing numbers of alcoholic units drunk against minutes of exercise undertaken), and stories of enjoying the solitary pleasures of activity, given the emphasis in most accounts of the benefits of sociability. Paying attention to the complexities as well as dominant strands of narratives can, they suggest, offset the tendency to over-simplify messages about the implications of findings for practice.

Being Attentive to what is Assumed or is Invisible in Accounts

Ryan and Bernard (2003), in their useful overview of techniques to identify themes in data, suggest that as well as looking for the themes that are evident in the content of your data, a

useful technique is to look for ‘lacunae’ or the missing information, in order to identify the knowledge that is taken for granted as something simply ‘known’. Care is needed to ensure that what is missing is not simply missing because the interviewer hasn’t prompted adequately for it, or because the interviewee simply doesn’t know, or is not concerned with the topic. The missing data may suggest the ‘taken for granted’: that which is assumed to be true, or obvious, by respondents. This kind of ‘tacit’ knowledge is difficult to get at directly in interviews, as what is obvious to ‘insiders’ in a culture may be taken as natural and inevitable: it would be absurd to spell it out to an interviewer. In Box 10.1, for instance, the phrase ‘it’s not like we are carrying white sticks’ to indicate why strangers may assume that you are ‘sighted’ relies on the hearer knowing that, in this setting, those with eyesight problems may use a white stick to aid mobility. The speaker does not have to spell this out: she assumes that the interviewer knows this.

Jokes and laughter can be useful indicators of this kind of tacit knowledge, given that what is unthinkable, or socially awkward, may be literally ‘laughable’. In a study of ‘active travel’ in London, UK, the research team were interested in why some population groups rarely cycle (Nettleton and Green, 2014). In interviews and focus groups, various ‘barriers’ were elucidated, such as the dangers of cycling, or the difficulties of finding somewhere to keep your bike in a crowded city apartment. However, in less formal interviews, the question ‘Do you ever cycle?’ elicited immediate laughter, and comments such as ‘What me? No!’ For many respondents, the practical barriers were perhaps less important than the general view that cycling was just not something people like them did, and this is suggested by the joking responses which emerge in informal, if not formal, interviews.

Comparing Data or Findings Across Studies

Comparing your own findings to those from other fields and settings can also be a useful way of uncovering what is taken for granted in your own data. Phil Strong, reflecting on his study of clinics in the Scottish National Health Service (NHS) (Strong, 2006 [1988]), notes that only when he looked at data from a study in the United States did he see ‘routine happenings that never or almost never occurred in any Scottish clinic [...] things which immediately revealed what was systematically absent from most NHS consultations’ (2006: 45). One was the fact that patients knew little about their doctors in the (publicly-funded) NHS system: the patients had little power to ‘choose’ a doctor, and consequently little agency in the consultation. Only when compared with routine consultants in the (private) US system, in which patients typically were well informed about the different individuals responsible for their health care, was Strong able to explicate the ‘normal’ routines of the NHS system.

Conversely, comparisons with other settings can also guard against assumptions about what is going on. In the study of primary care in Uzbekistan, which we described in Case Study 3.2, Ahmedov and colleagues identified that many physicians treated patients in ways that were not consistent with international guidelines for heart disease. One initial explanation from local health service researchers was that this resulted from the absence of accessible guidelines for the management of disease within their country. However,

comparing physicians' accounts from Uzbekistan to those from the UK, where clinicians did have access to guidelines, found that they also talked treated patients in what they called 'individualized' ways rather than necessarily in accordance with the guidelines. Thus, whether or not evidence-based guidelines were available, doctors often stressed the need to adapt therapeutic regimes to particular patients' needs, and to exercise 'discretion' in prescribing. This comparison, then, suggested that the lack of national guidelines was unlikely to be a sufficient explanation for clinicians' behaviour.

Generalizability and Transferability

Generalizability refers to the extent to which findings from a study apply to a wider population or to different contexts. In a sample survey, probabilistic sampling allows generalizability through the principle that the study sample is likely to be statistically representative of the larger population of interest, so findings can be extrapolated to that population. In qualitative work, study participants are rarely sampled to provide a statistically representative sample of the wider population, and the logic of generalizability is usually rather different. In essence, three different approaches to the question of generalizability in qualitative research might be characterized as:

1. It is an inappropriate goal: qualitative research aims to provide thick, contextual descriptions and understanding of what is going on in particular cases.
2. In applied research, there are ways of strengthening empirical generalizability to ensure that findings are widely applicable to other contexts and settings.
3. The goal is not empirical generalizability, but conceptual generalizability. That is, the extent to which findings from one case can be seen as exemplifying more general principles about phenomena and their relationship.

There are good reasons why researchers in the field of health do have to address the issue of generalizability, even if they consider this an inappropriate primary goal for qualitative research. First, if researchers are to make claims for their findings being useful, at whatever level, to health practice, they do have to consider the theoretical import of their findings: the extent to which they refer to some setting or population wider than that of the research itself. As we discussed in Chapter 2, it is 'theory' that provides the link between the case of the empirical research and broader claims about the concepts and phenomena of that case. Second, and more pragmatically, the credibility of qualitative findings in non-social science fields is often fragile, and qualitative research is easily marginalized as 'interesting, but not research evidence' because the generalizability is questionable. Addressing these concerns does not mean adopting, or even adapting, the procedures of quantitative approaches and attempting to imitate the kinds of probabilistic sampling appropriate for studies of incidence or prevalence, or necessarily by comparing the study population to wider ones. Instead, it involves thinking through what kind of relationship the study findings have to other populations and settings, and unpacking exactly what inferences can be drawn from the data analysis.

Qualitative research provides 'sensitizing' concepts

For perspectives that position qualitative work as properly aiming to provide 'thick' description, or to address particularities, rather than to provide 'typical' accounts or generalizable findings, the key issues for contributing to evidence may be around 'sensitizing' concepts. In a study of how patients diagnosed with asthma understood their condition, Stephanie Adams and colleagues (1997) found that many of the 'asthma' patients they interviewed did not believe they had asthma. At one level, it does not matter how representative this sample was of the whole population: the key point is that practitioners are sensitized to the fact that some patients may not accept the diagnosis. At a more theoretical level, qualitative studies may generate concepts that are 'good to think with', and thus will have a utility beyond their immediate research setting in sensitizing other researchers to useful concepts. In their study of asthma, Adams and colleagues also noted that one reason for patients not accepting their diagnosis was that asthma was still rather stigmatized, in ways that other chest conditions were not. The researchers drew on the concept of 'stigma' from Erving Goffman's (1963) work on the impact of stigmatizing attributes on social interaction. Again, in Goffman's original study, it perhaps matters little how far his data are representative of the population, or whether the findings can be generalized in an empirical sense: what matters is the theoretical usefulness of the concepts (such as stigma) that he developed, which have been used widely in qualitative research. This overlaps with the third position above: that the most appropriate way of thinking about generalizability in qualitative work is in terms of conceptual generalizability.

Empirical transferability

For perspectives that do consider the general question of where and how the findings of qualitative research can be extrapolated, a first answer is to consider empirical generalizability or **transferability**: how can we strengthen the chance that our findings are likely to be widely applicable? For many qualitative traditions, rather than aiming for generalizability (how far the case can be seen to be representative of a whole population of similar phenomena), the question is transferability. Here, the question is, 'To what extent are these findings transferable to other settings?' This is what the practitioner or policy-maker reading your report is going to want to know: is this something I can apply to my clinic, or my patients, or my country? Answering this question relies on thinking through what is context-specific and what might be more widely applicable within the findings. Enhancing transferability – the ability of readers to assess what is likely to be relevant in other settings or contexts – relies on good descriptions of the particularities of the setting of the case, and good theoretical analysis which allows credible inferences to be made from the data. Comparisons between studies can help here. This is not simply a case of merely 'adding' to the weight of evidence that a particular concept is commonly found (as for generalizability), but rather by using comparisons to specify relationships at a more abstract level, such that they are likely to be more transferable to a greater range of contexts.

One strategy for strengthening empirical generalizability is described in chapter 13: that of synthesizing the findings across multiple studies, in some kind of systematic review or

evidence synthesis. Thus, in Case Study 13.2, Carl May and colleagues (2003) draw on an integration of three studies of telemedicine to draw out more abstract conceptual findings about ‘normalization’ of technologies in medical practice.

This logic can also be applied to datasets, whereby multiple datasets (or several from one larger study) are integrated to enhance generalizability. Alex Broom and colleagues (2021), for instance, combined semi-structured interviews from studies in three countries (Australia, India and the UK) on how clinicians and hospital managers discuss antibiotic resistance to point to some common findings across all settings, such as the impact of marketization, and suggest that the challenges of antibiotic stewardship are related not to individual failings in the knowledge or behaviour of professionals, but rather to similar systemic organizational and political issues. Here, drawing on similar studies in diverse settings enables a credible claim to transferable findings.

Conceptual generalizability

If well analysed, the key elements that are generalizable from qualitative research may not be the narrow findings but the concepts, that is, the ways of thinking about or ‘making sense of’ the world. These concepts, whether from grand or middle-range theory (see Chapter 2) might inform our understanding of similar contexts or issues. Goffman’s work on stigma is an obvious example from the ‘classic’ literature in medical sociology, but this also applies to more applied work as well. For example, Joseph Opala and Francois Boillot (1996) conducted an ethnographic study of traditional beliefs about leprosy among the Limba people in Sierra Leone. Here, the key question of generalizability might not be ‘How far are the beliefs they identified typical of other countries, or the whole population of Sierra Leone?’ but rather, ‘How far do these findings help us understand what is going on in situations where biomedicine meets traditional beliefs?’ As Opala and Boillot (1996) note, workers in the field of leprosy are interested in studies of traditional beliefs, as they recognize that effective health care can only be provided when the user’s perspective is taken into account. The ‘generalizable’ findings of Opala and Boillot are that to do this adequately relies on a detailed understanding of not just beliefs about leprosy, but also an understanding of the worldview of which these beliefs form a part. In their study, which explored why different groups of Limba had different attitudes to the stigma of leprosy, they found that there were considerable variations in terms of views of traditional and biomedical treatments and when to take medicines. The specifics of beliefs about medications are not generalizable, but the *concept* that there are local variations – and these are important for health care workers to identify – is. Similarly, they found a number of misconceptions that medical workers held about local beliefs. These included the idea that local people believed leprosy was caused by eating one’s totem, or that the majority used traditional medicines. Neither of these beliefs was supported by the research evidence, and to ‘counter’ non-existent beliefs in health promotion messages might well be counterproductive. Again, these specific misconceptions may not be generalizable, but the general point (that we should focus on medical workers’ ideas of lay health beliefs, as well as the health beliefs themselves) is.

Conclusion

Qualitative data analysis relies on a rigorous approach, but also one which draws critically on theory and a social science imagination to answer meaningful questions about the social world. To inform health care practice and policy, the aims of that analysis should be primarily oriented towards understanding what is going on. This requires more than simply describing the content of participants' views, or actions. It entails analysing your data to uncover the tacit assumptions and practices that make those views or actions possible, normal or legitimate. One risk of applied work is the pressure to move too early to deductive analysis, in line with the initial aims of an evaluation. Early inductive analysis will answer the research question, but it is also likely to refine that research question, generate a more useful question and produce knowledge that is conceptually generalizable. Learning the right question to ask is arguably a more practical contribution to health research than answering the wrong question.

In practice, most qualitative researchers draw on a number of strategies for analysing data. Key elements common to most approaches are: beginning analysis at the outset of a project and writing memos as you go; maintaining a critical approach to emerging hypotheses about 'what is going on'; and rooting your analysis in a broad grounding of theory and other research.

Key Points

- Analysis, as well as description, of data is important for applied qualitative health research.
- Discourse analysis, grounded theory and narrative traditions have provided a number of useful strategies for researchers wanting to move beyond describing the content of their data.
- Analysis generally happens alongside data generation, starting at the outset of a project and informing ongoing sampling. Analysis also requires considering actions in the material world as well as words.

Exercises

1. Take the interview extract you summarized and coded in Exercise 2 at the end of the last chapter. Now try 'open coding' the first few lines of this extract, using the techniques of grounded theory introduced in this chapter. Ask a series of questions about each line of the data: What is going on here? How can we label that as a provisional concept? Are there any in vivo codes? What are the properties and dimensions of the concepts that are emerging? Draw on your experience and reading to provide comparisons for each provisional concept, to aid this process. If possible, do this exercise in a group with colleagues.
2. Compare your original list of themes with the provisional list of concepts generated by the open coding exercise.

Further Resources

Charmaz, K. (2012) 'The power and potential of grounded theory', *Medical Sociology Online*, 6 (3): 2–15. This open access paper is a succinct guide to doing grounded theory. <https://ecrag.wordpress.com/wp-content/uploads/2014/02/charmaz-power-of-grounded-theory.pdf>

Silverman, D. (2024) *Interpreting Qualitative Data: Methods of Analysing Talk, Text and Interaction* (7th edition). London: Sage. This accessible introduction balances a theoretical discussion of qualitative enquiry with detailed analysis of observational data such as consultations, texts and visual data as well as interview transcripts.

Strauss, A. (1987) *Qualitative Analysis for Social Scientists*. Cambridge: Cambridge University Press. Detailed account of the principles of grounded theory, quoting extensively from Glaser and Strauss's (1967) book, *The Discovery of Grounded Theory*. Includes examples on coding and analysis.

For those new to analysis, navigating the various approaches can be daunting. There is a useful page on the Grounded Theory Online website, on which type of grounded theory might suit your approach. This site also has links to join discussion groups, notices of upcoming seminars, and links to further resources: www.groundedtheoryonline.com

(All URLs accessed November 14, 2024).