Ethnography

Ethnography is the direct description of a group, culture or community. Nevertheless, the meaning of the word ethnography can be ambiguous; it is an overall term for a number of approaches. Sometimes researchers use it as synonymous with qualitative research in general (for instance, Brewer, 2000), while at other times its meaning is more specific. In this chapter, we adopt the original meaning of the term, as a method within the social anthropological tradition. Ethnography can be qualitative and quantitative though ethnographers in the healthcare field adopt mostly qualitative procedures.

As the oldest of the qualitative methods, it has been used since ancient times; for instance, in the descriptions of Greeks and Romans who wrote about the cultures they encountered in their travels and wars. Deriving from the Greek, the term ethnography means a description of the people – 'writing of culture'. Ethnographers focus on cultural members, phenomena and problems in the context of culture and subcultures. Ethnographic data collection takes place mainly through observation, interviews and examination of documents (see Chapters 6 and 7).

Researchers stress the importance of studying human behaviour in the context of a culture in order to gain understanding of cultural rules, norms and routines. Ethnography does, however, refer both to a process – the methods and strategies of research – and to a product – the written story as the outcome of the research. People 'do' ethnography: they study a culture, observe its members' behaviours and listen to them. They also produce *an ethnography*, a written text (or, unusually, a performed piece of work) which is the ethnographic account; thus ethnography is both 'process' and 'product'.

The historical perspective

Modern ethnography has its roots in social anthropology and emerged in the 1920s and 1930s when famous anthropologists such as Malinowski (1922), Boas (1928) and Mead (1935), while searching for cultural patterns and rules, explored a variety of non-Western cultures and the life ways of the people

within them. After the First and Second World Wars, when tribal groups in the traditional sense were disappearing, researchers wished to preserve aspects of vanishing cultures by living with them and writing about them.

In the beginning these anthropologists explored only 'primitive' cultures (a term that demonstrates the patronising stance of many early anthropologists). When cultures became more linked with each other and Western anthropologists could not find homogeneous isolated cultures abroad, they turned to research their own cultures, acting as 'cultural strangers', that is, trying to see them from outside; everything is looked at with the eyes of an outsider. Sociologists too, adopted ethnographic methods, immersing themselves in the culture or subculture in which they took an interest. Experienced ethnographers and sociologists, who research their own society, take a new perspective on that which is familiar. This approach to a culture known to them helps ethnographers not to take assumptions about their own society or cultural group for granted.

The Chicago School of Sociology, too, had an influence on later ethnographic methods because its members examined marginal cultural and 'socially strange' subcultures such as the slums, ghettos and gangs of the city. A good example is the study by Whyte (1943) who investigated the urban gang subculture in an American city. *Street Corner Society* became a classic, and other sociologists used this work as a model for their own writing. In some form, ethnography as a method is around a century old (Gobo, 2008) but its origins are much older.

A focus on culture

Anthropology is concerned with culture, and ethnography differs from other approaches by this emphasis. Culture can be defined as the way of life of a group – the learnt behaviour that is socially constructed and transmitted. The life experiences of members of a cultural group include a shared communication system. This consists of signs such as gestures, mime and language as well as cultural artefacts – all messages that the members of a culture recognise, and whose meaning they understand. Individuals in a culture or subculture hold values and ideas acquired through learning from other members of the group. The researchers' responsibility is to describe the patterns of beliefs and behaviour and the unique processes in the subculture or culture they study. It must be stressed, however, that the values and beliefs of cultural members depend on their location in the culture or subculture in which they live, on their gender, age or ethnic group. Indeed, sometimes conflicting value systems may exist.

Social anthropologists aim to observe and study the modes of life in a culture. This they do through the method of ethnography. They analyse, compare and examine groups and their rules of behaviour. The relationship of individuals to the group and to each other is also explored. The study of change, in particular, helps ethnographers understand cultures and subcultures. In areas where two

cultures meet, they might focus on the conflict between groups if this is seen as important, for instance, in studies of interaction with doctors and other health professionals.

Applying ethnographic methods – especially observation – helps health professionals to contextualise the behaviour, beliefs and feelings of their clients or colleagues. Through ethnography, nurses and midwives become culturally sensitive and can identify the cultural influences on the individuals and groups they study. The goals of ethnographers in the health arena, however, differ from those of researchers in a subject discipline such as anthropology or sociology. Much ethnography in education, for instance, was intended to improve practice. Health professionals too, see the production of knowledge only as a first step; on the basis of this, they seek to improve their clinical practice.

Sometimes health researchers examine subcultures and situations with which they are familiar.

> **Examples**
>
> A nurse and a doctor in the accident and emergency department (A&E) might wish to study the culture of the A&E setting in the local hospital. They will closely observe the events, critical incidents and behaviour of patients and professionals in this setting in order to improve the system.
>
> A midwife explores the work of the local midwifery unit. She observes the situation and asks her colleagues about the routine actions they perform. She also finds that some of the clients have problems with the way in which they are cared for and asks them about their feelings and perceptions.

Ethnographic methods

Researchers distinguish between several types of ethnography, some of which overlap. The main ways of using this approach is through the following:

- Descriptive or conventional ethnography
- Critical ethnography
- Autoethnography

Descriptive or conventional ethnography focuses on the description of cultures or groups and, through analysis, uncovers patterns, typologies and categories. This is used in most ethnographic studies.

Critical ethnography has its basis in critical theory and, as discussed by Thomas (1993), Carspecken (1996) and Madison (2005), it involves the study of macro-social factors such as power and examines common-sense assumptions and hidden agendas and is therefore more political. Thomas (p: 4) states the

difference: 'Conventional ethnographers study culture for the purpose of describing it; critical ethnographers do so to change it'. Critical ethnography can be important for health researchers, particularly nurses, physiotherapists and midwives, because they are concerned with the empowerment of people. Indeed, Hardcastle *et al.* (2006) suggest that critical ethnography is used in healthcare research to address this issue of power in particular to emancipate the research participants. Using Carspecken's approach, the researchers studied renal nurses' decision-making and describe it.

Example of critical ethnography

The article by Blackstone (2009) explored the social construction of compassion by using critical ethnographic research in two areas, breast cancer and anti-rape movements. These studies focus on the participants' perceptions of 'doing good' and 'being good'. The researcher participated in and observed two sites in the Midwestern States of the United States, where she 'hung out' (her own words) for several years ('immersion in the setting'). She found that these two organisations had similarities. Fieldnotes provided a wealth of data. In this study, the findings were used to provide a framework for understanding in order to bring about change and empowering the women involved in these movements.

(For more detail see Blackstone (2009))

Autoethnography implies that researchers centre their studies on their own selves, their thoughts and feelings rather than focusing exclusively on others. Of course, any qualitative study is reflexive and takes into account the feelings and thoughts of the researcher, but in autoethnography they tell their own experiences rather than those of others. Anderson (2006) distinguishes between evocative and analytic autoethnography; the former focuses on the feelings and experiences of the researcher, the latter is more analytic than descriptive and designed to discuss social phenomena reaching beyond the researcher's own experience. The genre is often used in healthcare research (See discussion in Anderson (2006)).

Streubert Speziale and Rinaldi Carpenter (2007) cite many more specific types of ethnography, and they claim that there is no standard form. These approaches to ethnography might arise from different ideological or procedural bases, but they are similar in data collection and management.

Ethnography in healthcare

Ethnographic methods were first used in healthcare, specifically in nursing in the United States. One of the best known nursing ethnographers is Janice Morse who has written several well-known texts and is probably the best-known qualitative researcher in the nursing arena and has qualifications in anthropology. Leininger

(1985) uses the term 'ethnonursing' for the use of ethnography in nursing. She developed this as a modification and extension of ethnography. Ethnonursing deals with studies of a culture like other ethnographic methods, but it is also about nursing care and specifically generates nursing knowledge. Nurse ethnographers differ from other anthropologists in that they only live with informants in their working day and spend their private lives away from the location where the research takes place. Nurses, of course, are familiar with the language used in the setting, while early anthropologists rarely knew the language of the culture they examined from the beginning of the research, and even modern anthropologists are not always familiar with the setting, the terminology and the people they study.

Ethnography in the healthcare arena is applied research. Chambers (2000) uses this term in approaches that are linked to making decisions in the interest of clients and in the area of decision-making. In nursing and midwifery the method is used as a way of examining behaviours and perceptions in clinical settings, generally in order to improve care and clinical practice.

Example

Brown and McCormack (2006) carried out an ethnographic study to examine pain management processes for patients admitted to a colorectal unit of a hospital based on observation and pre- and post-operative interviews with patients and nurses. They found that pain management was not satisfactory in the acute surgical setting.

From their findings the researchers concluded that comprehensive pain assessment, appropriate documentation and effective communication were essential to improve pain management practice.

The ethnographic approach can also be a useful way of studying health promotion issues as it provides the social context and explores the social conditions in which participants live and by which they are influenced (Cook, 2005). In particular, critical ethnography offers an understanding of the differences and inequalities in the health of people.

Ethnographies in this field incorporate studies of healthcare processes, settings and systems. They are typified by observations of wards or investigations of patient perspectives or specific groups whose members have experienced a condition or illness. Socialisation studies are also important in the field of professional practice. They often examine the negotiation and interaction in the subculture of clinical practice or ward and classroom settings.

Schensul *et al.* (1999) give useful advice to ethnographers that might be adopted by nurse and midwife researchers too. They can take a number of steps:

They describe a problem in the group under study.

Through this, they understand the causes of the problem and may prevent it.

· They help the cultural members to identify and report their needs.
· They give information to affect change in clinical or professional practice.

Ethnographers do not always investigate their own cultural members. In modern Britain, health professionals care for patients from a variety of ethnic groups and need to be knowledgeable about their cultures. Culture becomes part of all aspects of healthcare because both professionals and clients are products of their group in a particular social context. Savage (2006) gives examples from the field of healthcare such as research carried out in hospice settings, studies on rules and rituals, pain and illness experience.

The main features of ethnography

The main features of ethnography are the following:

○ Data collection through observation and interviews
○ The use of 'thick' description
○ Selection of key informants and settings
○ The emic–etic dimension

Data collection through observation and interviews

Researchers collect data by standard methods, mainly through observation and interviewing, but they also rely on documents such as letters, diaries and taped oral histories of people in a particular group or connected with it.

As in other qualitative approaches, the researcher is the major research tool. Direct participant observation is the main way of collecting data from the culture under study, and observers try to become part of the culture, taking note of everything they see and hear as well as interviewing members of the culture to gain their interpretations. Huby *et al.* (2007) make the point that data can be collected both formally and informally, which is one of the advantages of being immersed in setting.

Health researchers commonly observe behaviour in clinical or educational settings. The decisions about inclusion and exclusion depend on the research topic, the emerging data and the experiences of the researchers. The participants and their actions are observed as well as the ways in which they interact with each other. Special events and crises, the site itself and the use of space and time can also be examined. Observers study the rules of a culture or subculture and the change that occurs over time in the setting. It does not suffice, however, to use the fieldnotes for description only and add a description of the interview data. The participants' accounts are transformed and translated by the researcher into more abstract and theoretical concepts as in most qualitative research reports.

Observations become starting points for in-depth interviews. The researchers may not understand what they see, and ask the members of the group or culture to explain it to them. Participants share their interpretations of events, rules and roles with the interviewer. Some of the interviews are formal and structured, but often researchers ask questions on the spur of the moment and have informal conversations with members. Often they uncover discrepancies between words and actions ('words and deeds') – what people do and what they say – a problem originally discussed by Deutscher (1970). On the other hand there may be congruence between the spoken work and behaviour. If any discrepancies exist, they must be explained and interpreted.

Ethnographers take part in the life of people; they listen to their informants' words and the interpretation of their actions. In essence, this involves a partnership between the investigator and the informants.

The use of 'thick description'

One of the major characteristics is *thick description*, a term used by the anthropologist Geertz (1973) who borrowed it from the philosopher Ryle. It is description that makes explicit the detailed patterns of cultural and social relationships and puts them in context. Ethnographic interpretation cannot be separated from time, place and events. It is based on the meaning that actions and events have for the members of a culture within the cultural context. Description and analysis have to be rooted in reality; researchers think and reflect about social events and conduct. Thick description must be theoretical and analytical in the sense that researchers concern themselves with the abstract and general patterns and traits of social life in a culture. Denzin (1989) claims that thick description aims to give readers a sense of the emotions, thoughts and perceptions that research participants experience. It deals with the meaning and interpretations of people in a culture.

Thick description can be contrasted with 'thin description', which is superficial and does not explore the underlying meanings of cultural members. Any study where thin description prevails is not a good ethnography.

Selection of key informants and settings

As in other types of qualitative research, ethnographers generally use purposive sampling that is purposive (criterion-based) and non-probabilistic. This means ethnographers adopt certain criteria to choose a specific group and setting to be studied, be it a ward, a group of specialists or patients with a specific condition. Some of researchers use samples from such subcultures as groups of recovering alcoholics and patients with myocardial infarction, or from professional education such as an investigation of mentoring. The criteria for sampling must be justified in the study and be explicit. Researchers should choose

the people in the setting are not aware; they also translate the insights and words of the participants into the language of science.

The meaning of the participants differs from scientific interpretations. Researchers move back and forth, from the reality of informants to scientific interpretation, but they must find a balance between involvement in the culture they study and scientific reflections and ideas about the beliefs and practices within that culture. This can be described as 'iteration', where researchers revise ideas and build upon previous stages (Fetterman, 1998) (See also Chapter 1).

Fieldwork

The term fieldwork is used by ethnographers and other qualitative researchers to describe data collection outside laboratories. The major traits of ethnography have their basis in 'first-hand experience' of the group or community, and this usually, though not only, involves participant observation and interviewing (Atkinson *et al.*, 2007). Ethnographers gain most of their data through fieldwork. They become familiar with the community or group with whom they want to carry out research. Fieldwork in qualitative research means working in the natural setting of the informants, observing them and talking to them over prolonged periods of time. This is necessary so that informants get used to the researcher and behave naturally rather than putting on a performance. The observation of a variety of contexts is important. Spradley (1980: 78) provides a list in order to guide researchers when they observe a situation, although these guidelines cannot be seen as complete or all inclusive (see Chapter 7). The physical location of the researcher in the setting is necessary for observation in fieldwork.

The initial phase in the field consists of a time for exploration. Health researchers learn about an area of study and become familiar with it. This is not difficult, because they are already part of the community and well aware of patient and professional cultures. Acceptance need not be earned because health professionals have been part of these cultures, while anthropologists in foreign cultures must achieve entry through learning the ways of the group from the beginning. Fieldwork aims to uncover patterns and regularities in a culture which the people living in that community can recognise. There are several steps in fieldwork. In the first stage the researchers gain access to observe and study the culture in which they are interested and write notes on their observations. Secondly researchers start focusing on particular issues. They question the informants on the initial observations. In the third stage researchers realise that saturation has occurred, and they start the process of disengagement.

The best method of data collection in ethnographic research is participant observation, the most complete immersion in a culture. For instance, a nurse who intends to explore the work of a nursing development unit would either be a member of this unit or take part in it in order to observe the practices and reactions of the individuals within.

Micro-ethnographies focus on subcultures or settings such as a single ward or a group of specialist nurses. Fetterman (1998) claims that micro-studies consist of research in small units or focus on activities within small social settings. Ethnographers might select a setting such as a pain clinic, an operating theatre, a labour ward or a GP practice; two of our students, for instance, studied a mixed gender ward. Most students choose a micro-ethnographic study as it makes fewer demands on their time than macro-ethnography. It also seems more immediately relevant to the world of the health professional while policy makers would find macro-ethnography more useful.

There is a continuum between large- and small-scale studies, macro- and micro-ethnographies. A macro-ethnography examines a larger culture with its institutions, communities and value systems. This might be a hospital, or the nursing, midwifery or physiotherapy culture. A large-scale study means a long period of time in the setting and is often the work of several researchers. Both types of ethnography demand a detailed picture of the community under study as well as strategies for data collection and analysis. The type of project depends, of course, on the focus of the investigation and the researcher's own interests.

Ethnographic research can be very useful during changes in a culture. In a changing healthcare system, health professionals sometimes study developments not only in larger settings such as hospitals or communities but also in the smaller world of wards and theatres. Change – the transition from one stage or one ideology to another – can provide a useful focus for health or health policy research. Maternity wards, GP surgeries and other small units but also bigger sites and settings can be appropriate settings for ethnography.

Example of micro-ethnography

Cloherty *et al.* (2004) reported on ethnographic research in the postnatal ward of a maternity unit, involving observation and interviews with mothers and health professionals. The aim was to explore beliefs, expectations and experiences concerning supplementation of breastfeeding.

Example of macro-ethnography

The aim of a study by Fudge *et al.* (2008) was to explore the understanding of user involvement in health organisations and what influences them to put this involvement into practice. To achieve this aim, they used observation, interviews and documentary sources in a programme set up to improve stroke services in two London boroughs. Along with other findings, these researchers gained an understanding that the interpretation of the concept of user involvement is different in health professionals and service users. User involvement encompassed a large range of activities.

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analytic description of a culture or subculture. Ethnographers often start with domain analysis, that is, the area which they study and where they note specific events, incidents and activities.

The process of analysis involves several steps though ethnographers might explain this in different ways (see, for instance, the table in LeCompte and Schensul, 1999: 82–3):

- Ordering and organising the collected material
- Breaking the material into manageable – and meaningful – sections
- Building, comparing and contrasting categories
- Searching for relationships and grouping categories together
- Recognising and describing patterns, themes and typologies
- Interpreting and searching for meaning

These processes must not be seen necessarily as linear or sequential, and each step or stage can be revisited or repeated. There is also overlap between these activities. Spradley (1979: 92) claims that analysis involves the 'systematic examination of something to determine its parts, the relationship among parts, and their relationship to the whole'. Agar (1980) stresses the non-linear nature of the process: researchers collect data through which they learn about a culture, they try to make sense of what they saw and heard, and then they collect new data on the basis of their analysis and interpretation.

Researchers listen to their tapes, read the transcripts and fieldnotes from observation and note down significant elements. Of course they re-read and listen many times, and sometimes recognise differences between the first and the second reading and listening.

The data are scanned and organised from the very beginning of the study. If gaps and inadequacies occur, they can be filled by collecting more data or refocusing on the initial aims of the study. While this work goes on, researchers choose to focus on particular aspects which they examine more closely than others. While re-reading the data, thoughts and observations are being recorded, and a search for regularities can begin. The material is organised and broken down into manageable chunks. These pieces (of sentences, groups of words or paragraphs) are each given a meaningful label. This initial coding of data generates categories. The 'coding for descriptive labels' (Roper and Shapira, 2000) reduces or collapses the mass of data obtained.

For instance, the first interview – or the first detailed description of observation – is scanned and marked off into chunks, which are given labels. The second and third interview transcripts are then coded and compared with the first. Commonalities and similar codes are sorted and grouped together. This happens for each interview (or observation). Thematically, similar sets are placed together and grouped into categories. The researcher then tries to find the ideas that link the categories, and describes and summarises them. From this

stage onwards diagrams are helpful because they present the links and patterns graphically.

The researcher compares the emerging categories and reduces them to (or collapses into) themes (major categories, constructs) and tries to find regularities. Broad patterns of thought and behaviour emerge. The patterns and regularities have their basis in the actual observations and interviews; they will be connected with the personal experiences of the researcher.

At that stage a dialogue starts with categories and themes drawn from the relevant and related literature. Ethnographic texts describe this 'taxonomic analysis' – analysis by classification or grouping of categories into an organised system which points to the relationship between these categories. They also might uncover a typology of participants: for instance, a midwife might recognise in the research on a maternity unit three 'types' of client, the 'dependent' the 'independent' and the 'controlling' client. A doctor might classify patients into passive and active individuals. These groupings generate a typology.

This does not present all the processes of ethnographic research. It also means searching for contrasts between categories, stating their dimensions and looking for conditions under which certain actions occur (see also Angrosino, 2007; Gobo, 2008).

Interpretation

Researchers take the last step, that of interpretation during and after the analysis, making inferences, providing meaning and giving explanations for the phenomena. While describing and analysing, they interpret the findings, that is, they gain insight and give meaning to them. Interpretation involves some speculation, theorising and explaining although it must be directly grounded in the data. It links the emerging ideas derived from the analysis to established theories through comparing and contrasting others' work with the researcher's own.

Eventually the story is put together from the descriptions, analyses and interpretations. LeCompte et al. (1997) compare this to assembling a jigsaw puzzle where a frame is quickly outlined and small puzzle pieces are collected together and placed in position within the frame. The difference is that one knows about the final picture of a jigsaw and has something to work towards, while in qualitative research one merely has an emerging picture where one can only imagine the outline which may change in the process of assembly.

(Pitfalls and problems)

There are a number of problems with ethnographic research in the health arena and elsewhere. First, it is difficult to examine one's own group and become a 'cultural stranger' questioning the assumptions of the familiar culture whose

rules and norms have been internalised. Vigilance and advice from outsiders are very important. Second, because health professionals often have a background in the natural sciences and are taught to adopt a systematic approach to their clinical work, they sometimes may find it difficult to suffer ambiguity. It is better, however, to admit to uncertainty than to make unwarranted claims about the research. It resembles a diagnosis: signs and symptoms are examined for meaning but should never become once-and-for-all interpretation. Findings can be re-interpreted at a later stage in the light of reflection or new evidence.

Our students often write up their research, making statements that seem to be applicable to a whole range of similar situations. The findings from an ethnography cannot simply be generalised, however, and they are not automatically applicable to other settings though often theoretical ideas can be generalised. The researcher can compare with other specific situations similar to the case studied and can achieve typicality.

Novice researchers are often too descriptive and present raw data without analysis and interpretation. Even the quotes of the participants in the study are not raw data but purposefully selected by the researcher (see Chapter 17). Nevertheless, at the start of a research career, it is advisable to give more descriptive detail, clear analysis and to be careful with interpretation. With experience the balance might change. It is interesting that on revisiting the work at a later stage, many researchers start reinterpreting the data.

Summary

The main features of ethnography as a research method are as follows.

- Ethnographers immerse themselves in the culture or subculture they study and try to see the world from the cultural members' point of view.
- Data are collected during fieldwork through participant observation and interviews with key informants as well as through documents.
- Researchers observe the rules and rituals in the culture and try to understand the meaning and interpretation that informants give to them.
- They compare these with their own etic view and explore the differences between the two.
- Fieldnotes are written throughout the fieldwork about events and behaviour in the setting.
- Ethnographers describe, analyse and interpret the culture and the local, emic perspective of its members while making their own etic interpretations.
- The main evaluative criterion is the way in which the study presents the culture as experienced by its members.

Chapter 7 is particularly useful for ethnography.

References

Agar, M.H. (1980) *The Professional Stranger: Informal Introduction to Ethnography.* New York, NY, Academic Press.

Anderson, L. (2006) Analytic autoethnography. *Journal of Contemporary Ethnography*, 35 (4), 373–95.

Angrosino, M. (2007) *Doing Ethnographic and Observational Research.* London, Sage.

Atkinson, P., Coffey, A., Delamont, S., Lofland, J. & Lofland, L. (eds) (2007) Introduction to part one. In *Handbook of Ethnography*, pp. 9–10. London, Sage (paperback edn).

Blackstone, A. (2009) Doing good, being good and the social construction of compassion. *Journal of Contemporary Ethnography*, 38 (1), 85–116.

Boas, F. (1928) *Anthropology and Modern Life.* New York, NY, Norton.

Brewer, J.D. (2000) *Ethnography.* Buckingham, Open University Press.

Brown, D. & McCormack, B. (2006) Determining factors that have an impact upon effective pain management with older people, following colorectal surgery. *Journal of Clinical Nursing*, 15 (10), 1287–98.

Carspecken, P. (1996) *Critical Ethnography in Educational Research: A Theoretical and Practical Guide.* New York, NY, Routledge.

Chambers, E. (2000) Applied ethnography. In *Handbook of Qualitative Research* (eds N.K. Denzin & Y.S. Lincoln), 2nd edn, pp. 851–69. Thousand Oaks, CA, Sage.

Cloherty, M., Alexander, J. & Holloway, I. (2004) Supplementing breastfed babies in the UK to protect their mothers from tiredness and distress. *Midwifery*, 20 (2), 194–204.

Cook, K.E. (2005) Using critical ethnography to explore issues in health promotion. *Qualitative Health Research*, 15 (1), 129–38.

Denzin, N.K. (1989) *Interpretive Interactionism.* Newbury Park, CA, Sage.

Deutscher, I. (1970) Words and deeds: social science and social policy. In *Qualitative Methodology: Firsthand Involvement with the Social World* (ed. W.J. Filstead), pp. 27–51. Chicago, IL, Markham Publishing.

Fetterman, D.M. (1998) *Ethnography: Step by Step*, 2nd edn. Thousand Oaks, CA, Sage.

Fudge, N., Wolfe, C.D.A. & McKevitt, C. (2008) Assessing the promise of user involvement in health service development: ethnographic study. *British Medical Journal*, 306, 313–17 Retrieved August 2008 from *BMJ*, doi:10.1136/bmj.39456.552257.BE (published 29 January 2008).

Geertz, C. (1973) *The Interpretation of Cultures.* New York, NY, Basic Books.

Gobo, G. (2008) *Doing Ethnography.* Los Angeles, CA, Sage.

Hammersley, M. & Atkinson, P. (2007) *Ethnography: Principles in Practice.* 3rd rev. edn. Andover, Routledge.

Hardcastle, M., Usher, K. & Holmes, C. (2006) Carspecken's five-stage critical qualitative method: an application to nursing research. *Qualitative Health Research*, 16 (1), 151–63.

Harris, M. (1976) History and significance of the emic/etic distinction. *Annual Review of Anthropology*, 5, 329–50.

Huby, G., Hart, E., McKevitt, C. & Sobo, E. (2007) Editorial: addressing the complexity of health care: the practical potential of ethnography. *Journal of Health Services Research Policy*, 12 (4), 193–4.

Grounded Theory

Grounded theory (GT) has been used in healthcare research and particularly in nursing for decades and is still popular; indeed Cutcliffe (2005: 421) states that it has become 'a global phenomenon'. It is an approach to collecting and analysing data. The finished product is also called a GT – it is a development of theory directly based and grounded in the data collected by the researcher. From its very start, this approach has been modified, not only by the main protagonists themselves but also by researchers who adopted and adapted it during its application to their own inquiry. In this chapter, we will describe the main features of GT and trace development and changes over time.

This approach has its origin in sociology, particularly symbolic interactionism (SI), and was initially developed in the collaboration of the sociologists Barney Glaser and Anselm Strauss who were trained respectively in quantitative and qualitative methods. Indeed, GT can comprise both qualitative and quantitative procedures but is most often allied to qualitative research. GT is not tied, however, to a specific discipline or even to a particular form of data collection – there are studies in psychology, healthcare, business management and other fields. GT, like other qualitative approaches, is often adopted by researchers where not much knowledge exists about the phenomenon under study.

Data sources can be varied, such as interviews, observations or documents, and visual and oral presentations or events. Health researchers particularly appreciate the systematic and organised way of the GT process. Caring is an interactive process, hence the focus in GT on interaction, communication and active engagement in social situations, suits most health professionals.

History and origin

GT originated in the 1960s by Barney Glaser and Anselm Strauss, who worked together on research about health professionals' interaction with dying patients in 1965. From research, writing and teaching, the classic text *The Discovery of Grounded Theory* (Glaser and Strauss, 1967) emerged. Four other books on GT followed – *Field Research: Strategies for a Natural Sociology* (Schatzman

this study by pointing to the lack of previous research about the influences of socialisation and perceptions of professional development. The researcher followed the tenets of GT by revising and reworking ideas when new data emerged from the interviews. The development of the study was not linear but flexible and changed direction when the need arose.

This research demonstrates that GT research is not a simple and orderly process, though it is systematic.

The GT style of research uses constant comparison. The researcher compares each section of the data with every other throughout the study for similarities, differences and connections. Included in this process are the themes and categories identified in the literature. All the data are coded and categorised, and from this process, major concepts and constructs are formed. The researcher takes up a search for major themes that link ideas to find a core category for the study.

Strauss (1987) sees the processes of induction, deduction and verification as essential in GT, and he believes that the approach should be both inductive and deductive. GT does not start with a hypothesis though researchers might have 'hunches'. After collecting the initial data, however, relationships are established and provisional hypotheses conceived. These are verified by checking them out against further data. Glaser (1992) however, questions the process of verification as discussed later in this chapter and stresses the inductive element and the 'emergence' of theory. Theoretical sampling, one of the main features of GT, is discussed below.

Grounded theorists accept their role as interpreters of the data and do not stop at merely reporting them or describing the experiences of participants. Researchers search for relationships between concepts, while other forms of qualitative research often generate major themes but, generally, do not develop theories.

Data collection, theoretical sampling and analysis

Data are collected through observations in the field, interviews of participants, diaries and other documents such as letters or even newspapers. Researchers use interviews and observations more often than other data sources, and they supplement these through literature searches. Indeed, the literature becomes part of the data that are analysed. Everything, even researchers' experience, can become sources of data; Glaser (1978) believes that 'everything is data'. The work is based on prior interest and problems that researchers have experienced and

reflected on, even when there is no hypothesis. Data collection and analysis are linked from the beginning of the research, proceed in parallel and interact continuously. The analysis starts after the first few steps in the data collection have been taken; the emerging ideas guide the collection of data and analysis. This process does not finish until the end of the research because ideas, concepts and new questions continually arise which guide the researcher to new data sources and concepts. Researchers collect data from initial interviews, observations or documents and take their cues from the first emerging ideas to develop further interviews and observations. This means that the collection of data becomes more focused and specific as the process develops (progressive focusing).

The researcher writes fieldnotes from the beginning of the data collection throughout the project. Certain occurrences in the setting, or ideas from the participants that seem of vital interest, are recorded either during or immediately after data collection. They remind the researcher of the events, actions and interactions and trigger thinking processes.

According to Glaser (1978) the following are necessary for GT:

- Theoretical sensitivity
- Theoretical sampling
- Data analysis: coding and categorising
- Constant comparison
- Literature as a source of secondary data
- Integration of theory
- Theoretical memos and fieldnotes
- The core category

Researchers must be theoretically sensitive (Glaser, 1978). Theoretical sensitivity means that researchers can differentiate between significant and less important data and have insight into their meanings. There are a variety of sources for theoretical sensitivity. It is built up over time, from reading and experience which guides the researcher to examine the data from all sides rather than stay fixed on the obvious.

Professional experience can be one source of awareness, and personal experiences, too, can help make the researcher sensitive.

Example 1: Professional experience

A specialist nurse, an expert on anorexia nervosa, explores this condition from the perspectives of those who suffer from it. He has expert knowledge in the field gained in his long professional career. His professional experience makes him sensitive to patients' feelings and perceptions (Newell, 2008).

Example 2: Personal experience

A general practitioner has had diabetes from an early age. When she observes or interviews patients about their condition, she might include questions on the feelings patients had on the diagnosis of diabetes or their thoughts about living with this condition.

The literature sensitises, in the sense that documents, research studies or autobiographies create awareness in the researcher of relevant and significant elements in the data. Strauss and Corbin (1998) believe that theoretical sensitivity increases when researchers interact with the data because they think about emerging ideas, ask further questions and see these ideas as provisional until they have been examined over time and are finally confirmed by the data.

Theoretical sampling

Sampling guided by ideas with significance for the emerging theory is called *theoretical sampling*. In theoretical sampling 'the emerging theory controls the research process throughout' (Alvesson and Sköldberg, 2000: 11). One of the main differences between this and other types of sampling is *time* and *continuance*. Unlike other sampling, which is planned beforehand, theoretical sampling in GT continues throughout the study and is not planned before the study starts. Cutcliffe (2000) shows that the initial data collection and analysis guides the direction of further sampling.

At the start of the project researchers make initial sampling decisions. They decide on a setting and on particular individuals or groups of people able to give information on the topic under study. Once the research has started and initial data have been analysed and examined (one must remember that data collection and analysis interact) new concepts arise, and events and people are chosen who can further illuminate the problem. Researchers then set out to sample different situations, individuals or a variety of settings, and focus on new ideas to extend the emerging theories. The selection of participants, settings, events or documents is a function of developing theories.

Theoretical sampling continues until the point of data and theoretical saturation. Students do not always understand the meaning of the concept 'saturation', and believe it to be a stage when no new information or concepts are obtained through data collection and analysis. For Glaser and Strauss (1967) 'theoretical saturation' has occurred when no more data emerge that can be used to find dimensions and develop properties of the categories the researcher has established and not when a concept is mentioned frequently and is described in similar ways by a number of people, or when the same ideas arise over and over again. Instead, it only occurs when no new data of importance for the developing theory and for the achievement of the aim of the research emerge.

It is very difficult to reach saturation; indeed, one might ask if it can ever truly be established, but the attempt at saturation is necessary. Saturation occurs at a different stage in each research project and is difficult to recognise. Draucker *et al.* (2007) present a sampling guide to assist in both systematic decisionmaking and category development.

Theoretical sampling, though originating in GT, is occasionally used in other types of qualitative analysis.

Coding and categorising

Coding and categorising goes on throughout the research. From the start of the study, analysts *code* the data. Coding in GT is the process by which concepts or themes are identified and named during the analysis. Data are transformed and reduced to build *categories* which are named and given a label. Through the emergence of these categories theory can be evolved and integrated. Researchers form clusters of interrelating concepts, not merely descriptions of themes. Sometimes these codes consist of words and phrases used by the participants themselves to describe a phenomenon. They are called *in vivo* codes (Strauss, 1987). A new recruit to the profession might declare in an interview: 'I was thrown in at the deep end', for instance. The code might be 'thrown in at the deep end'. *In vivo* codes can give life and interest to the study and can be immediately recognised as reflecting the reality of the participants. In this process of analysis, the first step is concerned with open coding which starts as soon as the researcher receives the data. Open coding is the process of breaking down and conceptualising the data.

In GT, all the data are coded. Initial codes tend to be provisional and are modified or transformed over the period of analysis. At the beginning of a project or a study, line-by-line analysis is important, although it may be a long drawn-out process for analysts. Codes are based directly on the data, and therefore the researcher avoids preconceived ideas. An example of an interview with a nurse tutor gives some idea of level 1 coding.

Example

Well I suppose most people get fed up with doing the same things year in, year out.	Getting bored
I really felt like a change.	Desire for change
Regular hours are important to me.	Wish for regularity
I hadn't been promoted to the level to which I could function.	Lack of promotion

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The analyst groups concepts together and develops categories. At the start a great number of labels are used, and after initial coding, analysts attempt to

Strauss (1987) claims some major characteristics for the core category:

It must be the central element of the research related to other categories and explain variations.

It must recur often in the data and be part of a pattern.

It connects with other categories without a major effort by the researcher.

The core category develops in the process of identifying, describing and conceptualising.

The core category is usually fully developed only towards the end of the research.

Coding and categorising involves constant comparison. Initial interviews are analysed and codes and concepts developed. By comparing concepts and sub-categories, researchers are able to group them into major categories and label them. When they code and categorise incoming data, they compare new categories with those that have already been established. Thus, incoming data are checked for their 'fit' with existing categories. Each incident of a category is compared with every other incident for similarities and differences. The comparison involves the literature. Constant comparison is useful for finding the properties and dimensions of categories. It helps in looking at concepts critically as each concept is illuminated by the new, incoming data. Strauss and Corbin (1998: 4) stress that they do not offer prescriptions but 'essentially guidelines for suggested techniques'. However, it is useful if researchers are completely familiar with the main features of the GT approach.

The place of the literature in a GT study is problematic; experts have different perspectives on this. Some purists believe that there should not be an initial literature review of the specific topic to be researched but an overview of the more general area. The reason for this is that researchers would not be directed to particular issues in their field, but that their own data retained priority in the study. Others feel that an initial review sensitises the researcher to issues related to the topic and stimulates questions to be asked. One can give arguments for and against a long literature review before collection and analysis of data begins. Researchers must be able to justify their study, and therefore they need to find out the type and extent of knowledge that already exists in the field. They should not, however, generate a focus from other people's studies but rather from their own data which have priority.

Strauss and Corbin (1998) list a number of points about the use of the literature.

Concepts from the literature can be compared with those deriving from the study.

The literature can stimulate theoretical sensitivity. It can make researchers aware of existing ideas.

The literature can generate questions and problems.

Knowledge of existing theories can be useful in influencing the stance of the researcher.

The literature can be used as an added source of data although these do not have priority over the researchers' own data.

Researchers have to consider why the literature confirms or refutes their own ideas or data.

Even before the study starts, initial questions can help develop conceptual areas.

During the analysis process more questions can be generated, especially when the researchers' data and the findings of the literature show a discrepancy.

The literature can guide theoretical sampling. It can help decide where to go next. Ideas might arise which increase the chance of developing further the emerging theory.

The literature can be used to validate the researcher's categories. Concepts in the literature may confirm or refute the findings of the researcher.

The dialogue with the literature is critical in the process of theory development. Glaser speaks of several levels of literature and suggests that researchers initially read in the general area, while not studying the specifics related to their own research. The latter should not be carried out until fieldwork, coding and categorising is well under way, otherwise researchers might rely on ideas by others rather than develop their own. We suggest that the grounded theorists trawl the literature initially to find the gap in knowledge where they can contribute to the field, without studying it in detail or being directed to specific ideas, otherwise they might lose the primacy of their own data and be constrained by others' writing.

Most grounded theorists believe that the literature becomes a source for comparison. When categories have been found, researchers trawl the literature for confirmation or refutation of these categories. They try to discover what other researchers have found, and whether there are any links to existing theories. Researchers can also use the literature to compare their own theories with those previously developed.

To be credible the theory must have 'explanatory power', that is, establish a causal relationship. This is different from descriptive qualitative research. In a good project, categories are connected with each other and tightly linked to the data. Researchers do not describe static situations but take into account and develop processes.

Glaser and Strauss (1967) state that two types of theory are produced: substantive and formal. Substantive theory emerges from the study of a particular context or setting – such as a ward, or patients with myocardial infarction, or professional education – hence this type of theory is very useful for health researchers. It has specificity and applies to the setting and situation studied; this means that it is limited. Formal theory, however, is generated from many different situations and settings, and it is conceptual. It might be a theory about vocational education, general experiences of suffering or being a mother, for instance. The 'career' of the dying patients in hospital, the stages through which patients proceed, which Glaser and Strauss investigated is substantive theory. When this is linked to the concept of 'status passage' which can be applied to many different situations, it becomes formal theory. This type of theory has general applicability, that is, it holds true not just for the setting of the specific study but also for other settings and situations, and it is not speculative but based in the data.

In a small student project, it would be difficult to produce a formal theory with wide applications, but substantive theories can still be important and have general implications for the work of the nurse. Another example can be given from nursing:

Example: *A substantive grounded theory*

Sandgren *et al.* (2006) carried out research in the field of palliative cancer nursing through interviews and participant observation. The findings of their research showed that there was emotional overload through their work which they sought to reduce. Nurses adopted a variety of strategies to survive the emotional stress of the setting. Emotional shielding, emotional processing and emotional postponing were the strategies that they adopted to achieve emotional survival. Striving for emotional survival through adopting a number of strategies such as emotional shielding, processing and postponing, etc. became the substantive theory.

The theory developed is generalisable in the sense that it can be applied to other, similar situations. Other events and situations can be understood through the knowledge acquired in building the theory.

While going through the process of research, the researcher writes fieldnotes and memos. When observing and interviewing, the investigator writes fieldnotes from the beginning of the data collection. Certain occurrences or sentences seem of vital interest and they are recorded either during or immediately after data collection. They remind the researcher of events, actions and interactions and trigger thinking processes. There can be descriptions of the setting too to act as triggers for remembering.

Strauss and Corbin (1998: 110) define memos as 'records of analysis, thoughts, interpretations, questions and directions for further data collection', and they should be dated and detailed. Every GT researcher should write memos. They are meant to help in the development and formulation of theory. In theoretical memos, the researcher discusses tentative ideas and provisional categories, compares findings, and jots down thoughts on the research. Initially, memos might contain notes to remind the researcher 'don't forget...' or 'I intend to...'. Later they encompass micro-codes, and later still, major emergent categories, hunches, implications and concepts from the literature; memos become more varied and theoretical. Ideas for follow-up, related issues and thoughts about deviant cases become part of these memos.

Strauss (1987) suggests that memos are the written version of an internal dialogue that goes on during the research. Diagrams in the memos can help to remind the researcher and structure the study. Memo writing continues throughout the whole of the research, it goes through stages and becomes more complex in the process. Memos and diagrams provide 'density' for the research and guide the researcher to base abstract ideas in the reality of the data. Eventually, memos become integrated in the writing.

Pitfalls and problems

Wilson and Hutchinson (1996) discuss some of the common mistakes made in GT. They list six of these:

Muddling method (or method slurring)
Generational erosion
Premature closure
Overly generic analysis
The importing of concepts
Methodological transgression

Some of these are discussed further in other chapters, as they are common to several approaches. There are also problems with building a GT. Many researchers, particularly students in dissertations, projects and even theses, give good conceptual descriptions but do not develop a theory or even theoretical ideas. The difference between conceptualisation and description is significant. It is not enough to describe the perspectives of the participants or discuss 'themes' to develop a truly 'grounded' theory.

The term 'emerging categories' (or 'emerging theory') is problematic as they can only be achieved by hard work. This problem is linked to theoretical sampling. Often researchers use selective (or purposive) sampling procedures. Coyne (1997) differentiates clearly between purposeful and theoretical sampling. While the researcher decides on purposeful sampling beforehand according to certain criteria, dimensions and settings, for GT research this type of sampling is necessary but does not suffice. The decisions about theoretical sampling are not made on the basis of initial criteria but throughout on the basis of emerging concepts, because of the inductive nature of the research.

A number of computer programmes for qualitative research do exist (see Chapter 17). Becker feels that computers might prevent sensitivity to the data and the discovery of meanings. Computers distance researchers from the data. Although this need not be so, we realise that in health research, where emotional engagement and sensitivity is necessary, the use of computers could be problematic. Charmaz (2000) also maintains that in a study in which the researcher is deeply involved with the participants, computer analysis has an undesirable distancing effect.

Generalisability and replicability of GT research are often discussed. Of course, it is difficult to match the original situation and context. Each researcher has a personal approach and a relationship with the participants which cannot be exactly reproduced. However, if nurses and midwives make procedures explicit and clearly describe the original conditions and setting, others can follow the same rules and procedures and discover the same general scheme. Strauss and Corbin (1998) maintain that the findings of a GT study become more generalisable if the study is systematic, relies on theoretical sampling and examination of special conditions and discrepancies. A range of similar theoretical concepts from a variety of sources can become cumulative.

Glaser's critique and further development

Several versions of GT can be distinguished. The ideas of Strauss and Glaser, for instance, have diverged in the last decade. Glaser (1992) wrote a book in response to the book by Strauss and Corbin (1990), criticising the authors for

distorting the procedures and meaning of GT. Glaser claims that their book does not truly describe GT. He accuses the authors of 'forced conceptual description' (p. 5). He exhorts researchers not to impose their research problem but start with an interest and a questioning mind so that they see their informants' perspectives with no preconceptions. Thus, the researcher does not start with a research question but with a research interest. Although agreeing that Strauss and Corbin have described a research method, Glaser denies that its roots have much in common with the original 1967 volume. The new method, he claims, results in conceptual descriptions rather than in the emergence of concepts and formation of the links between them that explain variations in behaviour.

The difference between the ideas in Strauss and Corbin's text and the original development lies in the way in which concepts are generated and relationships explained. Glaser states that GT should not be verificational but inductive, it does not move between inductive and deductive thinking (although the 1967 book does mention verification). Deduction is rarely used except for reasons of conceptual guidance; this differs from the ideas of Strauss and Corbin who include the element of verification by suggesting that researchers test working propositions or 'provisional hypotheses' during their research.

Glaser also argues that participant observation does not suffice for a truly GT; interviews which explain the meanings of the participants are always necessary (many researchers see interviews as an integral part of participant observation in any case). Other differences exist between the two camps: Annells (1997) claims that Strauss and Corbin see theory as a construct 'cocreated' by the researcher and participants, while Glaser believes that theory is 'emerging' from the actual data. It is interesting that Glaser, who started out as a survey researcher, seems to have become more flexible and less structured over time, while Strauss develops a more prescriptive way of researching.

Glaser (1992) believes that any initial literature review on the specific topic would contaminate the data and denies the need for it because it might direct researchers to irrelevant ideas. This he had also stated in his earlier book (Glaser, 1978). However, he too suggests that the literature can be integrated in the developing concepts. Discrepancies between concepts developed from the researchers' original data and the data from the literature may be discovered and the reasons for them investigated. Theoretical sensitivity helps to generate ideas and relate them to theory.

Glaser also advises against taping and transcribing interviews as he believes it a waste of time. We believe, however, that taping interviews might help those who are forgetful or those who have difficulty writing fieldnotes while interviewing. Of course, listening to interviews after taping is of great importance. We would argue that the memory of researchers might not be accurate and lead to misinterpretation. Mills *et al.* (2006) suggest naming the branches of GT

'traditional' (Glaser, who himself calls it 'classic'), 'evolved' (Strauss and Corbin) and 'constructivist' (Charmaz uses this term).

Constructivist grounded theory

Charmaz (2006) criticises some of the early ideas in the GT approach and argues that it has developed from a more prescriptive and positivist style of research to a flexible way of thinking. She claims that the methods have developed in a number of different ways depending on researchers' perspectives. She sees this as developmental and she welcomes the move towards a more constructivist GT. As Charmaz suggests (p. 187) that the 'interpretation of the studied phenomenon is in itself a construction.' and that 'people ... construct the realities in which they participate'. This means that researcher, participants and readers co-construct the research. Reality emerges or is discovered in the context of interaction. Indeed constructivists sometimes suggest that 'truth', and reality, are socially constructed (many researchers would acknowledge the influence of context on research). Constructivist GT is hence more relativist and subjective.

An informative list of the differences between the approach of Strauss and Corbin and that of Glaser can be found in MacDonald (2001).

Which approach for the health researcher?

The varied approaches within GT seem to be based on different epistemological and methodological perspectives, though we would claim strong similarity between them. The development of GT itself has illuminated its elements and aspects in different ways.

Researchers can make up their own minds on which approach to follow when doing GT as long as they are knowledgeable about it and can explain why they have adopted a particular stance or followed specific processes. In any case, many researchers adapt methods during the process of research or use elements which they find useful. For a study to be called a 'Grounded Theory' the major features of GT should be included; most importantly the researcher must develop a theory, grounded in the data and with 'explanatory power'.

Summary

The aim of the GT approach is the generation or modification of theory. Data usually are collected through non-standardised interviews and participant observation but also by access to other data sources. Data collection and analysis interact.

Researchers code and categorise transcripts from interviews or fieldnotes. The researcher has a dialogue with the literature when discussing categories. Throughout the analytic process, constant comparison and theoretical sampling takes place. Memos – theoretical notes – provide the researcher with developing theoretical ideas. The theory that is generated has 'explanatory power' and is grounded in the data.

References

Alvesson, M. & Sköldberg, K. (2000) *Reflexive Methodology: New Vistas for Qualitative Research*. London, Sage.

Annells, M. (1997) Grounded theory method, part 1: within the five moments of qualitative research. *Nursing Inquiry*, 4 (2), 120–9.

Benoliel, J.Q. (1996) Grounded theory and nursing knowledge. *Qualitative Health Research*, 6 (3), 406–28.

Blumer, H. (1971) Sociological implications of the thoughts of G.H. Mead. In *School and Society* (eds B.R. Cosin *et al.*), pp. 11–17. Milton Keynes, Open University Press.

Bryant, A. & Charmaz, K. (eds). (2007) *The Sage Handbook of Grounded Theory*. London, Sage.

Charmaz, K. (2000) Grounded theory: objectivist and constructivist methods. In *Handbook of Qualitative Research* (eds N.K. Denzin & Y.S. Lincoln), 2nd edn, pp. 509–35. Thousand Oaks, CA, Sage.

Charmaz, K. (2006) *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London, Sage.

Chenitz, W.C. & Swanson, J.M. (eds). (1986) *From Practice to Grounded Theory: Qualitative Research in Nursing*. Menlo Park, CA, Addison-Wesley.

Coyne, I.T. (1997) Sampling in qualitative research: purposeful and theoretical sampling: merging or clear boundaries? *Journal of Advanced Nursing*, 26, 623–30.

Cutcliffe, J.R. (2000) Methodological issues in grounded theory. *Journal of Advanced Nursing*, 31, 1476–84.

Cutcliffe, J.R (2005) Adapt or adopt: developing and transgressing the methodological boundaries of grounded theory. *Journal of Advanced Nursing*, 51 (4), 421–8.

Draucker, C.B., Martsolf, D.S., Ross, R. & Rusk, T.B. (2007) Theoretical sampling and category development in grounded theory. *Qualitative Health Research*, 17 (8), 1137–8.

Fenwick, S., Holloway, I. & Alexander, J. (2008) Achieving normality: a key to the status passage to motherhood after a caesarean section. *Midwifery*, 25 (4), e5.

Glaser, B.G. (1978) *Theoretical Sensitivity*. Mill Valley, CA, Sociology Press.

Glaser, B.G. (1992) *Basics of Grounded Theory Analysis*. Mill Valley, CA, Sociology Press.

Glaser, B.G. & Strauss, A.L. (1967) *The Discovery of Grounded Theory*. Chicago, IL, Aldine.

Narrative Inquiry

The nature of narrative and story

Stories are reflections on people's experience and the meaning that this experience has for them. Narrative research is a useful way of gaining access to feelings, thoughts and experience in order to analyse them. For many decades, health research had focused on the decisionmaking and thoughts of professionals and their measurement of the treatment outcomes, while the feelings and ideas of the patient, the 'insider', tended to be neglected. This changed with the advent of qualitative health research. The perspectives of patients are uncovered through their stories.

Many researchers apply the terms 'narrative' and 'story-telling' interchangeably, although others make a distinction. Frank (1995) uses the concepts of story and narrative differently: He cites the term 'story' when discussing the tales people tell, and narrative when referring to 'general structures' that encompass a number of particular stories. Paley and Eva (2005) claim that story integrates plot and character – both need to be present – while narrative comprises both sequence of events and causal links between them. However, the line between story and narrative is blurred, and we shall occasionally use these terms interchangeably. Even Frank admits that a distinction between the two is difficult, and Riessman (2008) too sees these terms as ambiguous.

Researchers refer to life stories, biographies or narratives; Labov (1972), one of the first sociologists to carry out research through narratives, sees the term narrative as more specific – as events in the past that are being retold. First person narratives provide much material for research. It must be remembered, however, that their content emerges from memory, and that people's memories are selective (Skultans, 1998). Nevertheless, the remembered events, as well as the experiences people choose from their vast store of memory, focus on the significant aspects of their social reality.

Narrating helps people to make sense of their experience. It unveils the intentions and motives of human beings to the researcher. Individuals remember an experience, tell the story sequentially as they perceived it happening and seek explanations for events and actions while interpreting and reflecting on them. However, narrators prioritise; some events and experiences carry more

importance than others; according to the specific social context or the people to whom they speak, they emphasise different aspects of the story. They might neglect or fail to mention some issues or events, or they might exaggerate others, depending on their perspective or the audience to whom they speak.

Examples of narratives and narrative analysis

Carter (2004) illustrates the value of children's narratives of pain and how they can influence clinical practice by allowing professionals to hear children's voices and have empathy for them.

An Australian study of the mental health of men in rural areas used narrative inquiry (Gorman et al., 2007). These men's stories of resilience and survival showed how they coped with problems.

McIlfrick et al. (2007) used narrative analysis to explore patients' experiences of chemotherapy in a day hospital. These patients viewed their experiences as both negative and positive, the former relating to the dehumanising aspects of treatment and the latter to social relationships with other patients and the maintenance of a sense of normality. The researchers used an in-depth analysis of patients' narratives.

Narratives are not only used in research but also in psychotherapy and in clinical and developmental psychology, mostly in the form of life stories. In sociology and anthropology too, narrative is seen as useful for examining culture, society or social and cultural groups. They are popular in medicine or nursing to gain the patient perspective. Charon (2006), a doctor, discusses the 'practice of narrative medicine' to which we can add 'the practice of narrative nursing', meaning that health professionals witness the lived experiences of illness, and they become more aware of the suffering and pain of their clients.

Lieblich et al. (1998) maintain that it is natural for people to tell stories. Researchers can use this talent to elicit stories from their participants. Participants affirm their identities through narratives. Ricoeur (1984, 1991) also affirms the ability of human beings to integrate actions and thoughts into a coherent narrative and create a link between past, present and future. Narrators create and affirm their identities through telling their tale. While sociologists such as Arthur Frank, Julius Roth and others have written portrayals of their illness and told their own story, lay people tell of the process and progress of their condition. Riley and Hawe (2005) stress the processual, dynamic and culture-bound nature of narratives; thus time and context are essential elements which researchers need to take into account.

Narrative research

Narrative research is a broad term and can incorporate other approaches – a narrative study may be an ethnography, take a phenomenological approach or

use discourse analysis, but it can also stand as an approach on its own. It refers to 'any study that uses or analyses narrative material' (Lieblich et al., 1998: 2). In this chapter it is used as an approach which is separate from other qualitative forms of inquiry.

A few narrative researchers believe, as Elliott (2005) does, that narrative inquiry can be quantitative as well as qualitative; however, to have lengthy stories from participants needs a more flexible approach and open questions and for these quantitative methods are inappropriate.

Narratives in health research

Although the use of narratives for research and other purposes has gone on in an informal way for a while, it is relatively recent in health research (Frid et al., 2000). Narratives develop and increase professional knowledge, and through the acquisition of this knowledge they can improve care. Stories enable professionals to understand their clients and gain access to their experience and the meaning they give to this experience. For clinical and professional practice it means 'the focus of narrative will enable nursing [and other health professions] knowledge to be grounded in concrete situations' (Frid et al., 2000: 3). It is not easy for health researchers to abandon their own assumptions and focus on the stories of ill people. Frank (2000) gives examples of this. He also refers to the difficulty professionals have to listen to the voice of patients, to hear what is relevant to those who suffer, because professionals have more skills to respond to patients as 'medical *subjects*' rather than 'ill *persons*' (our italics).

Narrative accounts in healthcare can be obtained from a number of different groups:

- Patients or clients
- Caregivers and relatives
- Colleagues and other professionals

Narratives from the point of view of the patient can be seen in several ways.

Patients, for instance, might tell their experience of an illness or a chronic medical condition or of care and treatment by professionals. Ill people tell stories to show what it means to be sick. New mothers tell stories about the meaning of childbirth. Old people tell stories about the meaning of old age in the context of this society. Narratives can also be a reaction to care and medical treatment, or as a counterperspective to that of health professionals. Through narratives and narrative interpretations, patients and clients may also attempt to justify their own actions and behaviour. As long as patients tell their stories, they might feel that they have some control. In addition, they use these narratives to achieve an attempt at normality: they compare their ill selves to their normal social, physical and psychological condition. Holloway and Freshwater (2007)

summarise some of the reasons for storytelling which many authors have discussed, for instance Kellas and Manusov (2003), Riessman (2008) and others.

Through storytelling people have the possibility to

give meaning to experiences, in particular suffering;
interpret and verbalise important events and share them with others;
present a holistic view of experience and perspective;
try to find adjustment when conditions are unalterable;
confirm group membership in a shared culture;
attribute blame or responsibility to themselves or others;
take control over their own lives.

Many authors have shown that telling stories also has healing functions (for instance Pennebaker, 2000 or Brody, 2003), though narrative inquiry has a different purpose, and healing or alleviating suffering and pain are unintended consequences – though of course welcome.

McCance *et al.* (2001) use narrative methodology to explore caring in nursing practice. They use it as a means to 'tap into the patient experience'. It is not easy to gain access to people's feelings and thoughts but eliciting a narrative may help in this process. Telling stories about specific experiences rather than giving general accounts or thinking in general terms is 'real' for patients; they often tell the story sequentially along temporal dimensions. Greenhalgh and Hurwitz (1998: 45) claim that narratives used in healthcare research can

set a patient-centred agenda;
challenge received wisdom;
generate new hypotheses.

Through their stories, patients help health professionals to focus on their perceptions and experiences rather than applying a professional framework immediately. If professionals truly listen to patients, they might also hear the unexpected and will be able to change their own assumptions if necessary.

Relatives are narrators of their care-giving experience as it happened and seek explanations for their own behaviour, for the patients' reactions and for professional care and treatment. Through this, they are able to justify their own thoughts and actions to professionals and researchers. Caregivers of patients with Alzheimer's disease, for instance, tell the sequence of events and discuss the behaviour of their relatives and their own reaction towards them. Essentially, caregivers attempt to share what caring means to them.

Researchers and health professionals use patient narrative to locate the sufferer at the centre of his or her illness. They see the narrative as a useful path to the understanding of sick people and the illness experience, as interpreted by patients in a specific cultural framework. Professionals – be they individual professionals in interaction with particular patients or professional groups who define specific conditions or illnesses within a biomedical framework – give different versions from patients. Both versions are valid and together might give the full picture. Sakalys (2000), in particular, addresses the question of culture in a discussion of narratives and claims that the social and cultural interpretation defines the illness experience and the sick role for the individual. Narratives also demonstrate the conflicts and dilemmas between individual meanings and healthcare ideologies.

In professional education and practice, narrators might tell the story of interaction in specific situations and of learning or teaching experiences. The researcher's aim is the understanding of the essence of that experience in the context of the participants' lives. Josselson (1995) claims that empathy and narrative show the way to people's reality; understanding of this can be achieved through qualitative research. Kleinman (1988) also urges 'empathic listening'. Health professionals need both empathy for and stories from their clients. Nurse and midwife teachers, in particular, often use narratives to teach students reflection and clinical decisionmaking as well as empathy.

Example

The following research shows the value of narratives. An exploration of how people with motor neurone disease talk about living and coping with their condition demonstrates how survival is the essential element in the findings. Brown and Addington-Hall (2008) carried out longitudinal narrative interviews over 18 months with 13 individuals. Although the participants' narratives were unique, they also contained common elements. Brown and Addington-Hall point out that storylines are 'organising threads' that help professionals to understand and help these individuals and their families.

Types of narrative

Jovchelovitch and Bauer (2000) list the two dimensions of narrative and story-telling: the chronological dimension where narratives are told in sequential form with a beginning, a middle and an end, and the non-chronological, which is a plot constructed as a coherent whole from a number of events – small tales which combine into a big story. According to Paley and Eva (2005), certain conditions need to be fulfilled in the configuration of a plot:

The plot contains a central character.
This character encounters a problem.
A link exists between character and explanation.
The plot and its configuration elicits an emotional response in the listener.

It depends on the storyteller what he or she wishes to communicate to others or what to leave out of the story. People organise their experience through narratives and make sense of them, not least by relating them to time. Indeed, Bruner (2004: 692) states that the only way to account for 'lived time' is in the form of narrative. Narratives allow access to a person's perceived reality in many different ways. Richardson (1990) describes many of these types of stories:

- Everyday stories
- Autobiographical stories
- Biographical stories
- Cultural stories
- Collective stories

Often, narratives contain a number of overlapping stories. We shall illustrate these by examples (real, but not necessarily literal, comments):

In the everyday story, people tell how they did everyday things and carry out their normal tasks: '... And then I went out into the garden and did some work, and then I came inside and sat down.' Most patients import these everyday stories into the history of their condition, care and treatment.

> ### Example
> When researching people's experience in hospital, one of our students found that their narratives always tended to start at a time before they arrived. 'We were watching television, I had just made a cup of tea when it happened... and then my wife called the ambulance, I could hardly walk, and then they went through the night with all lights blazing and a lot of noise.'

In an autobiographical story people link the past to the present and future: 'I used to go dancing, but now I can't dance any more, I shall probably never dance again because of my pain.' Through autobiographical stories people also justify and explain their actions: 'Because I had such an awful pain in my back I could not have regular work.' In autobiographies in which individuals tell their illness history, they demonstrate that they see their own stories as unique and quite separate from those of others. The storyteller can link together various disparate events through narrative (Polkinghorne, 1995): '... And then I went

into the garden, and I did some work, and then my back went ... and that's why I am unemployed now.'

> ### Example of autobiographical tale
> Sparkes (1996) draws on his own experiences to illustrate the power of narrative. He connects his own story of 'the fragile body-self' with the experiences of others and their 'biographical disruptions'. Speaking of 'identity loss', chronic illness and feelings about masculinity, he links his discussion to the cultural and social context.

Biographical stories, however, link individuals with each other. Reading and listening to biographical stories enables them to share and compare their experiences. The stories guide beyond the subjective to intersubjective understanding and empathy by living in a shared world. By writing accounts of others' stories, researchers help readers understand the feelings and vulnerability of others. An element of the autobiographical or biographical tale is the victory story in which individuals demonstrate how they overcame adversity by describing their feelings and actions (Sandelowski, 1996).

Through the cultural story participants tell, they make visible and demonstrate meanings in a particular cultural context, for instance the meaning of death or the understanding of disease: 'I had epilepsy. In our society people don't understand that, and I was labelled as not quite normal.' Or 'My back pain is invisible, nobody believes that it exists, if I had a broken leg I would not be labelled lazy or work shy.' Or 'Everybody wants you to have the baby in hospital, in an earlier time, you could have it at home. Luckily times are changing again.'

In research the collective story is significant. By retelling a number of stories, for instance of patients, professionals or students, researchers reflect the thoughts and paths of a group or collective of people with similar experiences and give a portrayal of a condition or patterns of experience. For instance, a person suffering from pain might mention that others are much worse off, or that new mothers tell stories that are embedded in the culture of motherhood. Collectivity

creates a *Gestalt* or whole picture of the condition or experience. For nurses and midwives this means that they might recognise the needs of the group members and improve their care.

Illness narratives

Kleinman's (1988) *The Illness Narratives* is probably the best known example of narrative in the health and illness arena though not in research.

Patients use narratives to seek meaning and make sense of their suffering, and they want to share this with 'significant' others. The researcher on the other hand, re-tells stories in order to give voice about participants' feelings and thoughts. It is questionable, however, that the account is always the authentic voice of the participants because researchers translate and interpret the narrators' tales. Paley and Eva (2005) query the concept of truth as it is sometimes applied to narrative. They believe that 'truth' in the factual sense is irrelevant and that meaning and interpretation are important, not whether the story is factually 'real'. Sandelowski (1996: 122) also criticises the naïve notions of stories as either true or false. Nevertheless, researchers make an attempt to represent the ideas of the participants. Although the narration may be true in its meaning, it is not always based on fact or objective reality but is a social construction and perception of what has happened to the narrator. At a time when people have little power to act – for instance when they have experienced an illness, breaking up of a relationship or another trauma in their lives – they attempt to explain this in a different language from that of those in power. To paraphrase Bruner (1991: 11): the patient tells the tale in 'life talk' (that is, in ordinary language) while the professional listens to it and translates it into professional language.

People often tell stories about their illness, particularly when the condition threatens their lives such as in an acute illness or when it restricts their daily activities and intrudes on normal life. Through illness and suffering, individuals often have an impaired sense of self, and on this they reflect. As it is of such importance to them, they attempt to tell their story to their significant others such as family and friends, employers and work colleagues. They tell it also to the health professionals, doctors and nurses. For each of these groups, ill people adopt different ways of telling.

Illness narratives differ from other stories in that they have an altered temporality while in ordinary tales the present connects effortlessly to the past and future. The future of those telling about their illness is sometimes uncertain and occasionally non-existent.

Frank (1995) proposes three different forms that narratives can take:

The *restitution* narrative
The *chaos* narrative
The *quest* narrative

Example

Whitehead (2006) demonstrates how people who live with myalgic encephalomyelitis (ME) interpret their lives and conditions. Their stories about living with this condition reflect the restitution, chaos and quest narratives that were discussed by Frank. Their restitution narrative indicated the orientation of patients towards better health in the future; the chaos narrative focused on lack of control over their own fate; the quest narrative showed challenge, movement towards change and adaptation to the condition.

The different types of the narrative are not always distinct. Frank's justification for differentiating between narratives is to create 'listening devices' – the wish to sort out narrative threads in order to help listeners attend these stories, not to question the uniqueness of an individual's tale nor to give a unifying view of experience. In any case, most stories combine elements of all three forms of narrative. Each of these forms is a reflection of both the culture and the person of the storyteller.

The restitution narrative permeates the tale of those who have been ill. This includes the wish to get well soon. It can be connected with the concept of Parsons' (1951) sick role. Individuals are sick – they receive treatment and care – it is seen as their duty to get better – they will be better in the future. People emphasise not only their desire to get better, but they often claim that they are well and have achieved the state of normality: 'I am OK now'. Most restitution tales reflect Parsons' ideas about the sick role: the person inhabiting the role is not at fault; the patient is exempt from normal role responsibilities; he or she is expected to ask for expert help, comply with the advice and make every attempt to get better.

The restitution narrative reflects the predominant Western culture. Indeed, Frank claims that 'it is the culturally preferred narrative'. It takes the machine as a model: the machine breaks down, one takes it to a repair shop, and it is repaired. It is reconstructed, almost 'as good as new'. It also implies that people have control over their bodies and minds, and that the future is, to some extent, predictable.

Excerpt from restitution tale

My husband did all the housework
Because I couldn't
I had to leave my paid employment
I was in such pain

But I went to the doctor's
He told me not to stay in bed all the time
He prescribed some painkillers
And then it got better
Very slowly
(paraphrased and condensed from an interview)

The chaos narrative suggests that the person will not ever get well again and encompasses his or her suffering in words and silences. This tale is not always tolerated in the predominant culture that focuses on cure (the 'machine' can be fixed or repaired). Perhaps a chaos narrative is easier to listen to for nurses because they focus on care. This narrative has no order and little structure, and it is told by people who have a serious chronic condition, or a life-threatening or terminal illness. This tale is more difficult to understand because it is never linear; it does not have a proper beginning, middle and end nor does it follow the same direction.

For the story to be effective, the storyteller must have some distance from it as the person in the middle of an experience finds it difficult to talk about it. There is iteration with narrators going backwards and forwards much of the time. The chaos narrative implies the narrators' lack of control over their lives. The illness generates complete 'biographical disruption'. Frank claims that health professionals should not hurry patients on when they are telling the tale as this denies the patients the right to their experience. He advises professionals to have tolerance for chaos within a story.

Excerpt from a chaos story

They don't know what it's like to be trapped in your own home for weeks on end and not be able to go anywhere. I only half accept it. My mind is telling me 'you should be doing this and that', but my body is telling me the exact opposite. I almost think it makes you become two people. (Holloway *et al.*, 2007)

The quest narrative is told by people who are on a mission, who accept the challenge to learn something from their experience and feel that they are on a journey during which they change their identity. People think they must transmit to others what they have learned. They tell the story chronologically. Disability stories often contain the element of challenge and mission. We have all read of people with a serious illness who tell their story to the newspapers or on television 'to help others'. They often maintain that the illness has transformed them; the narrative has a moral dimension. Even though the condition may not improve, the ill person has control over his or her life.

Example of quest narrative

Thomas-MacLean (2004) demonstrates all three types of narratives and claims that in her research, the quest narrative is rare. She gives examples of the determination to experience life as much as possible by people who realise they have cancer, the different priorities they now have, and how they attempt to assist others in the same position.

Narrative interviewing

To obtain a narrative from participants, researchers use narrative interviews in which individuals can tell of their experience. The tale is not the experience itself but a representation of the experience as it is stored in the memory of the individual. Ochs and Capps (2002: 127) suggest 'remembering is a subjective event'; but participants see it as true, although it cannot necessarily be corroborated or verified. Nevertheless, the perception of the 'truth' of the event, treatment or care determines, or at least influences, both perception and action.

Narrative interviewing does not break a story into pieces and take it out of context, which other types of interview sometimes do; the latter 'often fracture the text' (Riessman, 1993: 3). Narrative interviewing has a main area of deep interest to participant and researcher. A stimulus or reminder provides the trigger for the story. Riessman does stress that narratives differ distinctly from other types of discourse such as question and answer interviews.

Jovchelovitch and Bauer (2000) state that the topic area must be both familiar and also experiential to the participant. The initial question must be broad enough to trigger a long story. For instance, 'Tell us about your time in hospital' might encourage patients into narrating a lengthy tale about what happened to them in the hospital setting. If the interviewer interrupts this story continually, it cannot flow. When the narrative is completed, however, the interviewer might ask some questions to develop the story by including the words of the participant. For instance: 'You said to me that time hung heavily while you were in hospital, can you tell me more about that?' Narrative interviews, like all other forms of interview, are affected by the relationship between the researcher and the participant, perhaps even more so as the researcher does not just ask questions to receive some answers but gives the participants control of the interview and as much time as they need to tell their story. Narrative

interviews sometimes contain elements of question and answer exchange but mostly sections of narrative. It is not always possible to draw boundaries and discover where the narrative starts and finishes. There is a worrying tendency to carry out semi-structured interviews and call these narrative interviews, but in true narrative interviews, there is little interruption by the researcher.

Narrative interviews often focus on life histories or life stories as they show development of experience and perspective over time. One colleague for instance explored the experiences of international students who were studying for a master's degree at a university in Britain, to show whether there had been cultural adaptation and change for these students (Brown, 2008).

Narrative analysis

This whole chapter is about narrative analysis and what it implies. Riessman (2008) does not acknowledge a specific standard set of procedures for analysing the data but offers a choice to researchers. The actual data analysis of narratives is similar to that in other types of qualitative research and depends on the methodological framework. Polkinghorne (1995: 15) defines narrative analysis as 'the procedure through which the researcher organizes the data elements as into a coherent and developmental account'. The main steps include data transcription and reduction. The first step is the verbatim transcription of the narrative data (see the section on transcribing and sorting, in Chapter 17).

There are different approaches to analysing narrative data such as, for instance, thematic, structural and dialogic/performance analysis according to Riessman (2008) but other ways of analysing narratives are also legitimate.

The researcher analyses a narrative as a whole. In this type of analysis it is important to identify the main statements – the core of the experience that reflects and truly represents the narrators' accounts, even though they might not have given the story in a sequential and ordered way. It centres on the contents of the participants' story and the meanings inherent in it. The units of text in the transcription are reduced to a series of core sentences or ideas. The core statements of the experience integrate its various elements. This essence of experience is highly auditable in the examples below.

> **Example**
> Your life is pain
> It stops you doing . . .
> Going out

> Just trying to be a normal person
> I don't feel like doing anything
> All you want to do is to dwell on your own suffering
> Pain becomes an obstacle
> To any type of performance
> (excerpt from participants' tales in a pain experience study)

The essence of these statements and the core of the experience is that 'the pain takes over'. Other themes can be linked to this statement. Both Riessman and Elliott advocate this type of analysis in applied research, particularly for novice researchers; Riessman calls it thematic analysis and claims that it is the most straightforward. In this, researchers interpret and theorise from the whole story and its meaning, rather than breaking it into categories. The attention focuses on the contents, on 'what' is in the story, rather than 'how' it is told. Unlike analysis in grounded theory, the story is not taken apart but kept together for interpretation. (For further advice see Riessman 2008: 53–76.)

The term thematic analysis is not unambiguous in qualitative inquiry; here it is described the way Riessman uses it in her book.

This type of analysis has its origin in the work of Labov and Waletzky (1967). It does not focus on contents but on form, 'how' the story is told, and it is tied to the text of the story. These sociologists developed a structural model of narrative in which they broke down the story and analysed its elements. These six elements are the following (adapted from Riessman 2008: 84; Elliott, 2005: 42. They describe the Labov/Waletzky model):

Abstract: The summary of the story matter
Orientation: The time, place, situation and participants
The complicating action: The sequence of events, i.e. the plot with its inherent crisis
Evaluation: The appraisal of the story and its meaning for the storyteller
Resolution: The outcome of the plot
Coda: The return to the present time

(For a detailed discussion see Riessman 2008: 77–103.)

The last of Riessman's approaches to analysis of data is that which she calls dialogic/performance analysis which is a 'broad and varied interpretive approach'

(Riessman, 2008: 105) to narrative. It investigates the emergence of interactive talk. This seems to be similar to conversation or discourse analysis where the focus is not only on the content and form but also on the people involved and to whom they orient their talk. She calls this a 'hybrid' form of analysis which takes components from other approaches. We would not recommend this type of analysis to novice researchers.

Visual analysis

The last type of Riessman's narrative analysis focuses on visual images. This is becoming popular and useful in illness narratives, in particular photographs, but sometimes also other images such as painted work, film or theatre (see also Chapter 15). The images can be specifically generated for a topic area or researchers might use existing images from the past or the present (photographs of medical conditions; films of interaction between health professionals and clients; paintings of disfigured people). Lorenz (2007) presented a paper of her work with a survivor of traumatic brain injury. In this she explored the story of a woman who took photographs of living with her injury over a period of five years. The woman showed her pictures to Lorenz and told her what they meant to her. A participant's story can, of course, be told with images, thus having a great visual impact, but the researcher's scholarly work needs analysis and interpretation, and this generally does involve some writing.

Problematic issues

One of the issues in narrative research is that of 'truth'. For the researcher it is difficult to decide on the veracity or falsehood of stories as they are retrospective and also rely on memory. Is the truth being told, or 'the truth as the participants see it'? Hidden motives might underlie the way the narrator tells the story. There are inconsistencies and tensions that lie within it. These problems need reflection and discussion. If the stories fit into the social context and framework, they become more credible, but of course the researcher may never know whether the story was accurate. These issues and the debates about it can become a topic of exploration. People select from their memory banks what they wish to remember, or they might forget what 'really' happened. However, the way the story is told, what is withheld or included, what is dramatised or forgotten, is important for the data analysis. Even ostensible 'untruths' might become significant.

The narratives of people and the storytelling by the researcher can be problematic in other ways. On the one hand, Lieblich *et al.* (1998) state that narratives are often seen more as art than as science because they are rooted in intuition and experience. On the other, they argue for a structured and coherent approach to storytelling.

Atkinson (1997) highlights three major issues:

1. Narratives of health and illness play an important part in medical sociology and anthropology (and we would add in nursing and healthcare).
2. Sometimes these narratives are based on inappropriate assumptions and on mistaken methodological and theoretical claims.
3. Narrative analyses must be systematic and should not be seen as single solutions to problems.

Atkinson criticises the unexamined assumptions that underlie these narratives in which researchers take a simplistic view of this form of research; the link between narratives and experiences is complex and they should not be seen as individualistic and romantic constructions of self but located within the context of interaction and social action. They are no more 'authentic' (a favourite word of narrative researchers), he claims, than other forms of research. Readers of narratives need 'thick description' of socio-cultural settings in which the narratives are embedded. Atkinson and Delamont (2006) add that overuse and uncritical acceptance is a recurrent problem in narrative inquiry. The research suffers from a lack of analysis and attention to social context and culture. Researchers, they suggest, should approach narrative research with 'a degree of caution and methodological scepticism, (p.18). Narrative research is not merely a re-telling or re-storying of narratives of personal experience that help participants to have their voice heard and represented but also detailed scholarly analysis and evaluation.

Frank (2000) answers Atkinson by presenting his own ideas on some of the issues important in narrative. He makes five major points:

1. He suggests that, although narrative and story are used interchangeably, people tell stories, they are not telling narratives. Narratives contain structures on which stories are based. Storytellers use these but are not fully aware of them.
2. People share their stories with the listener, and through this sharing of the story the listener becomes part of a relationship in which the story is told.
3. Stories create distance between storytellers and the threats they experience. They do perform the 'recuperative role' that Atkinson attributes to them.
4. Stories are not just the data for analysis to be transformed into text. They affirm the purpose of the story, namely forming relationships.
5. The stories of illness need to be heard. Frank (2000: 355) refutes 'Atkinson's dichotomy' between storytelling and story analysis; he maintains that 'any good story analysis accepts its place in relations of storytelling' and researchers can only listen inside a relationship with ethical and intellectual responsibilities.

Ultimately Frank sees storytelling in a different way from Atkinson. Frank (2000: 355) states emphatically: 'Storytellers do not call for their narratives to

be analysed; they call for other stories in which experiences are shared, commonalities discovered and relationships built'.

The discussion about the purpose of narrative and storytelling is ongoing. Regardless of the stance of individual health researchers, they should be aware of the ongoing debate.

Conclusion

The writer, the participants and the reader together 'create' the final story. The researcher interprets the participants, stories in the research account, and the readers in turn read through the lenses of their own understanding. Although researchers interpret and edit the thoughts and ideas of the participants, 'even edited stories remain true' (Frank, 1995: 22). The 'good' research report entails collaboration between researcher and participant. The social and cultural world of narrators or researchers is not simple but complex; it always influences the story.

Summary

Narratives are tales of experience or imagination and come naturally to human beings.

Narratives are rarely simple or linear, and they often consist of many different stories rather than of a clearly defined tale.

Illness narratives are expressions of illness, suffering and pain.

Narratives are often tales of identity.

Health professionals gain knowledge of the illness experience from their patients which assists in understanding the condition and the person.

There are a number of different ways of analysing narrative data, and all are legitimate.

In narrative inquiry the final story is constructed by participant, researcher and reader.

Illness and professional narratives are always located in the socio-cultural context as well as in the individual.

References

Atkinson, P.A. (1997) Narrative turn or blind alley? *Qualitative Health Research*, 7 (3), 325–44.

Atkinson, P. & Delamont, S. (2006) Rescuing narrative from qualitative research. *Narrative Inquiry*, 16 (1), 164–72.

Brody, H. (2003) *Stories of Sickness*, 2nd edn. New York, NY, Oxford University Press.

Brown, L. (2008) *The Adjustment Journey of International Postgraduate Students at a University in England: An Ethnography*. Unpublished PhD thesis, Bournemouth University.

Brown, J. & Addington-Hall, J. (2008) How people with motor neurone disease talk about their illness: a narrative study. *Journal of Advanced Nursing*, 62 (2), 200–8.

Bruner, J. (1991) The narrative construction of reality. *Critical Inquiry*, 18 (1), 1–21.

Bruner, J. (2004) Life as narrative. *Social Research*, 71 (3), 691–710.

Carter, B. (2004) Pain narratives and narrative practitioners: a way of working 'in relation' with children experiencing pain. *Journal of Nursing Management*, 12 (3), 210–16.

Charon, R. (2006) The self-telling body. *Narrative Inquiry*, 16 (1), 191–200.

Elliott, J. (2005) *Using Narrative in Social Research: Qualitative and Quantitative Approaches*. London, Sage.

Frank, A.W. (1995) *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago, IL, University of Chicago Press.

Frank, A.W. (2000) The standpoint of storyteller. *Qualitative Health Research*, 10 (3), 354–65.

Frid, I., Öhlen, J. & Bergbom, I. (2000) On the use of narratives in nursing research. *Journal of Advanced Nursing*, 32 (3), 695–703.

Gorman, D., Buikstra, E., Hegney, D. *et al.* (2007) Rural men and mental health: their experience and how they managed. *International Journal of Mental Health Nursing*, 16 (5), 298–306.

Greenhalgh, T. & Hurwitz, B. (1998) Why study narrative? In *Narrative Based Medicine* (eds T. Greenhalgh & B. Hurwitz), pp. 3–16. London, BMJ Books.

Holloway, I. & Freshwater, D. (2007) *Narrative Research in Nursing*. Oxford, Blackwell.

Holloway, I., Sofaer, B. & Walker, J. (2007) The stigmatisation of people with chronic pain. *Disability and Rehabilitation*, 29 (18), 1456–64.

Josselson, R. (1995) Imagining the real: empathy, narrative and the dialogic self. In *Interpreting Experience: The Narrative Study of Lives* (eds R. Josselson & A. Lieblich), pp. 27–44. Thousand Oaks, CA, Sage.

Jovchelovitch, S. & Bauer, M.W. (2000) Narrative interviewing. In *Qualitative Interviewing with Text, Image and Sound* (eds M.W. Bauer & G. Gaskell), pp. 57–74. London, Sage.

Kellas, J.K. & Manusov, V. (2003) What's in a story? The relationship between narrative completeness and adjustment to relationship dissolution. *Journal of Social and Personal Relationships*, 20 (3), 285–307.

Kleinman, A. (1988) *The Illness Narratives: Suffering, Healing and the Human Condition*. New York, NY, Basic Books.

Labov, W. (1972) *Sociolinguistic Patterns*. Philadelphia, PA, University of Pennsylvania Press.

Labov, W. & Waletzky, J. (1967) Oral versions of personal experience. In *Essays on the Verbal and Visual Arts* (ed. J. Helm). Seattle, WA, University of Washington Press.

Lieblich, A., Tuval-Mashiach, R. & Zilber, T. (eds). (1998) *Narrative Research: Reading, Analysis and Interpretation*. Thousand Oaks, CA, Sage.

Lorenz, L. S. (2007) *Living with traumatic brain injury: Narrative analysis of a survivor's photographs and interview.* Poster Presentation, 26th Annual Conference, Brain Injury Association of Massachusetts, Marlborough, MA, March 22.

McCance, T.V., McKenna, H.P. & Boore, J.R.P. (2001) Exploring caring using narrative methodology: an analysis of the approach. *Journal of Advanced Nursing*, 33 (3), 350–6.

McIlfrick, S., Sullivan, K., McKenna, H. & Parahoo, K. (2007) Patients' experience of having chemotherapy in a day hospital setting. *Journal of Advanced Nursing*, 59 (3), 264–74.

Ochs, E. & Capps, L. (2002) Narrative authenticity. In *Qualitative Research Methods* (ed. D. Weinberg), pp. 127–32. Malden, MA, Blackwell.

Paley, J. & Eva, G. (2005) Narrative vigilance: the analysis of stories in health care. *Nursing Philosophy*, 6 (2), 83–97.

Parsons, T. (1951) *The Social System.* New York, NY, Free Press.

Pennebaker, J.W. (2000) Telling stories: the healing benefits of narrative. *Literature and Medicine*, 19 (1), 3–18.

Polkinghorne, D.E. (1995) Narrative configuration in qualitative analysis. In *Life History and Narrative* (eds J.A. Hatch & R. Wisniewski), pp. 5–23. London, The Falmer Press.

Richardson, L. (1990) Narrative and sociology. *Journal of Contemporary Ethnography*, 19 (1), 116–35.

Ricoeur, P. (1984) *Time and Narrative*, Vol. 1. Chicago, IL, Chicago University Press.

Ricoeur, P. (1991) *Time and Narrative*, Vol. 2. Chicago, IL, Chicago University Press.

Riessman, C.K. (1993) *Narrative Analysis.* Newbury Park, CA, Sage.

Riessman, C.K. (2008) *Narrative Methods in the Human Sciences.* Thousand Oaks, CA, Sage.

Riley, T. & Hawe, P. (2005) Researching practice: the methodological case for narrative inquiry. *Health Education Research*, 20 (2), 226–36.

Sakalys, J.A. (2000) The political role of illness narratives. *Journal of Advanced Nursing*, 31 (6), 1469–75.

Sandelowski, M. (1996) Truth/storytelling in nursing inquiry. In *Truth in Nursing Inquiry* (eds J.F. Kikuchi, H. Simmons & D. Romyn), pp. 111–24. Thousand Oaks, CA, Sage.

Skultans, V. (1998) Anthropology and narrative. In *Narrative Based Medicine* (eds T. Greenhalgh & B. Hurwitz), pp. 225–33. London, BMJ Books.

Sparkes, A. (1996) The fatal flaw: a narrative of the fragile body-self. *Qualitative Inquiry*, 2 (4), 463–94.

Thomas-MacLean, R. (2004) Understanding breast cancer stories via Frank's narrative types. *Social Science and Medicine*, 48 (9), 1647–57.

Whitehead, L. (2006) Quest, chaos and restitution: living with chronic fatigue syndrome/myalgic encephalomyelitis. *Social Science and Medicine*, 62 (9), 2236–45.

Atkinson, P.A. & Delamont, S. (eds). (2006) *Narrative Methods*, 4 Volumes. London, Sage.

Charon, R. (2006) *Narrative Medicine: Honoring the Stories of Illness.* New York, NY, Oxford University Press.

Clandinin, D.J. (ed). (2007) *Handbook of Qualitative Inquiry: Mapping a Methodology.* Thousand Oaks, CA, Sage.

Harter, L.M., Japp, P.M. & Becker, C.S. (eds). (2005) *Narratives, Health and Healing: Communication Theory, Research and Practice.* Mahwah, NJ, Lawrence Erlbaum.

Hatch, J.A. & Wisniewski, R. (eds). (1995) *Life History and Narrative.* London, The Falmer Press.

Hydén, L. & Brockmeyer, J. (2008) *Health, Illness and Culture: Broken Narratives.* New York, NY, Routledge.

Josselson, R. & Lieblich, A. (eds). (1999) *Making Meaning of Narratives.* Thousand Oaks, CA, Sage.

Further reading

Adams, M., Squire, C. & Tamboukou, M. (eds). (2008) *Doing Narrative Research.* Los Angeles, CA, Sage.

Phenomenology

Phenomenology is an approach to philosophy and not specifically a method of inquiry; this has often been misunderstood. Indeed, Caelli (2001: 275–6) argues: 'Because phenomenology is first and foremost philosophy, the approach employed to pursue a particular study should emerge from the philosophical implications inherent in the question'. To give a basis to phenomenological research, we have traced the complex history of the philosophy of phenomenology and then discussed its adaptation as a qualitative research approach in nursing, midwifery and other health professions. This might set the scene for the phenomenological research approach. As a method of inquiry, phenomenological research has not often been carried out at undergraduate level in the past but has recently been much more popular particularly in postgraduate health studies. Unfortunately, some phenomenological researchers, especially novices, neglect the philosophical origin of the method.

Various ways of 'doing' phenomenology exist. They all have similar aims however; their data gathering and analytic procedures overlap. The major aim of a descriptive phenomenological research approach is to generate a description of a phenomenon of everyday experience to achieve an understanding of its essential structure while hermeneutic inquiry emphasises understanding more than description and relies on interpretation (see Giorgi, 1992).

Descriptive phenomenologists, such as Giorgi and Todres in particular, mainly use the philosophy of Husserl and his followers, others incorporate the ideas of Heidegger and his colleagues who believe that phenomenology is interpretive, for instance Van Manen (1990, 1998) or Rapport (2005). Either approach can be used; researchers have overlapping though not congruent ideas on the way of doing phenomenological research (see later in this chapter).

Essentially, phenomenology has three major streams: the *descriptive* phenomenology of Edmund Husserl (1859–1938); the *hermeneutic* phenomenology of Martin Heidegger (1889–1976); and the *existentialist* phenomenology of Merleau-Ponty (1908–1961) and Jean-Paul Sartre (1905–1980). There are ongoing philosophical debates about the distinctions and overlaps between these streams, but the differing emphases indicated in this chapter generally remain.

The term 'phenomenology' derives from the Greek word *phainomenon* meaning 'appearance' (the concept was first developed by the philosopher Kant). Phenomenological philosophy is partly about the epistemological question – about the theory of knowledge – of 'how we know', the relationship of the person who knows and what can be known (McLeod, 2001). It is also connected to the ontological question: 'what is *being*'. The ontological question is concerned with the nature of reality and our knowledge about it, 'how things really are'. Giorgi and Giorgi (2003) suggest that phenomenology is 'a study of consciousness.'

As philosophy in general, the study of phenomenology is not immediately understandable. It has, however, informed the human sciences and in particular phenomenological psychology where it is used within qualitative research.

It is useful to trace the history of phenomenology. The following section will outline the background of phenomenology from so-called 'continental philosophy', the subsequent ideas Edmund Husserl (initially based on Brentano), as well as the later development of the phenomenological movement and schools of phenomenology.

Intentionality and the early stages of phenomenology

Phenomenology begins with Husserl who was the core figure in the development of phenomenology as a modern movement. It is important, however, to trace the earlier history of phenomenology in the influence of Franz Brentano (1838–1917) on the work of Husserl. Brentano was part of the preparatory phase of this movement (Cohen *et al.*, 2000).

One of the main themes of phenomenology is the concept of *intentionality*. Husserl takes this term from Brentano though he does not use it in the same way. Giorgi (1997: 237) describes the notion of intentionality as Husserl sees it. In Husserl's work, intentionality is 'the essential feature of consciousness' which is directed towards an object. When human beings are conscious, they are always conscious of something. Consciousness in phenomenology relates to the person's consciousness of the world (Langridge, 2007)

This critical statement concerning the notion of intentionality shows the complexity of any attempt to define the act of conscious thought. In the human sciences, according to Giorgi, consciousness overcomes the dilemma of the subject–object debate, the mind–body relationship which is understood holistically and structurally. Philosophers, psychologists and natural scientists, including doctors and psychiatrists, neither agree nor have firmly established what exactly consciousness is, or what is the true relationship between mind and body. The ideas presented in this chapter cannot resolve the mind–body problem. However, it is useful to note that phenomenology is, in fact, one approach that attempts to do this. Priest places phenomenology within mind–body theories arising from the following:

Descartes' dualism which separates mind and body.

So called logical behaviourism: this is a belief that everything concerns behaviour.

Notions of idealism: all that exists can be explained in terms of the mind.

Materialism: everything in the universe can be explained in terms of matter.

Functionalism: everything is a kind of cause and effect. The mind is given a stimulus and responds physically or behaviourally.

So-called 'double aspect theory': the physical and mental are, in fact, merely aspects of something else, another reality, outside notions of the mental and the physical.

The phenomenological view: this is an attempt to describe lived experiences, without making previous assumptions about the objective reality of those experiences.

Whilst these ideas are presented as theories within philosophy, phenomenology is, in fact, also a practice. It is this practice that is so exciting for nursing, health and social care alike, because it offers the possibility of ' . . . characterizing the contents of experience just as they appear to consciousness with a view to capturing their essential features' (Priest, 1991: 183).

Phases and history of the movement

As has already been stated, phenomenology has philosophical origins. In 1960, the first edition of Spiegelberg's review of the history of the phenomenological movement was published. He described what he termed three phases in the movement, the preparatory, the German and the French phases. Cohen (1987) summarises these in a paper giving her account of the history and importance of phenomenological research for nursing and stated that Brentano influenced this preparatory phase.

The German phase

The German phase involved primarily Husserl and later Heidegger. Cohen *et al.* (2000) discuss Husserl's contribution to the movement and highlight his centrality for phenomenology, his search for rigour, his criticism of positivism (all knowledge is derived from the senses – linked to scientific inquiry of observation and experiment) and his concepts of *Anschauung* (phenomenological intuition) and phenomenological reduction. In the former, a different kind of experience is apparent, closely involved with the imagination. Experience suggests a relationship with something real, such as an event, while *Anschauung* can also occur in imagination or memory. The latter is a process to suspend attitudes, beliefs and suppositions in order to properly examine what is present. Husserl termed this part of phenomenological reduction *epoché* (from the Greek,

meaning 'suspension of belief'). Bracketing (a mathematical term) is the name given by Husserl to this process of suspending beliefs and prior assumptions about a phenomenon. Bracketing and phenomenological reduction are important features of the method, the actual 'doing' of phenomenology. The complex approach of various forms of phenomenology and the idea of bracketing in Husserl's and Heidegger's work has been debated in many books and articles explaining phenomenology to and for nurses both by well-known and new researchers, such as, for instance, Jasper (1994), Crotty (1996), Paley (1997), Berg *et al.* (2006), Streubert Speziale and Rinaldi Carpenter (2007).

Husserl's major contribution to phenomenology consisted of three elements in particular: intentionality, essences and phenomenological reduction (bracketing).

Several important elements of phenomenology were developed by colleagues and students of Husserl. The major concepts are intersubjectivity and the idea of 'lifeworld' (*Lebenswelt*). Intersubjectivity is about the existence of a number of subjectivities which are shared by a community, that is, by individual persons who share a common world. The intersubjective world is accessible because humans have empathy for others. The way of making sense of experience is essentially intersubjective (Schwandt, 2007).

The concept of lifeworld (*Lebenswelt*) is about the lived experience that is central to modern phenomenology. Human beings do not often take into account the commonplace and ordinary; indeed, they do not even notice it. Phenomenological inquiry is the approach needed to help examine and recognise the lived experience that is commonly taken for granted.

The next stage in the German phase of phenomenology involved Heidegger who was an assistant to Husserl for a while. Due to the upsurge of interest (particularly in North America) in using the phenomenological framework for nursing and midwifery research, Heidegger is often mentioned in the work of a number of health researchers over the years. Benner's (1984) phenomenological research uncovered excellence and power in clinical nursing practice, and she references, amongst others, Heidegger. Her well-known study had a profound influence, particularly on nursing research. Heidegger's changed direction from Husserlian phenomenology and his break with it occurred in the way he developed the notion of *Dasein* which is explained fully in his work *Being and Time* in 1927 and translated into English in 1962. Heidegger's concern was to ask questions about the nature of being and about temporality (being is temporal). In this sense, he was interested in ontological ideas. Heidegger's notion of *Dasein* is an explanation of the nature of being and existence and, as such, a concept of personhood. Leonard (1994) makes five main points concerning a Heideggerian phenomenological view of the person. These are as follows.

The person has a world, which comes from culture, history and language. Often this world is so inclusive that it is overlooked and taken for granted until we reflect and analyse.

The person has a being in which things have value and significance. In this sense, persons can only be understood by a study of the context of their lives. The person is self-interpreting. A person has the ability to make interpretations about knowledge. The understanding gained becomes part of the self.

The person is embodied. This is a different view from the Cartesian, which is about possessing a body. The notion of embodiment is the view that the body is the way we can potentially experience the action of ourselves in the world.

The person 'is' in time. This requires a little more elaboration as outlined below.

Heidegger had a different notion from the one of traditional time, which is perceived to flow in a linear fashion, with an awareness of 'now'. According to Leonard (1994) he used the word 'temporality' which denotes a new way of perceiving time in terms of including the *now*, the *no longer* and the *not yet*.

As well as these ideas, Heidegger developed phenomenology into interpretive philosophy that became the basis for hermeneutical methods of inquiry (in classical Greek mythology Hermes was the transmitter of the messages from the Gods to the mortals). This often involved interpreting the messages for the recipients to aid understanding. Hermeneutics developed as a result of translating literature from different languages, or where direct access to authoritative texts, such as the Bible, was difficult. Hermeneutics became the theory of interpretation and developed into its present form as the theory of the interpretation of meaning. Text means language. Gadamer (1975) suggests that human beings' experience of the world is connected with language.

Linking the ideas of hermeneutics with phenomenology, Koch (1995: 831) states:

'Heidegger (1962) declares nothing can be encountered without reference to the person's background understanding, and every encounter entails an interpretation based on the person's background, in its 'historicality'. The framework of interpretation that we use is the foreconception in which we grasp something in advance.'

Heidegger's goes beyond mere description to interpretation. Heideggerian interpretive phenomenology is a popular research approach in nursing. This form of research explores the meaning of being a person in the world. Rather than suspending presuppositions, researchers examine them and make them explicit.

Cohen (1987) argues that Heidegger's major contribution to the phenomenological movement was his influence on French philosophy. She points out that

the main figures in this phase were Gabriel Marcel (1889–1973), Jean-Paul Sartre (1905–1980) and Maurice Merleau-Ponty (1908–1961). Marcel did not call himself a phenomenologist but viewed phenomenology as an introduction to analysing the notion of *being*.

Jean-Paul Sartre was the most influential figure in the movement but again did not want the label phenomenologist; rather he was termed as an *existentialist*. Phenomenological concepts and terms are difficult to grasp and it is often difficult to find a starting point. Understanding of terminology can be obviously further enhanced in progression from general to specific.

The idea of existence and essence are from Sartre; his famous and often quoted phrase is 'existence precedes essence'. This is Sartre's idea that a person's actual consciousness and behaviour (existence) comes before character (essence) (Cohen, 1987). In this sense, research would focus on real and concrete thoughts and behaviour before imaginary or idealised qualities or essences. The notion of intentionality features also in Sartre's work.

Merleau-Ponty's interest in phenomenology focused on perception and the creation of a science of human beings (for the purpose of this chapter it is not necessary to develop this further).

Another major figure in French phenomenology is Paul Ricoeur. Spiegelberg (1984) argues that Ricoeur's phenomenology is primarily descriptive and based on a Husserlian eidetic concern with essential structures. Ricoeur, like Gadamer, focuses on the intersubjective and on issues of language and communication.

There are then different approaches within phenomenology. Indeed most researchers acknowledge that phenomenology is not a single and integrated philosophical direction. In the next stage of this chapter, we will examine the schools of phenomenology outlined by Cohen and Omery (1994).

Schools of phenomenology

It has been shown thus far that phenomenology is an approach within continental philosophy. For purposes of qualitative research however, phenomenology has also been adapted and used as a framework within the so-called interpretive tradition that broadly includes grounded theory and ethnography as Lowenberg (1993) points out. She states: 'Basic to all these approaches is the recognition of the interpretive and constitutive cognitive processes inherent in all social life' (p. 58) and shows that there are many 'quandaries in terminology' which lead to misinterpretations in the nursing and education research literature, and sometimes in social research. She argues that there is a problem with phenomenology, the distinctions between the assumptions that lie behind the theories (e.g. Husserl and Heidegger) and the actual method, the 'doing' of phenomenology. Part of the purpose of this chapter is to try to unravel these perplexities.

A useful outline of phenomenological philosophy, guiding research and describing the development of schools with different approaches, is presented by Cohen and Omery (1994). The broad goal in each school remains the same, that is, to gain knowledge and insight about a phenomenon.

Three major schools can be found, but there is overlap and linkage between them. The first is the *Duquesne* School, guided by Husserl's ideas about eidetic structure (so called because its followers worked at one stage in time at Duquesne University). The second school is about the *interpretation* of phenomena (Heideggerian hermeneutics). The combination of both is found in the *Dutch* School of phenomenology.

The Duquesne School focuses mostly on the notion of description. Giorgi (1985) states that social scientists should describe what presents itself to them without adding or subtracting from it. His advice is to acknowledge the evidence and not go beyond the data although he believes that description cannot ever be complete. The 'interpretation of phenomena' approach concentrates on taken-for-granted practices and common meanings, whilst the Dutch School aims to combine both description and interpretation.

The phenomenological research process: doing phenomenology

Giorgi has always recognised the problem in applying a philosophical approach to a practice discipline. This means that new researchers are often uncertain of how to proceed when wishing to use phenomenological research. While developing ideas about complementarities of different phenomenological approaches as a philosophical basis for nursing research, Todres and Wheeler (2001: 2) discuss some philosophical distinctions in the approach to human experience that need to be included when carrying out practical research. They approach three areas in which they show that phenomenology, hermeneutics and existentialism have a contribution to make to health research: *grounding, reflexivity* and *humanisation*.

Grounding

Grounding means taking the lifeworld as a starting point. It includes the everyday world of common experiences. The lifeworld is more complex than that which can be said about it and contains inherent tensions. Lived experience for Husserl is the *ground* of inquiry. There is also a *need* for inquiry. The commonplace, taken for granted, becomes a phenomenon when it becomes questionable. The understanding of the lifeworld demands an open-minded attitude in which prior assumptions are bracketed so that descriptions can clarify meanings and relationships.

Hermeneutics has added certain dimensions to phenomenological research. Gadamer (1975) developed Heidegger's ideas about interpretation as integral to human existence. Human beings are self-reflective persons who are based in everyday life. Their personal relationships and experience happen in a temporal and historical context and depend on their position in the world. Preconceptions and provisional knowledge are always revised in the light of experience and reflection. The text is always open to multiple interpretations because researchers or reflective persons are involved in their own relationships with the world and others.

Human beings cannot be separated from their relationships in the world. Heidegger's notion of *Dasein*, being-in-the-world, entails a relationship between being human and being-in-the-world. Researchers search for fundamental and general categories of human existence that illuminate experiences that reveal a world. Heidegger (Todres and Wheeler, 2001: 5) reflects on fundamental structures that characterise the essential qualities of being-in-the-world such as

the way in which the body occurs;
the way the co-constituting of temporal structures occurs;
the way the meaningful word of place and things occurs;
the way the quality of interpersonal relationships occurs.

This is how Heidegger shows that body, time and space reflect the qualities of human presence rather than being notions of quantitative measurement.

From these ideas Todres and Wheeler (2001) conclude that phenomenology *grounds* research and stays away from theoretical abstraction. They also claim that hermeneutics adds the notion of *reflexivity*, which makes researchers ask questions meaningful and relevant in cultural, temporal and historical contexts. Lastly, these writers state that the ontological existential dimension *humanises* the research so it is not merely technical and utilitarian.

Phenomenological research focuses on the lifeworld, lived experiences which are described by the participants who reflect on them. These experiences might include 'the experience of diabetes', 'being a first-time father', 'living with epilepsy', and similar phenomena. From these experiences phenomenologists gain insight and extract common themes – essential structures or essences – which human beings have in common and that go beyond individual cases (Todres and Holloway, 2006). Thus, a phenomenological study presents the essential structure of a phenomenon. Here the concept of bracketing becomes useful for the researcher who, as said before, must exclude

(bracket) prior assumptions gained through experience or literature to see the phenomenon with an open mind. It is, however, not sufficient to confirm that bracketing has occurred; the researcher also has to show how and where this took place. This is important for the early stages of the inquiry, while later on the researcher has a dialogue with the literature about the phenomenon that is being illuminated. Bracketing means that the researchers can experience things as fresh and new as they do not prejudge. Husserl uses the term epoché (from the Greek for cessation) to characterise this suspension of judgement or bracketing. This phenomenological reduction is necessary to gain the essence of a phenomenon.

Van Manen (1990: 5) outlines some of the important features that characterise phenomenological research.

Phenomenological research is the study of lived experience.
Phenomenological research is the explication of phenomena as they present themselves to consciousness.
Phenomenological research is the study of essences or meaning (depending on the specific approach).
Phenomenological research is the description of the experiential meanings we live as we live them.
Phenomenological research is the human scientific study of phenomena.
Phenomenological research is the attentive practice of thoughtfulness.
Phenomenological research is a search for what it means to be human.
Phenomenological research is a poetizing activity.

The latter means that reflexive writing and aesthetic presentation is an essential and integral element in phenomenological research. Indeed, it is crucial. Giorgi and Giorgi remind the researcher that phenomenological inquiry should stay as close as possible to the phenomenon to be illuminated. To begin the process of phenomenological inquiry, researchers obviously need an area of interest, puzzlement, concern or a gap in general or specific knowledge about a phenomenon. 'Practising science', as Giorgi (2000) calls it, is distinctly different from 'doing philosophy'. Indeed he criticises researchers who write on nursing research, such as Crotty (1996) or Paley (1997) for not distinguishing between the two. Giorgi sees value in the use of phenomenological research in nursing but suggests that this means scientific work rather than doing philosophy. (Giorgi's engagement with the ideas of Crotty and Paley is important but cannot be followed up here.)

In all approaches the researcher has a responsibility to justify the type of theoretical framework (e.g. symbolic interactionism, phenomenology or any other) and specify and outline the approach to data analysis (e.g. grounded theory for the former, or Colaizzi's (1978) and other writers' approaches as regards the latter). Holloway and Todres (2003) argue that there is a need

to avoid 'method-slurring' and preserve the integrity of the approach. This is particularly important in phenomenology because of its distinctive underlying philosophy.

In data analysis for phenomenological inquiry, the researcher aims to uncover and produce a description of the lived experience. The procedural steps to achieve this aim vary with the approach taken by the researcher in terms of the three main types of phenomenology previously outlined. Various researchers have developed approaches to data analysis that follow the requirements of bracketing, intuition and reflection. One of these, Colaizzi (1978), outlined a seven-stage process of analysis. Although there has been criticism of pioneering work such as this (Hycner, 1985), this particular process of analysis for the eidetic approach of phenomenology is both logical and credible. Hycner (1985: 279) states, however, that 'there is an appropriate reluctance on the part of phenomenologists to focus too much on specific steps in research methods for fear that they will become verified as they have in the natural sciences'. There are, however, several interpretations of the data analysis process depending on the school of phenomenology chosen. For example Streubert Speziale and Rinaldi Carpenter (2007: 83) outline the different procedural steps from other, earlier, authors, such as Van Kaam (1959), Paterson and Zderad (1976), Colaizzi (1978), Van Manen (1990) and Giorgi (1985).

Procedures for data collection and analysis

The data collection starts with the specific and proceeds to the general. For instance in their search for the description of a phenomenon, researchers attempt to ask for a concrete example of their everyday experience of this phenomenon within its context. For instance, a first-time father might be asked: 'What was this experience like for you?' A study of the phenomenon of backpain might start with the researcher's question: 'Describe a situation in which your backpain occurred.' While asking these questions, the researcher brackets prior assumptions and presuppositions. During the rest of the interview the researcher will focus on clarifying the phenomenon. Many such interviews will uncover the essential structure or essence of the phenomenon which is common to all participants.

Many phenomenological research studies originate in the Duquesne School and use the approaches from one of the following authors, Colaizzi (1978), Giorgi (1985) or Van Kaam (1966). Although these authors are still popular – especially Giorgi – who made this his life's work – other approaches, in particularly interpretive phenomenology, have also flourished, though analysis is often similar to that of the following authors. Colaizzi advocates seven steps, Giorgi four and Van Kaam six but many of these steps are similar or overlap, and they are never rigidly applied.

In selecting a school of phenomenology, the researcher will be guided by the approach to the most appropriate procedural steps in data analysis. For the purposes of this chapter, we outline and discuss those developed by Giorgi (1985, 2000) and Colaizzi (1978). It is, however, a decision for student and supervisor (novice or expert researcher) to select the approach best suited for the phenomenon under investigation and to utilise the appropriate literature to guide the research methodology and analysis.

Both Giorgi (1985, 2000, 2008) and Colaizzi (1978) argue for a descriptive approach and provide a method for data analysis, for instance from transcribed tapes of interviews with participants. These are just examples of qualitative data analyses.

Giorgi's steps for analysis are as follows.

The entire description is read to get a sense of the whole. This is important as phenomenology is holistic and focuses initially on the 'Gestalt', that is the whole.

Once the Gestalt has been grasped, researchers attempt to constitute the parts of the description, make and differentiate between 'meaning units' – as the parts are labelled (these parts have to be relevant) – and centre on the phenomenon under study. It is important that these units are not theory-laden but the language of everyday life is used.

When the meaning units have been illuminated, the researcher actively transforms the original data and expresses the insight that is contained in them and highlights common themes which are illustrated by quotes from participants.

Giorgi suggests making the implicit explicit and to go from a concrete situation as an example to demonstrate of what this situation is an example. The researcher integrates the transformed meaning units into a consistent statement about the participants' experience across individual sources. This is called the *structure* of experience. In other words, it is the essence of the experience.

Although the researchers uncover structures of experience, finding it from the themes generated by individuals, they look at the phenomenon rather than focusing on individual narratives. This does not mean that there is no interest in individuals, but the search is for the overall structure of experience.

Colaizzi's seven-stage process is another approach to data analysis for the researcher but similar to that of Giorgi. The seven-stage process of analysis occurs as follows.

Read all of the subject's [sic] descriptions (conventionally termed *protocols*) in order to acquire a feeling for them, and to make sense out of them.

Return to each description and extract from them phrases or sentences which directly pertain to the investigated phenomenon; this is known as *extracting significant statements*.

Try to spell out the meaning of each significant statement; these are known as *formulated meanings*.

Repeat the above for each description and organise the aggregate formulated meanings into *clusters of themes*.

  Refer these clusters of themes back to the original protocols in order to *validate* them.

  At this point, discrepancies may be noted among and/or between the various clusters; some themes may flatly contradict others, or may appear to be totally unrelated to others. (The researcher is advised by Colaizzi to refuse the temptation to ignore data or themes which do not fit).

The results of everything so far are integrated into an *exhaustive description* of the investigated topic.

An effort is made to formulate the exhaustive description of the investigated phenomenon in as unequivocal a statement of *identification of its fundamental structure* as possible. This has often been termed as an essential structure of the phenomenon.

A final validating step can be achieved by returning to each participant, and, in either a single interview session or a series of interviews, asking the subject about the findings thus far.

These are descriptions of procedural steps adapted from Colaizzi (1978: 59–61).

Colaizzi encourages researchers to be flexible with these stages, and we have found this to be useful. For example, we have encouraged students to take the exhaustive description back to informants, rather than the final, essential structure, because it appears to be more recognisable for them for comment. This ensures rigour. A formal member check is not useful for phenomenologists as they translate the research to a more theoretical level, that of the researcher. It can be seen that many of the steps overlap in the analysis process of different writers on phenomenological research. However, many writers, including van Manen, have a less structured approach and focus on the general insight that phenomenological research offers. In any case, all inquiry goes beyond the formal steps. When Todres (2000: 43) discusses a specific example of phenomenological research, he lists some signposts that go beyond mechanical stages, and they could gain major importance for other researchers.

The presentation of his discoveries involves the following:

It will go beyond a definition or a series of statements; it will reflect a narrative coherence.

It will tell us something that connects with universal human qualities so that the reader can relate personally to the themes.

It will tell a story with which readers can empathise in imaginative ways.

It contributes to new understanding.

It will clarify and illuminate the topic to help the reader make sense of it without wholly possessing it.

These signposts are significant for phenomenological studies. They show that the search for the essence of a phenomenon and its meaning within a defined context is not merely a technique or a series of mechanical steps but an exploration of meaning.

Phenomenology and health research

Streubert Speziale and Rinaldi Carpenter (2007) suggest that professional nursing orientation towards holistic care provides the background for deciding whether to undertake phenomenological research. This should also be so for other health researchers. The holistic perspective, coupled with the study of lived experience, provides the foundation for phenomenological research. These authors like others advise the researcher to ask several questions about the intended topic. For example: is there some need for clarity concerning a phenomenon? Has there been anything published in relation to this, or is there a need for further inquiry? If there is, the health researcher should question whether inquiry concerning the lived experience is the most appropriate approach to collecting data. As the accounts of those experiencing the phenomenon are the primary data, the researcher needs to consider that this will yield both rich and descriptive data. Streubert Speziale and Rinaldi Carpenter argue that researchers examine their own style, preference and ability to engage with this approach to research. Further considerations for the research process concern completion and presentation of the study to relevant audiences.

Todres and Holloway (2006) see that this research approach yields very rich data, gives deep insight into the lifeworld of participants and does not stay on the surface. The findings resonate with researchers and readers alike because they concern essential perspectives of human beings. This is one of the reasons why participant observation is problematic as that is seen from the perspective of the researcher, an 'outsider' to the research, while interviews give the ideas of the 'insider'. Researchers need very varied skills, both scientific and communicative; they should be able to do 'good' and rigorous research as well as communicate the findings and meanings in a language that captures the richness of the lifeworld of the participants. It is also stated by Dowling (2007) that phenomenological research is complex and not easy although it can be successful in exploring the 'human condition' if attempted in a rigorous way and if health researchers place it within its philosophical base. It would be difficult for novice researchers to carry out phenomenological research.

Giorgi, his many students and followers who are descriptive phenomenologists (such as, for instance, Les Todres, Barbro Giorgi and Karin Dahlberg) stay close to Husserl while hermeneutic phenomenologists, such as Frances Rapport, make use of the philosophies of Heidegger, Gadamer and Ricoeur. Van Manen is one of the present-day hermeneutic researchers whose work is particularly known in the field of education.

These approaches differ in their details. For instance, while descriptive phenomenological researchers find and describe essential and universal structures, researchers who take the hermeneutic approach attempt to interpret the meaning of the phenomenon in context. Bracketing prior assumptions and preconceptions is important for descriptive phenomenologists, but hermeneutic researchers believe that these prior experiences might become sources of knowledge and sensitise the researcher to the meanings that might be presented in the narratives of participants. Interpretive phenomenology uses the term 'fusion of horizons' which has its origin in Gadamer's work on intersubjectivity, one horizon being that of the 'text' and the other that of the interpreter of the text. In the research approach it indicates the intersection of the researcher's and the participants' ideas. Both have individual perspectives on the phenomenon but they also live in a shared world where they have common perceptions. The term 'hermeneutic circle' also has its origin in the philosophy of Heidegger. In research it means that interpretation of text (participant narratives) looks at parts of the lived experience, then at the whole, and then back again in a spiralling process, the end of which is achieved when the researcher has gained a reasonable understanding and meaning of the text.

Summary

Phenomenology is primarily a philosophy but is sometimes applied as a research approach.

There are three main phases in the phenomenological philosophical movement: preparatory, German and French. There is overlap and interaction of ideas between the phases.

Writers developed different conceptual formulations, (very broadly) descriptive (Husserl), interpretive (Heidegger) and ontological-existential (Sartre) which have been adapted as methods of inquiry by researchers.

Researchers who use phenomenological methods have formulated various methods of data analysis.

The approach should not be mechanical but insightful and illuminate the phenomenon under study and capture its essence.

References

Benner, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing.* Menlo Park, CA, Addison-Wesley.

Berg, L., Scott, C. & Danielson, E. (2006) An interpretive phenomenological method for illuminating the meaning of caring relationship. *Scandinavian Journal of Caring Sciences*, 20 (1), 42–50.

Billhult, A., Stener-Victorin, E. & Bergbom, I. (2007) The experience of massage during chemotherapy in breast cancer treatment. *Clinical Nursing Research*, 16 (2), 85–99.

Caelli, K. (2001) Engaging with phenomenology: is it more of a challenge than it needs to be? *Qualitative Health Research*, 11 (2), 273–81.

Cohen, M.Z. (1987) A historical overview of the phenomenologic movement. *Image: Journal of Nursing Scholarship*, 19 (1), 31–4.

Cohen, M.Z. & Omery, A. (1994) Schools of phenomenology: implications for research. In *Critical Issues in Qualitative Research Methods* (ed. J.M. Morse), pp. 136–56. Thousand Oaks, CA, Sage.

Cohen, M.Z., Kahn, D.L. & Steeves, R.H. (2000) *Hermeneutic Phenomenological Research: A Practical Guide for Nurse Researchers.* Thousand Oaks, CA, Sage.

Colaizzi, P. (1978) Psychological research as a phenomenologist views it. In *Existential Phenomenological Alternatives for Psychology* (eds R. Vallé & M. King), pp. 48–71. New York, NY, Oxford University Press.

Crotty, M. (1996) *Phenomenology and Nursing Research.* Melbourne, Churchill Livingstone.

Dowling, M. (2007) From Husserl to Van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, 44 (1), 131–42.

Gadamer, H. (1975) *Truth and Method.* New York, Seabury Press (Originally published in 1960. Translated by G. Barden & J. Cumming; 2nd edn. 1989).

Giorgi, A. (ed.) (1985) *Phenomenology and Psychological Research.* Pittsburgh, PA, Duquesne University Press.

Giorgi, A. (1992) Description versus interpretation: competing strategies for qualitative research. *Journal of Phenomenological Psychology*, 23 (2), 119–35.

Giorgi, A. (1997) The theory, practice and evaluation of the phenomenological method as a qualitative procedure. *Journal of Phenomenological Psychology*, 28 (2), 235–60.

Giorgi, A. (2000) Concerning the application of phenomenology to caring research. *Scandinavian Journal of Caring Science*, 14 (1), 11–15.

Giorgi, A. (2008) Workshop on Phenomenology, Bournemouth University.

Giorgi, A. & Giorgi, B. (2003) Phenomenology. In *Qualitative Psychology: A Practical Guide to Research Methods.* (ed. J. Smith), pp. 25–50. London, Sage.

Heidegger, M. (1962) *Being and Time.* New York, Harper and Row (Translated from the original 1927 publication by J. Maquarrie and E. Robinson).

Holloway, I. & Todres, L. (2003) The status of method: flexibility, consistency and coherence. *Qualitative Research*, 3 (3), 345–57.

Hycner, R.H. (1985) Some guidelines for the phenomenological analysis of interview data. *Human Studies*, 8 (3), 279–303.

Jasper, M.A. (1994) Issues in phenomenology for researchers of nursing. *Journal of Advanced Nursing*, 19 (2), 309–14.

Koch, T. (1995) Interpretive approaches in nursing research: the influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21 (5), 827–36.

Langridge, D. (2007) *Phenomenological Psychology*. Edinburgh, Pearson Education.

Leonard, V.W. (1994) A Heideggerian phenomenological perspective on the concept of person. In *Interpretive Phenomenology: Embodiment, Caring and Ethics in Health and Illness* (ed. P. Benner), pp. 43–63. Thousand Oaks, CA, Sage.

Lowenberg, J.S. (1993) Interpretive research methodology: broadening the dialogue. *Advances in Nursing Science*, 16 (2), 57–69.

McLeod, J. (2001) *Qualitative Methods in Counselling and Psychotherapy*. London, Sage.

Mercer, A. (2008) Role transition and the nurse practitioner: An investigation into the experience of professional autonomy. Unpublished PhD thesis, Bournemouth University.

Paley, J. (1997) Husserl, phenomenology and nursing. *Journal of Advanced Nursing*, 26, 187–93.

Paterson, J.G. & Zderad, L.T. (1976) *Humanistic Nursing*. New York, NY, Wiley.

Priest, S. (1991) *Theories of Mind*. London, Penguin Books.

Rapport, F. (2005) Hermeneutic phenomenology: The science of interpretation of text. In *Qualitative Research in Health Care* (ed. I. Holloway), pp. 125–46. Maidenhead, Open University Press.

Schwandt, T.A. (2007) *Dictionary of Qualitative Inquiry*, 3rd edn. Newbury Park, CA, Sage.

Spiegelberg, H. (1984) *The Phenomenological Movement: A Historical Introduction*, 3rd edn (1st edn 1960). The Hague, Martinus Nijhoff.

Streubert Speziale, H.J. & Rinaldi Carpenter, D.R. (2007) *Qualitative Research in Nursing: Advancing the Human Imperative*, 4th edn. Philadelphia, PA, J.B. Lippincott & Co.

Thomas, S.P. & Johnson, M. (2000) A phenomenologic study of chronic pain. *Western Journal of Nursing Research*, 22 (6), 683–705.

Todres, L. (2000) Writing phenomenological psychological descriptions: an illustration to balance texture and structure. *Auto/Biography*, 8 (1/2), 41–48.

Todres, L. & Holloway, I. (2006) Phenomenology. In *The Research Process in Nursing*. (eds K. Gerrish & A. Lacey), pp. 224–38. Oxford, Blackwell.

Todres, L. & Wheeler, S. (2001) The complementarity of phenomenology, hermeneutics and existentialism as a philosophical perspective for nursing research. *International Journal of Nursing Studies*, 38 (1), 1–8.

Van Kaam, A. (1959) A phenomenological analysis exemplified by the feeling of being understood. *Journal of Individual Psychology*, 15 (1), 66–72.

Van Kaam, A. (1966) *Existential Foundations of Psychology*. Pittsburgh, PA, Dusquesne University Press.

Van Manen, M. (1990) *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. New York, NY, State University of New York Press.

Van Manen, M. (1998) *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*, 2nd edn. New York, NY, State University of New York Press.

Wojnar, D.M. & Swanson, K.M. (2007) Phenomenology: an exploration. *Journal of Holistic Nursing*, 25 (3), 172–80.

Further reading

Dahlberg, K., Dahlberg, H. & Nyström, M. (2008) *Reflective Lifeworld Research*, 2nd edn. Lund, Studentlitteratur.

Todres, L. (2007) *Embodied Enquiry: Phenomenological Touchstones for Research, Psychotherapy and Spirituality*. Basingstoke, Palgrave Macmillan.

Action Research

What is action research?

Action research (AR) is a type of inquiry generally undertaken by practitioners who become researchers, or who work in partnership with university researchers, to examine issues and problems in their own settings; it is carried out through a cyclical process in which each cycle depends on the one before. The aim is to solve practical problems in a specific location and improve the situation. It is a useful approach to organisational or professional change and improvement; it has been increasingly applied to professional and organisational settings in education since the early 1990s and in nursing and other forms of healthcare in the late 90s. Community development is another area in which AR is often carried out. Researchers can use both qualitative and quantitative methods, but many see it as 'the antithesis of experimental research' (see Hart and Bond, 1995: 39) and hence as essentially qualitative. Indeed AR is not a 'pure' research approach but a particular style and development, and researchers can use many of the well-known methods and strategies. AR is not distinguished from other types of research by the use of different research procedures but it differs in some of its aims and processes (see later in this chapter); any of the conventional approaches may be carried out in its research phase. As the name implies, AR includes both research and action. It should fulfil a number of criteria, which will be discussed in this chapter. Other terms often used instead of AR are co-operative inquiry or collaborative research. Badger (2000) claims that AR stands within a continuum of definitions and philosophies; it is not a single unitary approach.

Reason and Bradbury (2006) speak of a variety or 'a family' of approaches in the introduction to their book; these derive from various philosophical and psychological assumptions and have their basis in different traditions. Usually, action researchers use qualitative methods, as this type of inquiry is a reaction against positivist approaches.

Although some agreement exists about the nature and features of AR, there are a number of definitions, some of which are quoted here. All involve the concepts of change, participation and action. In one of the definitions (Carr and Kemmis, 1986: 162) it is claimed that AR is 'a form of self-reflective inquiry undertaken

by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of these practices, and the situations in which practices are carried out'. (Carr and Kemmis are educationists, and in the past AR has most often been used in education.)

Action research is more than mere production of knowledge about a problem, a topic or an area of study and involves situations where change is necessary or desirable, and researchers employ interventions to improve practice. Action researchers claim that AR differs from other research mainly because

- it has different aims, one of them being evaluation;
- researchers collaborate with practitioners, or are themselves participants in the setting to be studied;
- the process integrates action as an essential element;
- as well as research, it includes intervention and change in the situation under study;
- it is research in the setting where the changes take place;
- the findings can be of immediate benefit as solutions to problems can be implemented and assessed straight away.

Because of its complexity and time consumption, AR is more appropriate for small rather than large studies. Language use also differs from that of other approaches as it must be understood by all the participants and not be full of academic terminology or researcher jargon. Newman (2000) suggests that there is no 'right' way of carrying out AR, but that action researchers should modify their approach as they go through the process of planning, acting and evaluating.

Example 1

Davies *et al.* (2008) developed an AR project in which a research partnership was established between members of local communities in Wales and a professional researcher. The intentions were to improve health and well-being of over-50s individuals. The aim of the research was to work for positive change concerning disadvantaged groups. Free exercise classes were set up in local communities. This was achieved through people deciding on their own agenda. Programmes were set up, evaluated and discussed over a period of time to improve through 'feedback, reflection and adjustment'. (Although this study is not wholly qualitative, it incorporates the main features of AR)

Example 2

As hospital mealtimes tend to be problematic in many institutions, Dickinson *et al.* (2005) carried out an AR study which focused on the needs of patients in a unit for elderly people rather than fulfilling the agenda of the hospital. The research aimed ultimately to improve mealtimes and help to make them

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patient-centred. The first phase consisted of observations and interviews with staff and patients about mealtimes. The data from the first stage were presented to the staff who, in the second phase, developed an action plan to improve the situation. Phase three consisted of the evaluation of the implementation of the plan. At all stages, practitioners and research facilitator worked together. Dickinson *et al.* noted the necessity to educate and train the research team in the appropriate skills.

The origins of action research

AR does not have a very long history but started in the 1940s. It is becoming popular and interdisciplinary, but in education it has been used often and for a long time. Lewin (1946), the social psychologist, was one of the early pioneers to develop AR although he used it differently from more recent action researchers. The concept of change, however, was already present in this type of research, and he wanted to employ AR to bring about change in behaviour. Lewin adopted a number of stages, which consisted of

- planning an initial step to change a setting or individuals' behaviour;
- implementing the change;
- evaluating the results of the change;
- modifying the actions in the light of the evaluation;
- starting the process all over again.

Although modern action researchers still use the stage approach, much has changed; in particular AR has become more democratic and participatory. Action researchers now take account of the power relationships inherent in a setting.

The Tavistock Institute of Human Relations set up organisational AR from the late 1940s onwards – although at this stage the type of research was not called AR. The members of the Institute, in general psychologists, developed a problem-solving approach. At a later stage, this problem-solving approach was also used to help deprived communities to solve social and educational problems and ameliorate the 'cycle of deprivation'. Since the work of the Tavistock Institute, AR has been carried out in many disciplines including management, sociology, healthcare and other disciplines. Often it is interdisciplinary and interprofessional.

Critical social theory

Many ideas of modern AR have their basis in critical social theory and critical social science. Carr and Kemmis (1986) give an overview of these, and some of their ideas are summarised here.

Critical theory is critical of positivist and complementary to interpretive research. Critical theorists of the 1950s, such as Horkheimer, Adorno, Marcuse and others, criticised the dominance of positivist social science in the twentieth century which conformed to rigid rules and stifled critical and creative thinking although they did agree with the scientific aim of generating rigorous knowledge about social life. While retrieving for social science those elements that are connected with values and human interests, they also tried to integrate these into a new framework that included ethical and critical thought. Like positivists however, they still considered rigorous knowledge about social life as a requirement of social science.

Habermas (1974) discusses human behaviour in terms of interests and needs. He argues that knowledge consists of three constitutive interests, which he calls the *technical*, the *practical* and the *emancipatory*. The technical interest helps people to gain knowledge in order to achieve technical control over nature. This instrumental knowledge requires scientific explanations. Habermas suggests that, although this form of knowledge is necessary, not everything can be reduced to scientific explanations, and people need to grasp the social meanings of life to understand others. Generating knowledge through interpretive methods can serve 'practical' interests, but this still does not suffice. Human beings need 'emancipatory' knowledge in order to achieve freedom and autonomy, overcome social problems and change power relationships. This will diminish alienation. Habermas's (1972, 1974) thinking (developed in his books) is based in Marxist philosophy. (His theories cannot be developed here; this section merely gives a flavour of the thinking behind modern AR. Habermas also discusses the relationship between theory and practice.)

Educationists in the 1970s and 1980s developed ideas for AR, because they pressed for change in educational settings and society within a critical theory framework. The concept of 'conscientization' discussed by Freire (1970), the Marxist educationist, is also connected to critical social science. Freire believed that people become increasingly aware of the social and historical reality that influences their lives and are able to take action in order to change it. McTaggart and Kemmis (1982) developed guidelines in an AR planner. Although educational and community development studies are not directly connected to AR in nursing and healthcare, the underlying ideas are important as health researchers too desire the empowerment of patients who will be able to take control of their own lives and change their situation. AR has, however, lost much of the ideas of its Marxist antecedents, while valuing democracy and equality in action.

Action research in healthcare

As AR focused on improving education and society, it was also seen as useful in nursing and other healthcare arenas. In the words of Hart and Bond (1995:3),

'it represents a counter to positivism and can develop reflexive practice and general theory from this practice'. It is, in their view, a tool for practitioners, as knowledge is vital for improving healthcare practice; only those involved in the setting are fully able to apply this knowledge. AR generates practical knowledge intended to assist in raising standards of care and delivery of service in general. It is not 'blue skies research'. Health workers now use it frequently but do not always go back to its base and develop it merely on a practical level rather than taking into account its added importance in developing theory.

One of the aims of AR is bridging the theory–practice gap as this gap has been seen as detrimental to professional and clinical work. Rolfe (1996) argues that engaging practitioners from the clinical setting to carry out research in their own practice area would help to overcome this gap and generate direct improvement in practice and generate nursing knowledge. This, after all, is one of the justifications for doing health research. In the health professions, AR is also a useful way of attempting and evaluating change in order to improve settings and care in the clinical arena. Professionals are able, through AR, to undertake research into their own practices. Earlier deeply held assumptions might be questioned. This is linked to the reasons McNiff (1988) gives for engaging in AR, and these can be applied to nursing and health research. She suggests that the aims are political, professional and personal. Through AR, health professionals are able to make sense of the clinical situation and become aware of the impact of policies and practices imposed on them through the system. They will also recognise more clearly that the health services and guidelines for care and treatment should exist initially for the good of the patients and ultimately for the health of society.

As professionals, health researchers make independent decisions while adopting procedures based on theory and research rather than being controlled by outside forces. AR helps professionals to make decisions in the interest of their clients (Carr and Kemmis, 1986). Rather than accepting unsatisfactory decisions imposed on them, they observe and diagnose problems as well as plan and implement changes that are based on the knowledge gained through the research. In AR, professionals need to adopt a thinking and self-critical stance towards their practice which enables them to justify what they do.

On a personal level, AR not only improves the situation for clients and patients, but also enlightens the practitioners themselves and enhances their lives through reflection and engagement in the situation. The clinical setting provides the opportunity for active involvement and personal satisfaction and hence for personal growth.

The main features of action research

Action research is more than just the generation or production of knowledge about an area of interest in which change is seen as necessary or desirable

to improve practice. Researchers carry out interventions in the setting to be investigated. The main features of good AR include the following:

AR draws data and information from a range of sources.
AR is cyclical and dynamic.
AR is collaborative and participatory.
The aim of AR is to devise solutions to practical problems and to develop theory.
Researchers and practitioners are critical, self-critical and reflective.

AR draws data from a range of sources and perspectives: for instance, data sources might be interviews and observation, documents or diaries. AR is cyclical in the sense that it represents an action cycle consisting of planning, implementing action, observing and reflecting. Then the process starts again. Lewin (1946) already demanded these four stages which he developed into a 'spiral'. The difference between his and modern AR is that present-day research is not imposed from outside the organisation or setting but planned and carried out by insiders, namely participants in the setting.

Lewin's (1946) stages still form the basis for AR, and Parahoo (2006) describes the use of this process in nursing where the stages are similar, though the aims and character of AR are different in some ways in clinical and educational nursing from those of earlier AR:

Researchers identify a problem in practice.
They carry out research to assess the problem.
They plan and implement the change.
They evaluate the outcome.
After this, the cycle starts again.

These stages will be developed further in the section on practical considerations Waterman *et al.* (2001) demonstrated the cyclical process and the research partnership as 'fundamental' for AR.

Example of AR in nursing

Researchers from the Netherlands reported on a study of AR to enhance care of people who used heroin before attending methadone substitute outpatient clinics. The participatory action research (PAR) approach involved innovative care strategies and their evaluation. Its ultimate purpose was to improve the quality of nursing care, and it was – to a large extent – successful. Loth *et al.* (2007), the researchers, demonstrated that enhanced nursing knowledge can lead to enhanced nursing practice and better care for clients.

Example of AR in midwifery

Choucri (2005) chose an AR project to evaluate the work of the education and development group of the maternity services in a British hospital trust with the midwives involved in this, focusing in particular on women's needs. This happened in the context of the National Health Service modernisation agenda and was intended to develop innovations in practice. The work and its effect on practice was evaluated and re-planned for improvement. The steps the researchers took were those of AR, namely: preliminary exploration, choosing the research question, planning action, collecting and analysing data, re-planning in the light of findings, taking action and re-evaluating and re-planning (each step dependent on the previous stage). Throughout, the researchers reflected on the processes employed.

AR is collaborative. It involves individuals who choose this approach in the design, data collection and analysis and evaluation of the research as well as in its dissemination. This fulfils the criterion of empowerment and assists emancipation. Because the research influences and intervenes in the participants' working lives, they should be included in decisionmaking.

Once a problem or an important issue has been highlighted and the need for change and improvement is clearly observed, participants develop the focus for the research as co-researchers. The research centres on the problem or issue in the situation in which they work or learn and on a specific location. Modern day AR is always collaborative and participatory. The researchers are often themselves involved in the system they study, but even when they are not, they work with practitioners and professionals to carry out the research.

There are different types of AR as suggested before and many of these are used depending on the intentions of the co-researchers. The most common in nursing are identified by Hart and Bond (1995) and Holter and Schwartz-Barcott (1993), but the differences between them are not vast, and they overlap. Because the typology of the latter is inclusive, it will be discussed here.

Holter and Schwartz-Barcott distinguish between three approaches:

Technical collaborative
Mutual collaborative
Enhancement

In the *technical collaborative* approach, the researcher acts as a professional expert who pre-plans the research, carries out the research with practitioners,

advises on action and acts as facilitator. It has a pre-specified framework and theory and is rarely qualitative.

The *mutual collaborative* approach entails a more democratic process. The researcher(s) as facilitator and the practitioners collaborate to identify a problem. They plan intervention and change together, and they work as equal partners. Theory is developed rather than predetermined. This mode of AR is more flexible than the technical approach. It is designed to solve immediate and practical problems and needs quick decisionmaking. There is the danger, however, that the practitioners will not continue when the facilitator leaves the clinical area.

The goals of the *enhancement approach* are first, to bridge the theory and practice to solve problems and explain them and second, to raise awareness so that practitioners can identify problems and make them explicit. While the mutual collaboration approach fosters mutual understanding, the enhancement approach leads to emancipation of all participants. Some suggest that one of the aims of this approach is the creation of action-oriented policy which means that this type of AR continues after the facilitator leaves (Berg, 2006). The link between theory and practice generates empowerment because practitioners gain deeper understanding and are therefore able to apply it in different settings, not just in one location at a particular time.

Hart and Bond (1995) maintain that AR is not linked to just one approach but can involve a progression through the typology. Lax and Galvin (2002) describe the differences between AR and PAR, two terms that are often used interchangeably. The focus in their research was the development of a working group for 'families and young children'. The AR approach was adopted to support the development of improved childcare. Although often used in community development, PAR has not often been used in nursing. Kemmis and McTaggart (2000) stress the significance of participation in PAR which has a stronger element of participation than other types of AR. They state that it usually has three main features of importance:

Shared ownership: the projects are owned by all who take part in them
Community based analysis: the collaborators investigate social problems that occur in a community
Orientation towards community action: the findings will be acted upon among the participating group

Example of PAR

A PAR project on diabetes in a primary care setting was carried out in the United States by Mendenhall and Doherty (2007). Patients and their relatives as well as health professionals were involved over three years. A partnership in diabetes was established where support partners were trained 'to reach out' to those with diabetes and their relatives. The partnership was created to overcome the

hierarchical relationship between patients and physicians and other providers of care. The study had all the features of PAR such as a challenge to existing modes of care, community collaboration, a cyclical approach that highlights the problem, develops solutions and interventions, and evaluates outcomes. The researchers acknowledge that community-based participatory research can be a slow and rather chaotic process (a general problem with AR) but is worthwhile.

Early developers of PAR include Reason (1988), Heron (1996) and Fals Borda (2001) who claim that it is a way by which participants can take power and control in the research. Its aim is empowerment, emancipation and the generation of knowledge that benefits them directly. The researchers in this type of AR are much more aware of the elements of power and control.

Practical steps

We will now describe the practical steps which researcher-practitioners take while going through an AR cycle in clinical or educational practice. Meyer (2006) calls these phases the exploration, intervention and evaluation phase.

Researchers and practitioners carefully observe what is happening in the setting. Before starting the AR, all participants should agree on their participation in the project. Usually they formulate the question together and take decisions. This entails a number of meetings in which procedures will be discussed. These meetings include managers and policy makers who need to give permission for the project to proceed and for access to all the participants. Initially there is a critical assessment of all the aspects of current practice and a review of its effectiveness, quality and cost-effectiveness. In this early stage, much negotiation between different factions takes place.
Researcher-practitioners identify problem areas that they want to improve and thoroughly examine the practices that seem to need change and intervention. They 'explore the nature of the problem' (Meyer, 2006: 282) and then discuss this with their colleagues and others interested in the project, including clients, and ask for their ideas and confirmation of the areas in need of improvement. Observations, interviews and brainstorming and focus group sessions take place to ascertain the problem.
At this stage, researchers plan changes and interventions and implement them in the practice setting. Planning includes drawing up a budget, suggesting a timescale and giving the details of procedures happening.
During the implementation of change or intervention, an evaluation process takes place which carefully monitors all the steps and procedures. This is done through a number of meetings with the people in the setting as well as observation and interviewing.

In the light of this careful evaluation, practitioners modify their practices to improve on the intervention or change. Meyer states that there is no tidy end to AR; processes are often ongoing beyond the formal project, or they are sometimes disrupted because of new managers and colleagues that enter the setting.

The action and monitoring process continues until practitioners are satisfied with the level of improvement. Throughout the whole process there will be meetings and discussions. The number of meetings depends on the size and duration of the project. Record keeping too, is of major importance, and participants write progress reports and give account of their actions to each other and to their managers. One can use both focus groups, individual interviews, meetings and discussions about the research and the outcomes of actions but groups are more fruitful as these can generate quicker results and stimulate ideas (Stringer, 2007).

> **Example**
> Dowswell et al. (1999) report on their participatory process in developing a collaborative stroke training programme. Physiotherapists, nursing staff and managers were asked to identify training needs. They observed and interviewed practitioners and gave an account of what needed to be done. At the end of the research phase their reports were used to inform the content of the training course and its structure. The professionals interviewed were also involved in the development, implementation and evaluation of the training course.

Much useful AR can be carried out with patients, users of the services and lay carers. Dowswell et al. (1999: 751) advise researchers on the stages of AR while describing their own project. The following are some excerpts from their account and demonstrate what needs to be done by other researchers.

Preliminary stage: All participants are involved in the proposal and understand the reasons for the project. It is important that they all agree and willingly take part in it.
Assessment phase: Ethical issues are clarified and anonymity ensured. Aims and limitations are truthfully described.
Planning phase: Participants find innovative ways of solving problems and carry out agreed tasks and reflect on decision making.
Implementation phase: All participants, regardless of ability, must be comfortable with the materials and incorporate both theory and practice.
Evaluation phase: Interviews, observations and written reviews are used to evaluate the project.

The processes of data collection and analysis are those of other qualitative research.

It is advisable that all collaborators are trained in research skills to carry out observation and interviews as well as acquiring skills to analyse the data. They also learn to reflect on their own beliefs and assumptions and to make them explicit as well as on the situation. This also means identifying the audit trail of the research process, explaining in detail what they have done and thought. The ongoing documentation of what goes on also helps planning and avoids chaos.

Trustworthiness in AR

The criteria for validity or its equivalent are often discussed and developed by qualitative researchers (see Chapter 18). Waterman claims that an unquestioning acceptance of general criteria for qualitative research does not suffice for AR and describes three types of validity:

Dialectical validity: tensions and processes
Critical validity: moral responsibilities
Reflexive validity: valuing ourselves

First, Waterman (1998) points to the importance of examining the inherent tensions of an AR project. It implies attention to and description of details in the ongoing process as well as the conflicts and tensions between practice, theory and research. Second, she describes the moral responsibility of researchers who have to be aware and take account of the problems of people in the setting. Decisionmaking not only includes action but also knowing when not to take action. Waterman goes on to say that researchers have the responsibility to give reasons for their decisions and argue their cause, as the ultimate aim is 'to improve people's lives'. Third, the reflexive nature of AR is acknowledged. The final report of an AR project should reflect the variety of perspectives that were examined. There is the important dilemma of the multiple roles of researchers who are, in the same study, research participants, change agents and evaluators of change. This position needs a reflexive stance by researchers on their own practices and assumptions. Whilst 'valuing themselves', researchers must also be aware of their own biases and limitations. Another important aspect for judging AR is the existence of more than one cycle. Some researchers who maintain they have used AR do not go further than a single cycle.

Whatever the criteria for trustworthiness might be, all the collaborators involved in an AR study must agree on the issues. For a project to be truly based on AR, they should reflect together on data collection, analysis and other methodological and procedural issues, because reflection on action is inherent in this approach. In AR, researchers need perhaps more reflection and reflectivity

than in other research projects. Evaluation of a programme or action needs careful consideration, particularly when further actions are based on it. Meyer (2006: 284) asks the questions that can identify whether an AR project had 'quality'. This includes questions about the usefulness of the research and whether it led to major improvement, the involvement of all people in the setting, and the appropriateness of research methods. AR depends on active collaboration.

Guidance on assessment of the quality of AR projects and proposals can be found in Waterman *et al.* (2001: 43).

Problems and critique

Of course, AR can be problematic for a number of reasons. First, it is obvious that not everybody may wish to be involved. It takes diplomacy and persuasion to recruit reluctant participants. While undertaking the research, practitioners may be in conflict with each other. Managers too, may make objections especially if the process takes too much time or is expensive.

AR is not always appropriate, and it can be a-theoretical. Morton-Cooper (2000: 25) suggests certain situations in which it should not be used:

If the policy or service to be implemented is forced on the people in the setting, especially when managers have already made their own decisions about this
If the procedures and methodology used have not met the same quality criteria as other clinically based studies
If the members of the team giving care, treatment or service do not work well together
If the researchers want to enhance their own status and reputation

We would have to add that AR takes time and is complex because of its cyclical nature.

Meyer (1993) also notes some problems and limitations of AR. She identifies the problem of defining stages in AR when it is difficult to describe them before the start of the research as they develop during its process. This also means that informed consent is problematic because the stages are unknown beforehand. She warns researchers that the members of the participating team – which may consist of practitioners and facilitators as experts in research – have to be able to collaborate willingly and with a common aim rather than by edict and selection of management. Power relationships may also have inherent problems: research experts from outside have to negotiate rather than using their expertise as control. Waterman *et al.* (2001) suggest, among other problems, that the familiarity of co-researchers with the setting might 'cloud understanding'. Again, this means that they have to become 'professional strangers' or naïve observers of their own situation.

While researchers in other types of inquiry are advised to avoid research in their own setting, AR is carried out in their own location and thus situationally specific and unique. This of course, makes it more difficult and ethically complex. When undertaking research in one's own setting, issues of anonymity and confidentiality might become problematic; because of the different personalities and backgrounds of the people involved, it is not always easy to gain consent. Indeed, often tensions and conflicts between individuals occur which have to be resolved. All must be consulted and agree to the steps that will be undertaken and the decisions that are being made. As in all health research, participation should be voluntary.

Some health professions still do not see AR as a respectable, scientific type of research because it is not generalisable. It is, however, increasingly used in healthcare because it can offer practical solutions to problems and enhancement of theory. Morrison and Lilford (2001) describe the dilemma inherent in AR. Action researchers have developed innovative and imaginative ways of developing practice and theory that could be applied in all research approaches. In their enthusiasm, however, they maintain that a major difference from traditional research (or mainstream research) exists. In fact, so Morrison and Lilford argue, many of the tenets of AR could be applied to mainstream research. There is only one major difference: AR takes account of its unique social context. However, one might argue that this is true for much of qualitative research which is context-bound, meaning that the specific context in which it takes place has to be taken into account. This does not necessarily indicate that the findings of one specific context cannot be applied in other contexts, or that the theoretical advances are not useful in other settings. The researcher should also be able to apply what is learnt from one situation to another setting. AR is, nevertheless, of most use in a specific context in which a local problem needs a solution or where actions and thinking need improvement. This supports the claim by Waterman *et al.* (2001) about AR as 'real world research'.

This chapter does not tell researchers how to carry out the research, as the research strategies may include many types of qualitative (and indeed, occasionally quantitative) approach. Data collection and analytic procedures can be found in the other chapters of this book.

Summary

Inherent in AR is the wish for empowerment, collaborative working.
The outcome of AR is improvement in a specific situation.
AR draws data from a range of sources.
Researchers can apply a number of different approaches.
AR bridges the theory–practice gap and is 'real world' research.
AR includes planning, action or intervention and evaluation.
It is cyclical, reflective and dynamic.

References

Badger, T.G. (2000) Action research: change and methodological rigour. *Journal of Nursing Management*, 8 (4), 201–7.

Berg, B.L. (2006) *Qualitative Research for the Social Sciences*, 6th edn. Boston, MA, Allyn and Bacon.

Carr, W. & Kemmis, S. (1986) *Becoming Critical: Education, Knowledge and Action Research*. London, The Falmer Press.

Choucri, L. (2005) Creating change: developing a midwifery action research project. *British Journal of Midwifery*, 13 (10), 629–32.

Davies, J., Lester, C., O'Neill, M. & Williams, G. (2008) Sustainable participation in regular exercise among older people: developing an action research approach. *Health Education Journal*, 67 (1), 45–55.

Dickinson, A., Welch, C., Ager, L. & Costar, A. (2005) Hospital mealtimes: action research for change? *Proceedings of the Nutrition Society*, 64, 269–75.

Dowswell, G., Forster, A., Young, J., Sheard, J., Wright, P. & Bagley, P. (1999) The development of a collaborative stroke training programme for nurses. *Journal of Clinical Nursing*, 8, 743–52.

Fals Borda, O. (2001) Participatory (action) research in social theory. In *Handbook of Action Research: Participatory Inquiry and Practice* (eds P. Reason & H. Bradbury), pp. 27–37. London, Sage.

Freire, P. (1970) *Cultural Action for Freedom*. Cambridge, MA, Centre for the Study of Change.

Habermas, J. (1972) *Knowledge and Human Interest* (translated by J. Shapiro). London, Heinemann.

Habermas, J. (1974) *Theory and Practice* (translated by J. Viertel). London, Heinemann.

Hart, E. & Bond, M. (1995) *Action Research for Health and Social Care: A Guide to Practice*. Buckingham, Open University Press.

Heron, J. (1996) *Co-operative Inquiry*. London, Sage.

Holter, I.M. & Schwartz-Barcott, D. (1993) Action research: what is it? How has it been used and how can it be used in nursing? *Journal of Advanced Nursing*, 18 (2), 298–304.

Kemmis, S. & McTaggart, R. (2000) Participatory action research. In *Handbook of Qualitative Research* (eds N.K. Denzin & Y.S. Lincoln), pp. 567–605. Thousand Oaks, CA, Sage.

Lax, W. & Galvin, K. (2002) Reflections on a community action research project: interprofessional issues and methodological problems. *Journal of Clinical Nursing*, 11, 1–11.

Lewin, K. (1946) Action research and minority problems. *Journal of Social Issues*, 2, 34–46.

Loth, C., Schippers, G.M., Hart, H. & Van de Wijngaart, G. (2007) Enhancing the quality of nursing care in methadone substitute clinics using action research: a process evaluation. *Journal of Advanced Nursing*, 57 (4), 422–31.

McNiff, J. (1988) *Action Research: Principles and Practice*. London, Routledge.

McTaggart, R. & Kemmis, S. (1982) *The Action Research Planner*. Geelong, Victoria, Australia, Deakin University Press.

Mendenhall, T.J. & Doherty, W.J. (2007) Partners in diabetes: action research in a primary care setting. *Action Research*, 5 (4), 378–406.

Meyer, J.E. (1993) New paradigm research in practice: the trials and tribulations of action research. *Journal of Advanced Nursing*, 18 (7), 1066–72.

Meyer, J.E. (2006) Action research. In *The Research Process in Nursing* (eds K. Gerrish & A. Lacey), 5th edn, pp. 274–88. Oxford, Blackwell Science.

Morrison, B. & Lilford, R. (2001) How can action research apply to health services? *Qualitative Health Research*, 11 (4), 436–49.

Morton-Cooper, A. (2000) *Action Research in Health Care*. Oxford, Blackwell Science.

Newman, J.M. (2000) Action research: a brief overview. *Forum Qualitative Sozialforschung/Forum Qualitative Research* 1 (1), On-line journal. Available at http://www.qualitative-research.net/fqs

Parahoo, K. (2006) *Nursing Research: Principles, Process and Issues*, 2nd edn. Basingstoke, Palgrave, Macmillan.

Reason, P. (ed.) (1988) *Human Inquiry in Action: Developments in New Paradigm Research*. London, Sage.

Reason, P. & Bradbury, H. (eds). (2006) *Handbook of Action Research: Participatory Inquiry and Practice*, 2nd edn. London, Sage.

Rolfe, G. (1996) Going to extremes: action research, grounded practice and the theory–practice gap in nursing. *Journal of Advanced Nursing*, 24, 1315–20.

Stringer, E.T. (2007) *Action Research: A Handbook for Practitioners*, 3rd edn. Thousand Oaks, CA, Sage.

Waterman, H. (1998) Embracing ambiguities and valuing ourselves: issues of validity in action research. *Journal of Advanced Nursing*, 28 (1), 101–5.

Waterman, H., Tillen, D., Dickson, R. & de Koning, K. (2001) Action research: a systematic review and guidance for assessment. *Health Technology Assessment*, 5 (23), iii-157.

Further reading

Koch, T. & Kralik, D. (2006) *Participatory Action Research in Health and Social Care*. Oxford, Blackwell Science.

McNiff, J. & Whitehead, J. (2005) *All You Need to Know about Action Research*. London, Sage.

McNiff, J. & Whitehead, J. (2009) *Doing and Writing Action Research*. London, Sage.

Winter, R. & Munn-Giddings, C. (2001) *A Handbook for Action Research in Health and Social Care*. London, Routledge.

Whitehead, J. & McNiff, J. (2006) *Action Research: Living Theory*. London, Sage.

The best-known writer on this type of research, Robert Yin, has discussed case studies in various editions of his books (for example, Yin, 2003, 2009). Although his writing, on the whole, focuses on the quantitative framework, he sees the qualitative approach as valid. Case study research is not to be confused with other types of case work, case history or case study as sometimes used in student education to give examples and flavour of cases in clinical settings.

Generally researchers who develop case studies are familiar with the case they explore and its context before the start of the research. Health professionals study cases because they may be interested in it for professional reasons or because they need the knowledge about the particular case.

As in other types of qualitative research, the case study is a way of exploring a phenomenon or several phenomena in context. The researchers therefore use a number of sources in their data collection, such as observation, documentary sources and interviews so that the case can be illuminated from all sides. Observation, interviewing and documentary research are the most common strategies used in case study inquiry. The case study is neither a method nor a methodology as neither data collection nor analysis occurs through case study but through specific research approaches, but it can make use of a variety of methods (VanWynsburghe and Khan, 2007). It is something that the researcher chooses to study. Travers (2001) gives a range of qualitative approaches which can be applied to case study research which can be used; for instance, ethnography, grounded theory, narrative analysis or other ways of inquiry can be useful in doing case study research.

> **Example 2**
> The aim of the case study research by Walshe *et al.* (2008) was to examine the impact of referral decisions in community palliate care service. The case in point was the community care service in three specific settings within a primary care trust. Interviews took place with patients and health professionals in these settings. The researchers illuminated the influences on referral services.

The case study is determined by the individual case or cases, not by the approach to it that is taken by the researcher. The analysis of qualitative case studies involves the same techniques as that of other qualitative methods: the researcher codes and categorises, provides exhaustive descriptions, develops typologies or generates theoretical ideas.

Studies focus on individuals such as a patient or a group which might consist of individuals with common experiences or characteristics, a ward or a hospital. Life histories of individuals would also be interesting examples of cases. A process or procedure might also constitute a case.

> **Example 3**
> Walton *et al.* (2007) explored priority-setting in cardiac surgery at three cardiac centres of the University of Toronto. Data sources consisted of documents, observations and interviews with surgeons, cardiologists and triage nurses. The case is the process of priority-setting itself.

In health research with a psychological emphasis, cases often focus on individuals and an aspect of their behaviour, while the sociologist is more interested in groups. In any health organisation, single or multiple cases can be examined. The local 'case' focuses on both the physical and social elements in the setting.

As in other qualitative research, case studies explore the phenomenon or phenomena under study in their context, and indeed contextualisation is an important feature of all case studies. The lines of division between the phenomenon under study and the context, however, are not always clear (Yin, 2003).

Case studies can be exploratory devices, for instance as a pilot for a larger study or for other, more quantitative research, or they could illustrate the specific elements of a research project. One of our students demonstrated all the ideas she obtained from informants by writing up the case of one single participant. Usually the case study stands on its own and involves intensive observation. The description of specific cases can make a study more lively and interesting.

Case study research is used mainly to investigate cases that are tied to a specific situation and locality, and hence this type of inquiry is even less readily generalisable than other qualitative research (a debate can be found in Gomm *et al.* 2000). Therefore researchers are often advised to study 'typical' and multiple cases (Stake, 1995). Atypical cases, however, may sometimes be interesting because their very difference might illustrate the typical case. It is important, though, that the researcher does not make unwarranted assertions on the basis of a single case. Although there can be no generalisability of the findings from a single case, there might be some transferability of ideas if the researcher has given a detailed audit trail and used 'thick description' so that this case can illuminate other, similar cases.

Conversation analysis

Within the great variety of qualitative methods, some emphasise language and language use. Any professional–client interaction relies on language as a major communication device. Conversation(al) analysis (CA) is a type of discourse analysis (DA) that examines the use of language and asks the question of how everyday conversation works; in its basic form it is the study of talk in everyday interaction (Hutchby and Wooffitt, 2008). This type of inquiry focuses on ordinary conversations and on the way in which talk is organised and ordered

in speech exchanges. While researchers primarily examine speech patterns, they also analyse non-verbal behaviour in interaction such as mime, gesture and other body language. As Nofsinger (1991:2) explains: 'If we are to understand interpersonal communication, we need to learn how this is accomplished so successfully'.

Harold Garfinkel, Harvey Sacks, Emmanuel Schegloff and others initially developed CA in the 1960s and 1970s in the United States within the ethnomethodological movement. While other types of DA have their roots in the field of linguistics, CA originates in ethnomethodology, a specialist direction of sociology and phenomenology. Ethnomethodology focuses in particular on the world of social practices, interactions and rules (see Turner, 1974). Garfinkel attempted to uncover the ways in which members of society construct social reality. Ethnomethodologists focus on the 'practical accomplishments' of members of society, seeking to demonstrate that these make sense of their actions on the basis of 'tacit knowledge', their shared understanding of the rules of interaction.

CA focuses on what individuals say in their everyday talk, but also on what they do (Nofsinger, 1991). Through conversation, movement and gesture, we learn of people's intentions and ideas. The sequencing and turn taking in conversations demonstrate the meaning individuals give to situations and show how they inhabit a shared world. Body movements too, are the focus of analysis. Conversation analysts do not use interviewing to collect data but analyse ordinary talk, 'naturally occurring' conversations. Most sections of talk analysed are relatively small, and the analysis is detailed. According to Heritage (1988: 130), CA makes the assumptions that talk is structurally organised, and each turn of talk is influenced by the context of what has gone on before and establishes a context towards which the next turn will be oriented. There are two other fundamental tenets of CA according to Heritage: sequential organisation and empirical grounding of analysis. Talk happens in organised patterns; the action of the member who takes part in the conversation is dependent on and makes reference to the context, and researchers should avoid generalities and premature theory building (Silverman, 2006).

CA is more often used in sociological or education studies than in nursing or other disciplines within the healthcare arena. Indeed, Jones (2003) found few in nursing journals. We think, however, that it can contribute a valuable research approach in nursing and healthcare and lead to changes in the interaction between health professionals and patients. Researchers generally audio- or videotape these interactions and transcribe the conversations in a particular way (see transcription techniques in detail, in Button and Lee (1987)) largely developed by Gail Jefferson.

There are examples in health research of doctor–patient or nurse–patient interaction, particularly in consultations which show how talk is generated and organised by the participants and follows an orderly process in which a turn-taking system exists (Sharrock and Anderson, 1987; Bergstrom *et al.*, 1992). All the recent examples we discovered were in the area of medical consultations (see for instance Campion and Langdon, 2004). These interactions are usually taped and the tapes show what actually takes place in a setting.

Example

Maynard and Heritage (2005) use CA in medical education to demonstrate its value to the understanding of the interaction between doctors and patients. As these interactions are occurring in natural settings and are spontaneous, nothing has to be set up especially for the research. Maynard and Heritage show that CA is systematic and analytic in examining the structure of medical interviews. They give examples of how this method of research can be used for medical education.

Jones (2003) investigated the communication and interaction between nurses and patients in healthcare consultations and found that CA was a useful way to undertake this. He regrets that this way of studying talk is not often used in the field. Sequences of talk can be studied, and he suggests that they illuminate processes such as treatment, advice and assessment. The disadvantages of CA he sees as the length of time that is needed for this research approach, and the potential lack of context as the focus on direct interaction and communication might become isolated from the social context.

The analysis of CA includes the discovery of regularities in speech or body movement, the search for deviant cases and the integration with other findings without over-generalisation (Heritage, 1988). One of the disadvantages is the way in which conversation analysts emphasise the formal characteristics of interaction at the expense of content, however, much can be discerned from the way the communication and interaction proceeds. ten Have (2007) describes ways of analysing CA data, and researchers might find his book useful.

CA is difficult, highly complex and very detailed. Researchers may not find it easy, and we do not recommend it to novice researchers.

Critical incident technique

The critical incident technique (CIT) is a procedure designed to solve problems in clinical practice or educational settings. In the past, it was not often used in the health arena, but it has been applied in this field, and although neglected for a number of years, it has become more often used in the recent decade. It is not a specific method or methodology but a means of developing questions, whilst focusing on people's behaviour in critical situations in order to solve

problems in task performance. A critical incident is an observed event that is perceived as particularly important or critical. Researchers examine those events that are significant for a particular process. They collect examples of critical incidents in the situation under study by observation of behaviour and by asking participants to give an account of the way in which they deal in critical situations or times of crisis.

Flanagan (1954) who first developed this technique, suggests that in this approach, an incident has to occur in a situation with definite consequences and effects. CIT was initially developed as a result of the Aviation Psychology Program in the United States to collect information from pilots about their behaviour when flying a mission. In particular, psychologists asked for reports about critical incidents that helped or hindered the successful outcome of the mission. Through analysis of these reports, a list of components for successful performance was generated from the data. Flanagan refined the procedure for industrial psychology to assess the outcomes of task performance, and it was used also in other fields such as personnel selection. Although the method was neglected after the 1950s, it can be a useful, effective and qualitative approach to studying critical events in order to improve task performance and is thus very useful for the health professions. Flanagan (1954: 335) states that the technique is 'a procedure for gathering certain important facts concerning behaviour in defined situations'.

Critical incidents might occur in clinical practice, make visible problems in care and are noticed by health professionals who then decide to examine these, as well as the reasons for their occurrence. They then develop the specific plan and aim of their research and start collecting and analysing data. It can be seen that this type of inquiry follows the traditional path of data collection and analysis in qualitative research.

Researchers examine those events that are significant for a particular process. They collect examples of critical incidents in the situation under study, and participants give an account of the way in which they act in critical situations or times of crisis. Direct observation is the most important part of the data collection. Generally the researchers ask about the critical event and gain a perspective about effective and ineffective behaviour in specific decisive and important situations.

Example of CIT in clinical practice

Broström et al. (2003) developed a study in the area of congestive heart failure (CHF) breathing disorders which aimed to explore situations in which spouse influence and support was crucial in the sleep situation. Participants, the partners of individuals with CHF, were asked through semi-structured interviewing to provide specific situations in which they gave support or where their influence and support was inhibited. The implications of this study meant that health professionals could gain insight into the problems of the sleep situation and increase understanding, as well as learn how to facilitate support in practical ways.

Schluter et al. (2007) in a short guide to CIT (p.108) describe the five steps which Flanagan suggests:

1. Identification of the research question and aim
2. Identification of the specific types of incidents to be observed
3. Collection of data by observation and recording
4. Analysis and interpretation of the observed and recorded data
5. Writing the report and disseminating the data

The aim of the technique is to obtain information about each specific incident. This will include choosing the type of events on which researchers wish to focus, generally critical events or incidents in care or educational settings. The second stage involves selecting a purposive sample of incidents and people from which to collect data. The sample size depends on the number of critical incidents, not on the number of people interviewed or observed (Kemppainen, 2000). Initially, health researchers find out about critical incidents through incidental and casual observation, but when they decide to do the research, they observe and ask questions more purposefully. The data are analysed in a similar way as in other approaches. There is, however, a slight difference: Researchers choose a more defined frame of reference in this type of research as they wish to focus on particular events. It is also important that the terminology used is clear and appropriate for CIT; indeed, Butterfield et al. (2005) deplore the lack of consistency in studies which use this technique.

The goal of the researcher is to investigate a recurring problem and to find a solution to it. To examine the critical incidents, the health researcher has to be familiar with the setting and the nursing or midwifery tasks that are performed. Kemppainen (2000) advises that the responses of the participants to the researcher's questions should be specific and accurate, and not vague or unclear. We feel that this way of researching is under-explored and could be specifically useful in the healthcare field.

Discourse analysis

Cheek (2004) suggests that CA and DA are complex concepts and that confusion exists about this area of research. DA cannot be easily identified, as people use it in different ways; it is more a framework or holistic theoretical stance. Discourse in general is applied to talk and text, such as conversations, interviews or documents. Traynor (2006) re-emphasises that it is an analysis of naturally occurring talk, one of the most important sources of data, although talk is not the only discourse that might be analysed.

DA in psychology is an analysis of text and language drawing on 'accounts' of experiences and thoughts that participants present. This type of DA has been carried out mainly by psychologists. Accounts consist of forms of ordinary talk and reasoning of people, as well as other sources of text, such as historical documents, diaries, letters or reports and even images such as photographs, drawings or paintings. DA is not a method but a specific approach to the social world and research (Potter, 1996; Cheek, 2004). It focuses on the construction of talk and text in social action and interaction. In common with other types of qualitative inquiry, discourse analysts initially use an inductionist approach by collecting and reviewing data before arriving at theories and general principles as do other qualitative researchers. The way people use language and text is taken for granted within a culture (Gill, 1996) and this shows that discourse is context-bound. DA as the structural analysis of discourse, is often used in media and communication research to analyse data. An example would be an analysis of the speech messages of politicians.

Language itself and reality are socially constructed. The vocabularies which individuals and groups use are located in interpretive 'repertoires' that are coherent and related sets of terms. Crowe (2005: 55) adds to this that discourses show how 'social relations, identities, knowledge and power are constructed in spoken and written text.'

It is important to read the documents and transcripts carefully before interpreting them. The first step in the analysis is a close look at and detailed description of other, less language-based sources. The relevant documents are read and re-read until researchers have become familiar with the data, be they textual or visual. Immersion in the data, after all, is a trait of all qualitative research. Important issues and themes can then be highlighted. The analysis proceeds like other qualitative research: analysts code the data, look for relationships and search for patterns and regularities that generate tentative propositions. Through the process, they always take the context into account and generate analytical notes as in other forms of qualitative inquiry.

Also, like for other qualitative research, the findings from DA are not instantly generalisable; indeed researchers are not overly concerned with generalisability, because the analysis is based on language and text in a specific social context. There are a number of similarities between CA and DA: both CA and DA focus on language and text. While DA generally considers the broader context, CA emphasises turn-taking and explains the deeper sense of interaction in which people are engaged, particularly 'naturally occurring' talk, while discourse analysts look at the material more holistically, and they can also use records, newspaper articles or reports of meetings, etc.

Discourse analysts are interested in the ways through which social reality is constructed in interaction and action. DA is based on the belief that language (and presentation of images) does not just mirror the world of social members and cultures but also helps to construct it.

> ### Example 1
> DA is demonstrated by Fealy (2004) who analysed the way in which nurses were presented and the changes in their status in images to the Irish public over time. They pointed to the fact that the image of the nurse is both culture and time specific. Class, economic position, power and gender relationships were all important in the process of presenting images of the nurse to the public. (Fealy does draw parallel to images of nursing in other countries too.)

Potter and Wetherell (1987) developed the notion of 'interpretative repertoires' which they saw as a set of related concepts organised around one or several important metaphors. These provide researchers with common sense concepts of a group or a culture. Language is 'action oriented': it is used so people can 'do' and shaped by the cultural and social context in which it occurs. Social groups possess a variety of repertoires and use them appropriately in different situations. The discourses or narratives of people about various specific areas in their lives generate a text. Discourse analysts must therefore be aware of the context in which action takes place so that the context can be analysed as well. The same text can be interpreted in different ways: different versions of reality exist in different contexts. The DA of psychologists and linguists focuses on language and text. Readers can make judgements about this type of research because they themselves possess knowledge of everyday discourse and its construction. Wetherell *et al.* (2001) and Potter and Wetherell (2007) have since updated their work.

McHoul and Grace (1995) differentiate between Foucauldian and non-Foucauldian discourse (although these are not really separate). Michel Foucault, the French historian and philosopher, made the concept of discourse famous while describing the links of language with disciplines and institutions. For him, discourses are bodies of knowledge, by which he means both academic scholarship and institutions, which exist in disciplines. Indeed, he claims that discourse reproduces institutions. Social phenomena are constructed through language. Specific language is connected with specialist fields, for instance 'professional discourse', 'scientific discourse' or 'medical discourse'; for instance, Rayner *et al.* (2006) examine the values of the National Health Service Framework for coronary heart disease and identify three different discourses, the managerial, the clinical and the political, all with different messages and overtones.

In Foucault's works, discourses as specialist languages are linked to power.

> **Example 2**
>
> Hui and Stickley (2007) analysed the discourses of the literature and health policies of the government and those of service users in the mental health arena in a Foucauldian DA. These two types of discourse were distinct and competing. Different concepts had different meanings among these two perspectives. 'Power' in particular had varied connotations.

DA discovers the language that operates within the particular discourse under study and which has almost moral connotations. For instance, professionals use particular types of discourse to impose their own or the official version of reality on their clients. Traynor (2006) stresses that people persuade others, present themselves to others, and act in particular ways; how this occurs is important and involves power relationships. This can be shown in speech, text or image.

Feminist research

Feminist inquiry is research that focuses on the experience, ideas and feelings of women in their social and historical context. Researchers adopt a gender perspective to the phenomenon under investigation. Feminist approaches do not prescribe methods of analysing research but instead suggest ways of thinking about it. The intention is to make women visible, raise their consciousness and empower them. As Oleson (2000) states: 'It is research for rather than about women'. Because qualitative research has affinity with the ideas of feminists, it is used more often than quantitative approaches (although feminist researchers also see the latter as valid).

Feminist research is important for health researchers which are still female professions, and their members are well aware of gender and power issues. Some feminists believe in a separate and distinctive feminist research methodology, and that this type of inquiry is not merely a variation or branch of qualitative research (Stanley and Wise, 1993). Many early feminist researchers maintained (for instance Harding, 1987) that a distinctive feminist method does not exist, but that feminist authors address certain epistemological and methodological issues related to gender. They show in particular that structural and policy issues are as important as personal or individual factors. One major element of feminist research is critical theory. Feminist researchers often see women as an oppressed group controlled by the media, the political and economic systems and ultimately by men. Structural and political forces, so they believe, work against equality for women. Feminists believe that women are economically exploited and suffer social discrimination. Hearing the voices of women and raising their consciousness through research may therefore assist in overcoming inequalities.

The most common form of feminist inquiry is narrative or life history research, because it gives women the chance to tell their own stories in their own way, 'letting the women speak'. Feminist research and cooperative inquiry share many of their most important features such as complete equality between researcher and participant and a democratic non-judgemental stance (though one might say this about all qualitative research).

The feminist approach to research gives women the opportunity to voice their concerns and interests and is not merely concerned with the technical details of data analysis. The latter depends on the field in which researchers work and on the specific research question, although methods, too, reflect the feminist principles of equality between researcher and participant and focus on women's experiences and their empowerment. Taking into account the requirements of feminist research, researchers use grounded theory, ethnography and other types of data analysis. The focus on the 'lived experience' and the affective elements in the participants' lives mean that phenomenological approaches are often taken in feminist qualitative research.

The term 'feminist standpoint research' is used. It is a less specific term than feminist methodology and carries with it the implication that feminist research uses a specific type of analysis. Feminist standpoint researchers recognise that their view of the world is distinctive and different. There should be a fit, they suggest, between the world view of feminism and the methods adopted for research.

Feminist methodology has its roots in feminist theory. Writers such as Millett (1969), Mitchell (1971) and Oakley (1972) as well as others, particularly in the United States and Britain, were the pioneers who helped to direct the focus on women's interests and ideas. Early feminist writers in the professions in Britain include Stanley and Wise (1993) in social work and Webb (1984) in nursing.

A number of major issues emerge in thinking and doing research within a feminist methodological framework. Initially, feminist research was a reaction against positivist research and traditional strategies, which were seen as male-dominated and androcentric. Feminist approaches take up the issues of power, oppression and subordination although they are not only about women but also about the interests of men (Peters et al., 2008). Feminist writers used consciousness-raising as a methodological tool to empower women. It also becomes a tool for narrowing the distance between researchers and participants by generating reciprocity and collaboration. This affects all participants and gives individuals – including researchers – a sense of their identity. Women, so feminists believe, become aware of their position through the research process and relationships and aim to change their situation and become more powerful.

The concept of performance in research emerged in the 1970s. It is linked to the enactment of research in various ways. Austin, the philosopher, for instance, uses the term 'performative' in relation to utterances in text or speech which perform and enact (Schwandt, 2007). A text itself might be a performative production. The concept of PSS relates, however, mostly to the visual and audible. In the last two decades, qualitative researchers have often translated their data, findings and presentations into performances. Indeed, Denzin (2001: 26) states that we 'inhabit a performance-based dramaturgical culture'. Film, poetry and video for instance, open up new ways for qualitative inquiry and are often appropriate to evoke emotion and response in the audience; hence, they help listeners and viewers to grasp human concerns more fully.

Drama, dance and music and other tools also are performance-based modes of presenting research; it is not all image-based. Saldaña (2003) speaks of 'dramatizing data' where the participants play roles and are characters in a play. Some of our students, for instance, showed a fictional film about old people in a care home which presented the findings from their research. Rossiter *et al.* (2008) show how and why findings can be usefully communicated, through theatre for instance.

New and innovative technology is often the medium through which performative events can happen and films or dramatic presentations are obvious choices. Jones ties performativity to post-modernity and social constructionism, because of its multi-voiced and interdisciplinary character and for its diversity and lack of linearity. Roberts (2008: 1), however, warns against the collapsing of artistic or social science or activity into mere performance or simply transferring it, as this needs careful examination of 'skills, purpose, tradition and context'.

The Gergens (Gergen and Gergen, 2000) have used performances in their work for decades. They declare that in research, writing is only one way of expression. Films, drama and other modes of presentation can be used to this end, while in the past they were merely complementary to scientific writing. They also believe that in this genre boundaries between data collection and report become blurred in the process of research. Collecting data through images, poems and other means empowers the participants and centres on their perspectives.

Example of data collection

Spiers (2004) used an innovative, observational approach to the study about teenagers with diabetes to whom he gave cameras so they could film what it was like living with diabetes and the processes needed to care for themselves and to be cared for. He states as an advantage the control of events by the participants. Spiers also filmed interactions of these teenagers with nurses.

Keen and Todres (2007) give several examples of dissemination through performance methods and discuss the value of this type of presentation of findings.

The data collected by these techniques need of course to be analysed in detail to be used by health professionals. Indeed, vigorous and rigorous analysis is essential to make performance-based collection and presentation of data acceptable, particularly in academic settings. Nevertheless, through presentation in a storytelling or image-based way, the audience, particularly an audience of patients or users of services, is able to grasp the experience of pain and joy, stigma and other problems which are made more visible and concrete.

PSS is useful in health research as it can present vividly the voices of the participants – be it in film, theatre or other media. It is more immediate than reading a text produced by researchers, and assists the audience in understanding the experience of patients or health professionals. The producer of a performance, whether it is in a play, a film or any other form, becomes a recorder of experiences. His or her observations evoke a response in audiences who bring their own interpretations to the situation in interaction with the data or their presentation.

Performance cannot be used as a 'gimmick' where the dramatic is all important. Curtin (2008) suggests that drama and other performances need to have the same academic credentials such as rigour and analytic quality.

(Much of this material for this section is based directly on Holloway, 2008)

Conclusion

This chapter is aimed to give an overview of some qualitative research approaches that are either embedded in other methods, such as case study research and CIT, or those that are more (DA, PSS) or less (conservation analysis) frequently used in health research. All qualitative researchers need to have at least some knowledge about these methods. We have focused mainly on main stream approaches in the preceding sections.

References

Case studies

Bryman, A. (2008) *Social Research Methods*. Oxford, Oxford University Press.
Gomm, R., Hammersley, M. & Foster, P. (2000) *Case Study Method*. London, Sage.
Stake, R.E. (1995) *The Art of Case Study Research*. Thousand Oaks, CA, Sage.
Stake, R.E. (2000) The case study method in social inquiry. In *Case Study Method* (eds R. Gomm, M. Hammersley & P. Foster), pp. 19–26. London, Sage.
Travers, M. (2001) *Qualitative Research through Case Studies*. London, Sage.
VanWynsburghe, R. & Khan, S. (2007) Redefining case study. *International Journal of Qualitative Methods*, 6 (2), Article 6. Retrieved January 2009 from http://www.ualberta.ca/iiqm/backissues/6_2/vanwynsberghe.pdf

Walshe, C., Chew-Graham, C., Todd, C. & Caress, A. (2008) What influences referrals within community palliative care services: a qualitative case study. *Social Science and Medicine*, 67 (1), 137–46.

Walton, N.A., Martin, D.K. & Peter, E.H., *et al.* (2007) Priority setting and cardiac surgery: a qualitative case study. *Health Policy*, 80 (3), 444–58.

Whyte, W.F. (1943) *Street Corner Society: The Social Structure of an Italian Slum.* Chicago, IL, University of Chicago Press.

Yin, R.K. (2003, 2009) *Case Study Research*, 3rd and 4th edn. Thousand Oaks, CA, Sage.

Bergstrom, L., Roberts, J., Skillman, L. & Seidel, J. (1992) You'll feel me touching you, sweetie: vaginal examination during the second stage of labour. *Birth*, 19, 11–18.

Button, G. & Lee, J.R.E. (eds). (1987) *Talk and Social Organisation.* Clevedon, Multilingual Matters.

Campion, P. & Langdon, M. (2004) Achieving multiple topic shifts in primary care medical consultations: a conversation analysis study in UK general practice. *Sociology of Health and Illness*, 26 (1), 81–101.

ten Have, P. (2007) *Doing Conversation Analysis*, 2nd edn. London, Sage.

Heritage, J. (1988) Explanations as accounts: a conversation analytic perspective. In *Analysing Everyday Explanation: A Casebook of Methods*, pp. 127–44. London, Sage.

Hutchby, I. & Wooffitt, R. (2008) *Conversation Analysis.* Cambridge, Polity Press.

Jones, A. (2003) Nurses talking to patients: exploring conversation analysis as a means of researching nurse-patient communication. *International Journal of Nursing Studies*, 40 (6), 609–18.

Maynard, D. & Heritage, J. (2005) Conversation analysis, doctor-patient interaction and medical communication. *Medical Education* 39 (4), 428–35.

Nofsinger, R.E. (1991) *Everyday Conversation.* Newbury Park, CA, Sage.

Sharrock, W. & Anderson, R. (1987) Work flow in a paediatric clinic. In *Talk and Social Organisation* (eds G. Button & J.R.E. Lee). Clevedon, Multilingual Matters.

Silverman, D. (ed.) (2006) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, 3rd edn. London, Sage.

Turner, R. (ed.) (1974) *Ethnomethodology.* Harmondsworth, Penguin Books.

Broström, A., Strömberg, A., Dahlström, U. & Fridlund, B. (2003) Congestive heart failure, spouse support and the couple's sleep situation. *Journal of Clinical Nursing*, 12 (2), 223–33.

Butterfield, L.D., Borgen, W.A., Amundson, N.E. & Asa-Sophia, T.M. (2005) Fifty years of the critical incident technique: 1954–2004 and beyond. *Qualitative Research*, 5 (4), 475–97.

Flanagan, J. (1954) The critical incident technique. *Psychological Bulletin*, 51, 327–58.

Kemppainen, J.K. (2000) The critical incident technique and nursing care quality research. *Journal of Advanced Nursing*, 32 (5), 1264–71.

Schluter, J., Seaton, P. & Chaboyer, W. (2007) Critical incident technique: a user's guide for nurse researchers. *Journal of Advanced Nursing*, 61 (1), 107–14.

Cheek, J. (2004) At the margins? Discourse analysis and qualitative research. *Qualitative Health Research*, 14 (8), 1140–50.

Crowe, M. (2005) Discourse analysis: towards an understanding of its use in nursing. *Journal of Advanced Nursing*, 51 (1), 55–63.

Fealy, G. (2004) 'The good nurse': visions and values in images of the nurse. *Journal of Advanced Nursing*, 46 (6), 649–56.

Gill, R. (1996) Discourse analysis: practical implementation. In *Handbook of Qualitative Research in Psychology and the Social Sciences* (ed. J.T.A. Richardson), pp. 141–56. Leicester, BPS Books.

Hui, A. & Stickley, T. (2007) Mental health policy and mental health service user perspectives on involvement: a discourse analysis. *Journal of Advanced Nursing*, 59 (4), 416–26.

McHoul, A. & Grace, W. (1995) *A Foucault Primer: Discourse, Power and the Subject.* Melbourne, Melbourne University Press.

Potter, J. (1996) *Representing Reality: Discourse, Rhetoric, and Social Construction.* London, Sage.

Potter, J. & Wetherell, M. (1987) *Discourse and Social Psychology: Beyond Attitudes and Behaviour.* London, Sage.

Potter, J. & Wetherell, M. (2007) *Discourse and Social Psychology*, 3rd edn. London, Sage.

Rayner, M., Scarborough, P. & Allender, S. (2006) Values underlying the National Service Framework for coronary heart disease. *Journal of Health Services Research and Policy*, 11 (2), 67–73.

Traynor, M. (2006) Discourse analysis: theoretical and historical overview and review of papers in the Journal of Advanced Nursing. *Journal of Advanced Nursing*, 54 (1), 62–72.

Wetherell, M., Taylor, S., Yates, S.J. (eds). (2001) *Discourse as Data: A Guide for Analysis.* Milton Keynes, The Open University.

Harding, S. (ed.) (1987) Introduction. In *Feminism and Methodology*, pp. 1–14. Bloomington, IN, Indiana Press.

Millett, K. (1969) *Sexual Politics.* London, Abacus.

Mitchell, J. (1971) *Women's Estate.* Harmondsworth, Penguin.

Oakley, A. (1972) *Sex, Gender and Society.* London, Temple Smith.

Oakley, A. (2000) *Experiments in Knowing: Gender and Method in the Social Sciences.* Cambridge, Polity Press.

Oleson, V. (2000) Feminisms and qualitative research at and into the millennium. In *Handbook of Qualitative Research* (eds N.K. Denzin & Y.S. Lincoln), 2nd edn, pp. 215–55. Thousand Oaks, CA, Sage.

Peters, K., Jackson, D. & Rudge, D. (2008) Research on couples: are feminist approaches useful? *Journal of Advanced Nursing*, 62 (3), 373–80.

Ramazanoglu, C. & Holland, J. (2002) *Feminist Methodology: Challenges and Choices*. London, Sage.

Stanley, L. & Wise, S. (1993) *Breaking Out Again*. London, Routledge.

Travers, M. (2001) *Qualitative Research through Case Studies*. London, Sage.

Webb, C. (1984) Feminist methodology in nursing research. *Journal of Advanced Nursing*, 9 (3), 249–56.

Performative Social Science

Curtin, A. (2008) How dramatic techniques can aid the presentation of qualitative research. *Qualitative Researcher* (8), pp. 8–10.

Denzin, N.K. (2001) The reflexive interview and a performative social science. *Qualitative Research*, 1 (1), 23–46.

Gergen, M.M. & Gergen, K.J. (2000) Qualitative inquiry: tensions and transformations. In *Handbook of Qualitative Research* (eds N.K. Denzin & Y.S. Lincoln), pp. 1025–46. Thousand Oaks, CA, Sage.

Guiney Yallop, J.J., Lopez de Vallejo, I. & Wright, P.R. (2008). Editorial: overview of the performative social science special issue [20 paragraphs]. *Forum Qualitative Sozialforschung(Forum: Qualitative Social Research)*, 9 (2), Article 64. Retrieved July 2008 from http://nbn-resolving.de/urn:nbn:de:0114-fqs0802649

Holloway, I. (2008) *A-Z of Qualitative Research in Healthcare*. Oxford, Blackwell Science.

Jones, K. (2006) A biographic researcher in pursuit of an aesthetic: the use of arts-based (re) presentations in 'performative' dissemination of life stories. *Qualitative Sociology Review*, 2 (1), 66–85.

Keen, S. & Todres, L. (2007) Strategies for disseminating qualitative research findings: three exemplars [36 paragraphs]. *Forum Qualitative Sozialforschung(Forum: Qualitative Social Research)*, 8 (3), Article 17. Retrieved July 2008 from http://nbn-resolving.de/urn:nbn:de:0114-fqs0703174

Roberts, B. (2008) Performative social science: a consideration of skills, purpose and context [122 paragraphs]. *Forum Qualitative Sozialforschung(Forum: Qualitative Social Research)*, 9 (2), 1, Article 58. Retrieved July 2008 from http://nbn-resolving.de/urn:nbn:de:0114-fqs0802588

Rossiter, K., Kontos, P., Colantionio, A., Gray, J. & Keightley, M. (2008) Staging data: theatre as a tool for analysis and knowledge transfer in health research. *Social Science and Medicine*, 66 (1), 130–46.

Saldaña, J. (2003) Dramatizing data: a primer. *Qualitative Inquiry*, 9 (2), 218–36.

Schwandt, T. (2007) *A Dictionary of Qualitative Inquiry*. Thousand Oaks, CA, Sage.

Spiers, J.A. (2004) Tech tips: using video management/ analysis technology in qualitative research. *International Journal of Qualitative Methods*, 3 (1), Article 5. Retrieved July 2008 from http://www.ualberta.ca/iiqm/backissues/3_1/pdf/spiersvideo.pdf

Further reading

Hessebiber, S.N. & Leavy, P.L. (2007) *Feminist Research: A Primer*. Thousand Oaks, CA, Sage.

McHoul, A. & Grace, W. (1997) *A Foulcault Primer: Discourse, Power and Subject*. New York, NY, NYU Press.

Rose, G. (2007) *Visual Methodologies: An Introduction to the Interpretation of Visual Materials*, 2nd edn. London, Sage.

The special issue of *Forum Qualitative Research*, Vol. 9, No 2, a free on-line journal, contains a number of important and explanatory articles.