

The methodology of Focus Groups: the importance of interaction between research participants

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Abstract What are focus groups? How are they distinct from ordinary group discussions and what use are they anyway? This article introduces focus group methodology, explores ways of conducting such groups and examines what this technique of data collection can offer researchers in general and medical sociologists in particular. It concentrates on the one feature which inevitably distinguishes focus groups from one-to-one interviews or questionnaires – namely the interaction *between research participants* – and argues for the overt exploration and exploitation of such interaction in the research process.

Introduction

Focus groups are group discussions organised to explore a specific set of issues such as people's views and experiences of contraception (Barker and Rich 1992, Zimmerman et al. 1990), drink-driving (Basch et al. 1989), nutrition (Crockett et al. 1990) or mental illness (Grunic 1990). The group is 'focused' in the sense that it involves some kind of collective activity – such as viewing a film, examining a single health education message or simply debating a particular set of questions. Crucially, focus groups are distinguished from the broader category of group interviews by 'the explicit use of the group interaction' as research data (see Merton 1956 and Morgan 1988: 12).

There is nothing new about focus groups. They are first mentioned as a market research technique in the 1920s (Basch 1987; Bogardus 1926) and were used by Merton in the 1950s to examine people's reactions to wartime propaganda (Merton et al. 1956). In fact it is Merton who is often credited with developing the 'focused interview' with groups. (Although he never actually used the term 'focus group' and would beg to differ from some contemporary uses of the technique) (see Merton 1987).

Group discussions in their widest sense have continued to be popular as a method of data collection throughout the 1970s and 80s within particular niches. For example, group methods are often used within 'communication research' such as in the evaluation of health education material, and in film and television reception studies (Frazer 1987, Philo 1990, Schlesinger et al. 1992, Corner 1990). Such methods are also popular in studies designed to explore people's experiences of services such as health screening and in action research projects involving grass-roots participation (Gregory and McKie 1991, Watts and Ebbutt 1987). However, group work has not been systematically developed as a research technique within social science in general and although group interviews have often implicitly informed research they are rarely acknowledged as part of the process (see Frey and Fontana 1991: 177). Even when group work is explicitly included as part of the research it is often simply employed as a convenient way to illustrate a theory generated by other methods or as a cost-effective technique for interviewing several people at once. Reading some such reports it is hard to believe that there was ever more than one person in the room at the same time. This criticism even applies to many studies which explicitly identify their methodology as 'focus group discussion' – in spite of the fact that the distinguishing feature of focus groups is supposed to be the use of interaction as part of the research data. Reviewing over 40 published reports of 'focus group studies' I could not find a single one concentrating on the conversation between participants and very few that even included any quotations from more than one participant at a time. This article attempts to redress the balance through a detailed examination of the interactions between the research participants on the AIDS Media Research Project.

The AIDS Media Research Project: Why focus groups were used and how they were selected

The AIDS Media Research Project was a three-pronged study of the production, content and effect of media messages about AIDS (see Beharrell 1993, Miller and Williams 1993, Kitzinger 1990). Focus groups were used to examine the 'effect' element in this equation – to explore how media messages are processed by audiences and how understandings of AIDS are constructed. We were interested not solely in what people thought but in *how* they thought and *why* they thought as they did. We were also concerned to examine how diverse identities and social networks might impact upon research participants' perceptions of AIDS and their reactions to the media coverage. Such research objectives necessitated the use of in-depth work and we opted for group work because of our interest in the social context of public understandings.

We conducted a total of 52 different discussions, comprising 351 par-

ticipants. The bulk of these sessions were conducted by the author, others were run by colleagues on the project: Peter Beharrell, David Miller and Kevin Williams. Each group consisted of, on average, 6 research participants and the discussion lasted approximately 2 hours and was tape-recorded. All participants also completed individual questionnaires.¹ This represents a far more extensive use of focus groups than any other study which I have located to date. Many 'focus group studies' rely on no more than 4 or 5 groups, and this may be a perfectly adequate number when working with particular populations. In our case, however, the sample covered a wide range of different 'populations' in England, Scotland and Wales and the groups were selected in order to explore diversity, rather than in order to establish any kind of 'representativeness'. The sample included so-called 'general population' groups such as five women whose children attended the same play group, a team of civil engineers working on the same site, and six members of a retirement club. It also included some groups who might be expected to have particular perspectives on AIDS – groups such as prisons officers, male prostitutes, IV drug-users and lesbians.

We chose to work with pre-existing groups – clusters of people who already knew each other through living, working or socialising together. We did this in order to explore how people might talk about AIDS within the various and overlapping groupings within which they actually operate. Flatmates, colleagues, family and friends – these are precisely the people with whom one might 'naturally' discuss such topics, at least in passing, and these are major sites of 'collective remembering' (see Middleton and Edwards 1990). Although the practice of using existing friendship groups is discouraged by standard market research texts such wariness seemed unjustified in our case. By using pre-existing groups we were sometimes able to tap into *fragments* of interactions which approximated to 'naturally occurring' data (such as might have been collected by participant observation). The fact that research participants already knew each other had the additional advantage that friends and colleagues could relate each other's comments to actual incidents in their shared daily lives. They often challenged each other on contradictions between what they were *professing* to believe and how they actually behaved (e.g. 'how about that time you didn't use a glove while taking blood from a patient?' or 'what about the other night when you went off with that boy at the disco?').

Above all it is useful to work with pre-existing groups because they provide one of the social contexts within which ideas are formed and decisions made. Khan and Manderson recommended the explicit use of such informal as well as formal 'focus groups' for anthropological research into understandings of health and illness in village settings. They worked with groups composed, for example, of a woman, her daughter, daughter-in-law and unrelated immediate neighbours. 'Such natural

clustering of people' they point out, 'represent, in a loose fashion, the resources upon which any member of the group might draw [. . .] [for] information and advice. This is a group that may weave or repair nets together, while watching over children and discussing the events of the previous day. It is precisely this natural social network which provides the scripting for the management of an illness event – what to do with a child with bloody diarrhoea, for example; or how to nurse high fever; or who to call in the case of threatened miscarriage' (Khan and Manderson 1992:60). In the same way such 'natural clusterings' at work, social events or in the home (along with the mass media) provide part of the 'scripting' for people's response to AIDS in Britain.

It would be naive, however, to assume that group data is by definition 'natural' in the sense that it would have occurred without the group having been convened for this purpose. It is important to note that although, *at times*, the focus groups may approximate to participant observation the focus groups are artificially set up situations. Rather than assuming the group session unproblematically and inevitably reflects 'everyday interactions' (although sometimes it will) the group should be used to encourage people to engage with one another, verbally formulate their ideas and draw out the cognitive structures which previously have been unarticulated.²

Running the focus group sessions – maximising interaction between participants

Perceiving the research session as a forum within which ideas could be clarified rather than simply as a 'natural event' influenced the ways in which we chose to run the groups. Sessions were conducted in a relaxed fashion with minimal intervention from the facilitator – at least at first. This allowed the facilitator to 'find her feet' and permitted the research participants to set the priorities. However, the researcher was never passive. Trying to maximise interaction between participants could lead to a more interventionist style: urging debate to continue beyond the stage it might otherwise have ended, challenging people's taken for granted reality and encouraging them to discuss the inconsistencies both between participants and within their own thinking.

The facilitator also employed several group exercises. At the start of the session, for example, participants were asked to play 'the news game' which involved dividing into two small 'teams' and writing their own news bulletin using a pre-selected set of photographs taken from actual TV news bulletins. Later they were presented with a pack of cards bearing statements about who might be 'at risk' from AIDS and asked, as a group, to sort the cards into different piles indicating the degree of 'risk' attached to each 'type of person'. Such exercises involve people in work-

ing together with minimal input from the facilitator and encourage participants to concentrate on one another (rather than on the group facilitator) during the subsequent discussion. The card game also encourages everyone to talk as each participant reads out a statement in turn and the material existence of the cards seemed to embolden some people. Seeing the card physically placed under the 'wrong' category makes the dissenting individual twitch – often they have reached out and moved the card even before they have been able to articulate their dissent. Once having done so the onus is upon them to explain their reasoning. Transferring key statements onto large cards which have to be placed in different piles by the research participants is a useful technique which can be adapted to many different situations. For example, I have used the 'card game' with peace campaigners (asking them to sort statements about gender and violence into different 'agree'–'disagree' categories); old people in residential care (assigning degree of importance to different statements about the quality of their care) and with midwives (describing how they saw their professional role). The cards can carry statements about opinions, descriptions of people, accounts of events or even pictures. The categories into which these cards are to be sorted may range from degree of agreement or importance, to the perceived health risk attributed to a certain activity. The 'cards' can even be advertisements – with the group being asked to order them according to different criteria – such as 'offensiveness' or 'effectiveness'. The final layout of the cards is not important – it is the process of getting there which is revealing.

Such exercises not only provided invaluable data from each group but allow for some cross-comparisons *between* groups. Each discussion session has its own dynamic and direction – when it comes to analysis it is extremely useful to have a common external reference point such as that provided by the card game or the use of vignettes (Khan and Manderson 1992). At the very least such exercises served as a 'party game': 'warming up' participants and encouraging them to engage with one another. Unfortunately some people, of course, do not like party games and at worst such games could make people feel uncomfortable and reminded some research participants of school lessons!

Whether or not we were always successful our intentions were to encourage interaction between research participants as much as possible. When group dynamics worked well the co-participants acted as co-researchers taking the research into new and often unexpected directions and engaging in interaction which were both complementary (such as sharing common experiences) and argumentative (questioning, challenging, and disagreeing with each other). The following discussion explores the advantages of focus groups under these two headings of 'complementary' and 'argumentative' in order to examine how both the *similarities* between group participants, and their individual *differences*, contribute to the data collection process.

Complementary interactions: the importance of the shared culture

Group work is invaluable for 'grounded theory development – focusing on the generation rather than the testing of theory and exploring the categories which the participants use to order their experience (Glaszer and Strauss 1967). How do researcher participants think about 'risk', for example, and what criteria do they use to evaluate the threat posed by HIV (Irwin et al. 1991), hazardous waste (Desvousges and Smith 1988) or the factors influencing one's susceptibility to heart attack (Morgan 1988).

Group work ensures that priority is given to the respondents' hierarchy of importance', *their* language and concepts, *their* frameworks for understanding the world. In fact, listening to discussions between participants gives the researcher time to acclimatise to, for example, their preferred words for speaking about sex and prevents the researcher from prematurely closing off the generation of meaning in her own search for clarification. Take the following exchange between two research participants within one group:

LL1: I remember an AIDS advert with a huge tombstone thing

LL2: Oh, you mean the advert where they abseil down

LL1: That's right, the one that looks like a Benson and Hedges cigarette advert [Lesbians, group 1]

The exchange between the research participants not only allows the researcher to understand which advertisement they are talking about but to gather data on their shared perception of that image.

The fact that group participants provide an audience for each other encourages a greater variety of communication that is often evident within more traditional methods of data collection. During the course of the AIDS project group participants argued, boasted, made faces at each other, told stories and on one occasion, sang songs. Group work is characterised by teasing, joking and the kind of acting out that goes on among peers. For example, some participant acted out the 'look' of an 'AIDS carrier' (contorting their faces, squinting and shaking) and others took evident delight in swapping information about the vast quantities of saliva one would need to drink before running any risk of infection. (You'd need to swallow 'six gallons', 'eight gallons', 'ten gallons or 'bathe in it while covered in open sores'.) Brainstorming and loose word association was a frequent feature of the research sessions. In several groups any attempt to address the risks HIV poses to gay men were drowned out by a ritual period of outcry against homosexuality:

ITM: Benders, poufs

ITM: Bent bastards

ITM: Bent shops

ITM: they're poufs, I mean I don't know how a man could have sex with another man it's . . .

ITM: It's disgusting [. . .]

ITM: Ah, Yuk!

A certain amount of similar 'brain-storming' accompanied discussion of the idea that 'AIDS comes from Africa':

ITF: Look at all the famine over there, all the disease coming off the dead cows and all that, they die and all that

ITM: Dirtiness

ITM: Filthy

ITF: Blackness

JK: Blackness? what about it?

ITM: It's black

ITF: Black, Blackness, its black, that's what I mean its dirty

ITM: It's just disgusting. [Young people in intermediate treatment]

These sorts of interactions can make groups seem unruly (both at the time and when attempting to analyse the data) but such 'undisciplined' outbursts are not irrelevant or simply obstructive to the collection of data about what people 'know'. On the contrary, the enthusiasm with which some people acted out 'the look of an AIDS carrier' vividly demonstrates the voyeuristic fascination of 'the Face of AIDS' and the way in which some media images are reproduced, reinforced and reiterated through social interaction. The relish with which people swapped information about the vast quantities of saliva needed to pose any risk of infection highlights the potency of the 'yuk' factor in helping them to recall certain 'facts' about AIDS and suggest the potential of harnessing peer communication. The outcry provoked by any mention of homosexuality and the loose word-association about 'blackness' reveal an essential element in how people think about AIDS among gay men or in Africa. They form part of why some people believe that gay men (and lesbians) are inherently vulnerable to HIV or why they so readily accept that Africa is a hotbed of HIV infection (Kitzinger and Miller, 1992.)³ Tapping into such variety of communication is important because people's knowledge and attitudes are not entirely encapsulated in reasoned responses to direct questions. Everyday forms of communication such as anecdotes, jokes or loose word association may tell us *as much*, if not *more*, about what people 'know'. In this sense focus groups 'reach the parts that other methods cannot reach' – revealing dimensions of understanding that often remain untapped by the more conventional one-to-one interview or questionnaire.

In addition to the advantages discussed above focus groups facilitate the collection of data on group norms. Often a particular phrase will mobilise an assertion of group consensus. A group of mothers, for

example, discussing whether they had the 'right' to know if another child in the play group had the virus asserted that 'you think of your own first'. It was this phrase, and these sort of sentiments, which seemed to capture their consent and resulted in nods of agreement round the group and assertions that 'that's right' and 'of course'. Indeed, it was often the strength of the collective reaction that highlighted the specific context within which the research participants experienced AIDS information. When I asked one group of young women whether they had ever come across the advice that they could 'try sex which avoids penetration' they responded with initial bemusement followed by spontaneous protest: 'If you really wanted to prevent it everyone would end up locked in their house'; 'Its sort of saying don't bother having sex, don't bother even going out in the first place', 'It's [saying that sex is] a lost cause!' [School students].

This apparently unanimous agreement underlined the extent to which young heterosexual women may experience such safer sex recommendations in terms of prohibitions. Advice to avoid penetration is seen as yet more constraints on, and attempts to control their sexual expression. They do not perceive it as an invitation to explore other avenues of pleasure as suggested by some optimistic health educators and feminist writers. Their rejection of non-penetrative sex drew attention both to the style and context of such safer sex advice and to what Fine calls 'the missing discourse of desire' (Fine 1988). This is not to say that on an individual level these women might not find most pleasure in what they would call 'foreplay' – a 'subjective' experience that might be more easily tapped by interview – but the very lack of public discourse about this contributes to the difficulties women face when attempting to establish the validity of such experiences or to secure safer sexual practices with men.

The downside of such group dynamics is, of course, that the group may censor any deviation from group standards – inhibiting people from talking about certain things. Observation of how group members interacted certainly highlighted the potential stigma some groups attached to 'knowing too much' about AIDS. In several groups if one person revealed detailed information about how HIV was transmitted they were met with suspicion and cries of 'How come you know so much about this?' Ironically, in the context, ignorance can, it seems, earn more respect than interest or knowledge – a fact which, in itself, is important to confront. There were also certain items of personal information which research participants on the AIDS project were sometimes prepared to confide to the researcher – in person or via their questionnaire – but were *not* prepared to reveal to the group as a whole (e.g. being gay, having been raped, or having a bisexual husband). When using groups it is important to consider what information may be censored by particular group compositions. 'Minority' (female/black/gay) voices are muted within 'majority'/'general population' groups.

However, it should not be assumed that groups, by definition, are inhibiting relative to the supposed 'privacy' of an interview situation. In fact, depending on their composition groups can sometimes actively facilitate the discussion of otherwise 'taboo' topics because the less inhibited members of the group 'break the ice' for shyer participants or one person's revelation of 'discrediting' information encourages others to disclose. For example, when one group member revealed that needles were often left lying around in her block of flats another woman said that she experienced the same problem. She added that she would not usually volunteer such information because: 'you don't want folk to know it goes on in your bit' and it is not the sort of information you reveal to an 'outsider' [Residential group]. In another case the researcher was unable to persuade one woman to explain what she was thinking, and it was only the timely intervention of her friends that helped to clarify what was going through her mind. The extract reproduced below occurred after the researcher had shown the group an image from a particular advertisement. One participant, Gail, had immediate associations with the image – associations which I was at a loss to understand. However her friends, Tessa and Brenda caught on very quickly to what she was thinking and helped her to articulate it:

JK: Can any of you imagine what this means? What the slogan underneath might be?

Gail: [bursts out laughing, hides head in hands, suddenly Tessa joins in]

Gail: I'll say nothing! Oh, Brenda don't make me laugh

JK: Are you making up fantasy slogans for it in your head?

Gail: No, no, no! [pause]

JK: Can you imagine what it might say?

[laughter, followed by silence]

JK: Gail, please tell me!

Gail: No, no, no [laughter] don't make me laugh

JK: Please!

Gail: I don't know

JK: Would you be happier writing it down?

Gail: No! [all laugh] It just makes me think of things . . .

Tessa: What, are you thinking of? Oral sex?

Gail: Yes, that's right! [Cleaners]

Not only do co-participants help each other to overcome embarrassment but they can also provide mutual support in expressing feelings which are common to their group but which they might consider deviant from mainstream culture (or the assumed culture of the researcher). This may be particularly important when working with those who are oppressed or marginalised such as, in our case, drug users, and male prostitutes. Some writers seem to assume that focus groups are inappropriate for researching 'sensitive' topics or when working with 'sensitive'

research populations but in fact the opposite may be true.⁴ It is worth noting that focus groups have successfully been used to elicit data from people who are perceived by researchers as, by definition, 'difficult subjects' e.g. 'difficult-to-reach, high-risk families' (Lengua et al. 1992) and 'high apprehensives' who are anxious about communicating (Lederman 1983).⁵ Not only does safety in numbers make some people more likely to consent to participate in the research in the first place ('I wouldn't have come on my own') but being with other people who share similar experiences encourages participants to express, clarify or even to develop particular perspectives. Groups may be particularly useful when one wishes to gain access to critical comments from groups such as pregnant women, who tend to be 'grateful' and complementary about the services on offer. Some researchers have noted that group discussions can quickly become 'a collective "moan session"' as 'conversation seemed to feed on the climate of depreciation created' (Watts and Ebbutt 1987:31) and Geis and his colleagues, in their study of the 'lovers of AIDS victims', found that: 'The group meeting experience evoked more angry and emotional comments about the medical community than did the individual interviews . . . perhaps the synergism of the group "kept the anger going" and allowed each participant to reinforce another's vented feelings of frustration and rage . . .' (Geis et al. 1986:48). Group work is invaluable in enabling people to articulate experiences in ways which break away from the clichés of dominant cultural constructions. This may be particularly important for medical sociologists who are often working with people who share stigmatised or 'taboo' experiences (e.g. bereavement, mental illness, infertility, cancer).

To sum up, many authors write as if the impact of the group on the expression of individual points of view is a purely negative, inhibiting or distorting factor. In so far as such criticisms are accurate, they need not be seen as a problem. Even if the group does 'censure' certain types of information this does not invalidate the data from the group session: people do not operate in a social vacuum, knowing what is (and is not) expressed in a group context may be as important as knowing what is expressed in a confidential, one-to-one interview. (And if one wishes to explore this further one can, of course, use a *combination* of such methods). In any case it is unjustified to make such generalisations about group work. Most authors who draw such conclusions are actually making assumptions on the basis of working with only one type of group configuration (such as groups comprised entirely of strangers, or 'family units' or work colleagues). Our research, conducted with a variety of group types, makes such assumptions impossible. The AIDS Media project data demonstrate that groups may actually *facilitate* the expression of difficult or taboo experiences. Instead of generalising about the effect of 'groups' we need to pay close attention to the *composition* of groups and how the characteristics of any *particular* group may influence what is

said. We can then explore what this tells us about social pressures and the construction and the communication of knowledge.

Argumentative interactions: the importance of difference

The group process however, is not only about consensus and the articulation of group norms and experiences. Differences between individuals within the group are equally important and, in any case, rarely disappear from view. Regardless of how they are selected, the research participants in any one group are never entirely homogenous. Participants do not just agree with each other they also misunderstand one another, question one another, try to persuade each other of the justice of their own point of view and sometimes they vehemently disagree.

During the course of the group the facilitator can explore such differences of opinion and encourage the participants to theorise about why such diversity exists. In our 'pre-existing groups' people were sometimes surprised to discover how differently they thought about some things especially when the group otherwise appeared relatively homogeneous (e.g. by gender, race, and class). Such unexpected dissent led them to clarify why they thought as they did, often identifying aspects of their personal experience which had altered their opinions or specific occasions which had made them re-think their point of view. Had the data been collected by interviews the researcher might have been faced with 'arm-chair' theorising about the causes of such difference but in a focus group these can be explored 'in situ' with the help of the research participants.

The difference between participants also allows one to observe not only how people theorise their own point of view but how they do so in relation to other perspectives and how they put their own ideas 'to work'. This process in itself clarifies what people are saying. In both questionnaires and in individual interviews it is easy to assume that someone is giving the 'right' answer for the right reason. However, diversity within a group ensures that people are forced to explain the reasoning behind their thinking just as much when they give the 'right' answer as when they give the wrong one. For example, in several groups research participants asserted that 'you can *not* tell by looking who has HIV'. However, when challenged by other members of the group, several people justified this point of view by saying that it was simply impossible to distinguish between someone who has HIV anti-body positive and someone who looked ill for some other reason (such as having flu or 'ordinary' cancer).

Close attention to the ways in which research participants tell stories *to one another* also prevents the researcher from assuming that she knows 'the meaning' of any particular anecdote or account. During the course of the group session the researcher witnesses how such stories actually

operate in a given social setting, how they are mobilised in social interaction, what ideological work they are employed to achieve. For example groups members often enthusiastically shared tales about the 'vengeful AIDS carrier' who sleeps with an unwitting stranger and departs leaving the message: 'Welcome to the AIDS club'. A health educator commenting on this phenomena suggested that such tales could do more for the prevention of HIV transmission than all the health education campaigns put together (*Guardian* 30.10.91). If such stories do serve such functions it is certainly not all they do: in our 'general population' groups such tales were *not* often used to advise people to take precautions during sex with anyone – instead they were used to justify identifying and isolating 'AIDS carriers'.

People's different assumptions are thrown into relief by the way in which they challenge one another, the questions they ask, the evidence people bring to bear on an issue, the sources they cite, and what arguments seem to sway the opinion of other members of the group. When analysing the script of a group discussion it is well worth having special coding categories for certain types of interaction between participants such as 'question', 'cited sources', 'deferring to the opinion of others' and 'changes of mind'. When one person tells an anecdote or relates the plot of a TV programme, what line of questioning do the other members of the group pursue in order to decide, for instance, whether a particular person described in a story really is an 'innocent' victim of AIDS? When one participant describes an occasion when they think they might have put themselves at risk – what queries are raised by the co-participants or how do they seek to reassure their friend? When an argument breaks out, what sort of evidence seems to 'work' in influencing the opinion of others? And what is going on when people appear to change their minds in response to information or theories presented by co-participants. For example in one group there was a great deal of initial scepticism about the view that HIV was created in a laboratory but a story told by one of the other members of the group shifted the consensus:

PP: 'My-holier-than-thou mother-in-law to put it politely, keeps informing me that it was a man-made disease . . .'

PP: 'Well my brother works in a lab [. . .] in America and when that all came out that it was a man-made virus I wrote and asked him and his letter was censored, what he answered to me was all blanked out [. . .] That made me think, "aye, it is a man-made thing, there's something in that. Why should they blank out his letter?" [. . .]

JK: What do the rest of you think of this story?

PP: It makes it more probable

PP: It makes me think it could be the way it started

PP: There must be something [Women with children attending same playgroup]

This interaction was typical of many of the 'turning points' in the groups. People commonly appeared to change their minds in response to 'personal' evidence based on anecdotes or the perceived behaviour of professionals rather than information from leaflets or advertisements and there was a clear 'hierarchy of credibility' in operation between different types of sources (mothers-in-laws coming rather low down on the list in Western culture!).

Finally, one can also observe how language and forms of speech may facilitate or inhibit communication. For example there is a theory that if people's vocabulary does not contain the term 'HIV' they may be unable to comprehend the distinction between the symptom-free state of being HIV anti-body positive and the diagnosis of AIDS. This did not prove to be the case. Data from the AIDS Media Research Project show that people could understand the distinction without possessing the accurate medical language (and vice versa). However there was some evidence to suggest that if people do not have (or do not *use*) different words to identify HIV and AIDS they may have difficulty communicating the distinction to others. This is clearly illustrated by one brief extract from a tangled dispute between Alec (who knows the difference between being a 'carrier' and 'actually having the disease') and Kenny:

Alec: You can be a carrier or you can actually have the disease. [. . .]

Kenny: How can you carry something and not have it. Say you're carrying a shopping bag – you've got it.

Alec: It could be someone else's. You're just carrying it and you can pass it on to someone else. [. . .] A picture that I saw on the TV, she was a carrier she gave it to her baby, she didn't actually have it.

Kenny: How can you give somebody something that you've not got?

Alec: You're carrying a shopping bag, but it might not be actually your shopping bag.

Kenny: How can you give somebody something if you've not got it, for God's sake man, wake up, come off the mind expanding drugs please Alec. [School students]

The debate quickly became confused by the lack of linguistic specificity. Both boys resort to terms such as 'carrying it' and 'having it' and the discussion became hopelessly side-tracked by an inappropriate metaphor. This is actually a condensed extract of a much lengthier interchange between the two boys – they were unable to resolve their differences and the debate ended with a scornful Kenny declaring: 'I'm not arguing any more'. Such interactions help researchers to identify the precise influence of particular words or phrases and are invaluable when attempting to design or improve health education or other intervention strategies.⁶

Conclusion

Focus groups do not easily tap into individual biographies or the minutia of decision making during intimate moments, but they do examine how knowledge and, more importantly, ideas both develop, and operate, within a given cultural context. As such focus groups are perfect for 'filling in the gaps' so often exposed by KAP surveys and are ideal for inductive approaches aimed at generating concepts and hypotheses which, as Mullen and Reynolds point out, may have far more potential for health education research, theory and practice than the dominant deductive models (Mullen and Reynolds cited in Basch 1987:435).

To sum up, this paper has argued for the overt exploitation and exploration of interactions in focus group discussion. There are, it has been suggested, 10 main advantages to be gained from the interaction between participants. Such interaction:

- highlights the *respondents'* attitudes, priorities, language and framework of understanding
- encourages a great variety of communication from participants – tapping into a wide range and form of understanding
- helps to identify group norms.
- provides insight into the operation of group/social processes in the articulation of knowledge (e.g. through the examination of what information is censored or muted within the group)
- Can encourage open conversation about embarrassing subjects and facilitate the expression of ideas and experiences that might be left underdeveloped in an interview

Through detailed attention to the interaction between different members of the group a researcher can:

- explore difference between group participants in situ with them and, because, participants reflect upon each others ideas, ensure that the data is organic/interconnected.
- use the conflict between participants in order to clarify why people believe what they do. Examine the questions that people ask one another in order to reveal their underlying assumptions and theoretical frameworks.
- explore the arguments people use against each other, identify the factors which influence individuals to change their minds and document how facts and stories operate in practice – what ideological work they do.
- analyses how particular forms of speech facilitate or inhibit peer communication, clarify or confuse the issue (in ways directly relevant to improving communication).

This article is *not* arguing that the group data is either more or less 'authentic' than data collected by interviews; instead it is based on the premise that 'all talk through which people generate meaning is contextual, and that the contexts will inevitably somewhat colour the meaning' (Dahlgren 1988:292). It is a predictable sign of the dominance of the interview paradigm that when researchers have found differences between data collected by interviews and group discussion they have sometimes blithely dismissed the latter as 'inaccurate'. Hoijer, for example, is one of the few authors critically to address both interviews and group discussions. She used both techniques in her study of audience understandings of television programmes. However, at one point she states that 'Comparing interpretations and opinions expressed individually with what is later said in a group discussion, there are always several cases of diversion. In fact, too many to permit taking *the group discussion* as a valid basis for audience interpretations and reactions' (Hoijer 1990:34, my emphasis).

But difference between interview and group data can not be classified in terms of 'honesty' and 'dishonesty' or 'truth' versus 'falsehood'. Comparing the effects of different methodologies when talking to heterosexual men about sex, for example, some researchers have noted that these research participants are more likely to express macho attitudes (with a male researcher) or to sexually harass (a female researcher) in group settings than in individual interviews (Wight in press; Green et al. in press). The group data documenting macho or sexual harassing behaviour is no more 'invalid' than that showing the research participants' relatively acceptable behaviour in interview situations. Instead of disregarding data from group settings we need to acknowledge the different types of discourses that may be expressed in the 'private' and 'public' arena, or with peers versus with an interviewer. The fact that particular groups facilitate the articulation of particular kinds of perspectives can then be consciously addressed and the importance of that context can be considered.

We are none of us self-contained, isolated, static entities; we are part of complex and overlapping social, familial and collegiate networks. Our personal behaviour is not cut off from public discourses and our actions do not happen in a cultural vacuum whether that is negotiating safer sex, sharing needles, attending for a smear test or going 'queer bashing'. We learn about the 'meaning' of AIDS, (or sex, or health or food or cigarettes) through talking with and observing other people, through conversations at home or at work; and we act (or fail to act) on that knowledge in a social context. When researchers want to explore people's understandings, or to influence them, it makes sense to employ methods which actively encourage the examination of these social processes in action.

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Notes

- 1 The questionnaire provided data on each participants' attitudes and beliefs prior to the group discussion – allowing for some comparison between initial, individual responses and later group responses (for a discussion of the differences see Kitzinger, in press). Completion of questionnaires also helped to maximise subsequent debate and to encourage research participants to express their own point of view because, as other authors have noted, 'the process of writing things down reinforces a person's commitment to contributing them to the group, even in the face of apparent disapproval' (Morgan 1988, 58, Greenbaum 1987).
- 2 This paper does not address the relative merits of focus groups as opposed to participant observation. Although I was informally involved with some of the groups prior to the start of sessions (e.g. joining them in preparing a meal or sitting through the end of their business meeting) I do not have any way of systematically comparing such methods from this study. I agree with Morgan, however, when he suggests that focus group are particularly suited to the study of attitudes and cognition whereas participant observation may be more appropriate for studies of social roles and formal organisations (Morgan 1988, 17).
- 3 Such racist and heterosexist comments raise ethical dilemmas for any researcher. These may be particularly acute for the group facilitator if such comments are directed at other members of the group and take the form of bullying or intimidation. Such ethical problems can be addressed through (a) thinking about the composition of the groups prior to running any such sessions and (b) using dissent within the group to challenge and debate such attitudes. Looking through the transcripts it is also clear that, on a few occasions, I simply intervened to silence discussion, or at least 'move it along' because of my own discomfort with what was being said or the perceived discomfort of other members of the group.
- 4 I suspect that gender is one of the factors influencing both researchers' and research participants' reactions to group work. Women, unlike most men, have a well established tradition of sharing 'personal' information with other women and it is no coincidence that many self help and therapeutic techniques, not to mention, consciousness raising, are based on group work. Many so-called 'personal' topics have been very successfully explored by female researchers through group discussions with women (see, for example, Haug, 1983).
- 5 Group work can, however, discriminate against people with communication disabilities. Working on a study of residential care for the elderly I excluded at

least one potential group participant on the basis that it required my full-attention, and frequent repetition, to follow what he was saying and he became extremely agitated when I failed to understand. It was also clear within the subsequent focus groups that if each person had a different disability this could compound each of their communication difficulties. For example, deafness, dementia and partial paralysis made it difficult for three members of one group to sustain any sort of conversation with each other, although each could communicate with me. On the other hand it was also true that some of the old people who might have been unable to sustain a one-to-one interview were able to take part in the group contributing intermittently. Even some apparently 'unresponsive patients' eventually responded to the lively conversations generated by their co-residents. Considerations of communication disabilities should not rule out group work, but must be considered as a factor.

- 6 Medical sociologists and health educationalists often emphasise the importance of 'peer communication' and the 'community environment' and it is clear that group-based intervention programs may be more effective than those targeted at individuals (see Basch, 1987 pp 412-3). It is this understanding that has led some researchers to argue that focus groups are 'indispensable to translating behavioural theories into effective prevention programs in a given setting' (Valdiserri 1989). Uncovering people's own 'models of rationality' and understanding their perspective 'is integral to achieve a key goal of health education - empowerment - and focus group interviews are an appropriate method for understanding and developing sensitivity toward those we serve' (Basch 1987, 436).

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