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Developing an Interpretative Phenomenological Approach to Focus Group Data

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Interpretative phenomenological analysis (IPA) is an approach to qualitative research that is now well-established in British psychology. This approach is concerned with understanding people’s experiences of the world and of themselves. The aims of IPA studies have been met most frequently through the use of one-on-one interviews. Relatively few studies have used focus group discussions as the basis for IPA studies, but focus groups may provide rich experiential data. In this article, we describe a process for integrating focus group data into an IPA study. We developed this during a study of the experiences of carers of people with mental health problems. Here we outline the various steps of our analytic process and discuss how these might be employed and adapted by other researchers wishing to apply IPA’s concern with personal experience to the analysis of focus group data.

Keywords: experiential; group discussions; group interviews; IPA; positionality

Introduction

Interpretative phenomenological analysis (IPA) is an approach to qualitative research that is now well-established in British psychology (Brocki & Weardon 2006; Larkin, Watts & Clifton 2006; Reid, Flowers & Larkin 2005; Smith 2004). IPA researchers have taken an eclectic approach to phenomenological inquiry and have drawn variously on Giorgi (Smith 1996), Heidegger (Larkin et al. 2006; Smith 2007), Solomon, Merleau-Ponty, and Van Manen (Eatough & Smith 2006a, 2006b), Gadamer and Schleiermacher (Smith 2007) to articulate the conceptual underpinnings of the approach. These sources share a commitment to the hermeneutic understanding of people’s experiences and to situating their concerns in the context of the lived world. Thus, the aim of IPA is to understand and make sense of another person’s sense-making activities, with regard to a given phenomenon, in a given context.

In published studies, the contextual dimension of IPA has usually been no more than an implicit aspect, but it is an integral part of hermeneutic phenomenology. In these terms, person and world are not separate but instead are co-constituting and mutually disclosing. IPA is a flexible approach allowing for researchers to work with a range of emphases, and the general preference for a low-level explication of contextual matters has not been especially problematic. In part, this is because the aims of IPA studies have been met most
frequently through the use of one-to-one interviews. Sometimes, participants have been interviewed more than once (e.g., Clare 2002), and sometimes a number of interviews have been carried out with individuals “around” a single case (e.g., Murphy, Larkin & Rostill 2006). Relatively few studies have used group interviews or focus group discussions as the basis for IPA studies (Reid et al. 2005). However, these studies continue to appear (e.g., de Visser & Smith 2007), and several commentators have noted the need for some further examination of the compatibility of IPA with group-generated data (e.g., Langdridge 2007; Smith 2004). In this article, we aim to offer some examination of this issue. We will do this by describing and reflecting upon a process that we developed for integrating focus group data into an IPA study in order to solve a practical research problem of our own.

IPA and Individual Interviews

There are good reasons underlying IPA’s preference for in-depth individual interviews. IPA is best suited to forms of data collection which invite participants to articulate stories, thoughts, and feelings about their experiences of a target phenomenon (Smith 2004). This suits the approach’s idiographic commitments, allowing for rapport to be developed, and for one person’s understandings to be explored in considerable detail. Also, because IPA focuses principally upon the experiential claims and concerns of the participant rather than on discursive action, interviews do generally limit the scope of the communicative action to an exchange between one researcher and one respondent. Of course, this does not mean that the remaining social interactive elements are negligible, but it does make them more manageable, and thus more easily allows for an experiential focus to remain central (see Smith 2005).

IPA and Focus Groups

Focus groups may be less obviously suitable for IPA researchers because they offer a considerably more complex interactional environment. However, they have been employed in published IPA work. Occasionally this has involved some form of focus-group-interview hybrid. For example, MacLeod et al. (2002) interviewed “family units” presenting at a consultation. More commonly, the familiar format of a “facilitated group discussion” has been employed (e.g., de Visser & Smith 2007; Dunne et al. 2001; Flowers et al. 2000; Flowers et al. 2001). In each case, the standard IPA approach of bottom-up analysis, grounded in accounts of experience, was employed.

Focus groups can be attractive because they allow multiple voices to be heard at one sitting, drawing a larger sample into a smaller number of data collection events. There are also situations in which researchers may want to engage with a naturally occurring group (such as a team, family, friendship group, or support group) as a group and from an experiential perspective. Indeed, in some situations, a group discussion may elicit more experiential reflection than a one-to-one interview. For example, Flowers et al. (2001) suggest that rather than diluting accounts of personal experience, the group dynamics in their study added something extra to their analysis which would otherwise have been missed (see also Wilkinson 2003). However, the presence of multiple voices, the complexity of their individual and shared contexts, and the interactional complexity of the discussion itself do make it more difficult to infer and develop personal, phenomenological accounts. This is because in focus group settings any experiential claims, narratives, or reflections are likely to be nested within a fairly complex set of social and contextual relationships.
The accounts offered during such events are likely to be shaped not only by the researcher’s questions and reactions but also by the degree of shared experiences among participants, the nature of pre-existing relationships, the sensitivity or privacy of the subject matter, the positions opened up and closed down by other participants’ contributions, and the developing dynamic of the interaction itself. Smith (2004) noted that the successful use of focus groups requires some recognition of the problems involved in applying experiential analyses to more complex social activities. In all likelihood, he notes, this will involve approaching the analysis twice: “once for group patterns and dynamics and subsequently, for idiographic accounts” (Smith 2004, p. 50).

The protocol outlined in this article is offered as a springboard to help IPA researchers prepare to deal with some of the synergistic effects of working with groups and to permit both the experiential and interactional elements of focus group data to be explored side-by-side. In working through the steps of the protocol with our data, we hoped to develop a meaningful analysis of the patterns in our participants’ lived experience while acknowledging the wider socio-cultural factors involved in accessing their stories in this way.

The Meriden Programme

The Meriden Programme works closely with NHS Trusts providing mental health care across the West Midlands. It promotes and implements family-sensitive services and raises awareness of carers’ issues. The study reported here draws upon a Meriden-based project, which aimed to understand local mental health services from carers’ perspectives (Palmer, Larkin & Fadden in preparation).

Our encounter with the problem of focus groups and IPA was a pragmatic one. The first author inherited a large corpus of focus group data from her predecessors on the project. When we reviewed these data together, we were presented with a dilemma. The participants were the carers of people with mental health problems, and they were recorded in their extant support groups, in sessions that were each facilitated by two (of five) employees of the Meriden Programme. The participants’ discussions were littered with narratives and reflections that offered extraordinarily powerful, rich, and illuminating insights into their relationships with services and with their family members. However, these personal accounts were clearly embedded in a complex set of dynamics, some novel (responses to the facilitator’s style or agenda), and some presumably well-established (relationships with peers in the support group). We felt it was important to engage with the experiential accounts, and IPA seemed the ideal approach for this. On the other hand, we could not ignore the constitutive features of the interactive and social context of these discussions. A discursive analysis would certainly have accommodated the interactive aspects but would also have negated the centrality of the experiential components. As a result, we set out to develop a set of more socially situated, interactively aware coding practices, alongside the standard analytic processes for IPA. These took the form of a series of questions to ask of the data. We formulated these questions primarily in response to those features of the data which struck us as important. However, in identifying them as important, we were inevitably drawing on insights from a variety of systemic, narrative, discursive, and critical psychologies (e.g., Crossley 2000; Dallos & Draper 2000; Parker 1992; Wetherell, Taylor & Yates 2001a, 2001b; Willig 1999). It is important to acknowledge that there are some epistemological tensions here, but also that there are precedents for the resolution and accommodation of those tensions. For example, the experiential strand of narrative psychology (e.g., Bruner 1990; Crossley 2000) and the narrative strand
in phenomenological psychology (e.g. Langdridge 2007; Shaw 2004) both provide examples of theory and research which develop from a simultaneous interest in experience and the manner and context of its expression. Our approach here has been, wherever possible, to learn from the insights and practices of other approaches and to “translate” or “adapt” for epistemological coherence within the framework of a properly hermeneutic phenomenology (e.g., Langdridge 2003; Larkin et al. 2006). Hermeneutic phenomenology can accommodate such work because the defining quality of being-in-the-world, its central concept, is relatedness.

We developed this analytic process in the hope that we would be able to offer an account of our participants’ claims and concerns which kept the commonalities of their experiences at the centre of the analysis but which also accounted more explicitly for the context in which those claims and concerns arose. In phenomenological terms, the additional contextualising strategies that we adopted can be thought of as a complement to the practice of “bracketing,” or reflecting on one’s own knowledge and position (see Langdridge 2007). They share a similar aim in that they reveal the ground against which experiential understanding makes sense. However, while bracketing typically aims to reveal the analysts’ personal preconceptions, our strategies are intended to foreground the social context of the participants’ meaning making.

Note that what we offer here, then, is not some sort of “alternative discourse analysis.” Although our strategies owe some debt to the discursive psychologies, they have neither the powerful deconstructive outcomes nor the micro-analytic interactional focus typical of the main traditions in discursive work. What we offer instead is a means of accommodating some of the contextual elements of shared meaning making when in pursuit of an interpretative phenomenological account. This is consistent with the contextual and contingent sense of lived experience that emerges from writings in hermeneutic phenomenology (e.g., Glendinning 2007; Moran 2000a). From a Heideggerian perspective, we are “thrown” into an already existing world of language, objects, and relationships. Our being-in-the-world is always perspectival and always in-relation-to something. In this sense, hermeneutic phenomenological psychology offers its own distinctive view of our intersubjective, dialogical, and relational involvement in the world.

**Conditions of Data Collection**

Previous to the first, second, and third authors’ involvement, carers’ support groups were approached across the West Midlands region. Carers can be a “hard-to-reach” population, and this was seen as a good way of accessing sizeable, established groups of carers. For each of the support groups whose members agreed to take part in the study, Meriden researchers arranged a discussion session about participants’ general view of mental health services. Ethical approval for this study was granted by the West Midlands Multi-centre Research Ethics Committee, and participants gave written consent. In total, 55 people took part in five group discussions. Each group discussion was facilitated by two employees of the Meriden Programme: one assistant psychologist (who took part in all groups) and one of four clinical specialists (an experienced mental health professional). All recordings were transcribed verbatim by the first author. Transcripts were made at a broadly semantic level of detail standard for IPA (e.g., Smith & Eatough 2008).

The topic guide was not typical of the open-ended, loosely structured format usually favoured by qualitative researchers with an experiential focus (e.g., Mishler 1986; Smith 1995). Many of the questions were clearly driven by local pragmatic demands and tended to invite rather narrow information-gathering and service-evaluating responses. The story
of this research might have ended there, but as we shall see the participants’ responses often transcended the immediate focus of the questions they were asked.

**Development of Analytic Protocol**

The data were rich in experiential content, with participants sharing very detailed personal accounts of their caring experiences and of the impact on themselves and their families. For example, in the following extract, a carer describes a time when she had difficulty coping as a result of her son’s difficulties. The account is detailed and emotive and offers a good illustration of the lived experiences disclosed by participants across all of the focus groups:

“I sat on a car park one night, three o’clock in the morning, on my own, in tears, with my mobile phone, and I left him — ’cause he was on the drive — I drove off and he was chasing me down the road. I couldn’t cope with him. He was absolutely out of control and I thought, ‘What am I going to do? What am I going to do?’ Anyway, I phoned [my husband] and he said, ‘He’s gone now, I don’t know where he’s gone.’ We woke up in the morning and do you know where he was? He was by the bin in the back garden sleeping, and he just lay on the concrete and I felt so cruel. I mean, we didn’t know he was there, we thought he’d gone off.” (Female carer, Region 1)

Hopefully, the reader will now recognise the dilemma we described above: this account contains rich experiential data. In our attempts to address it, we embarked upon a process of exploratory coding and analysis with one of the transcripts, and as we worked we began to develop a structured set of questions to ask of the data, which was in turn refined and developed as it was applied to subsequent transcripts. This process of iteration took place over a long series of research meetings, which provided a forum for triangulation and discussion.

**Protocol**

The literature on analysis in IPA does not prescribe a single method for working with data. Instead, a set of common principles (e.g., moving from the particular to the shared and from the descriptive to the interpretative) are applied flexibly, according to the analytic task (see Reid et al. 2005). Typically, however, analysis is seen as an iterative and inductive cycle (Smith 2007), which proceeds by utilising:

- Reflection on preconceptions and processes (e.g., Smith 2007).
- Close, line-by-line analysis (coding) of the experiential claims, concerns, and understandings of each participant (e.g., Larkin et al. 2006), including close attention to language use.
- Identification of emergent patterns of commonality (themes) in this experiential material (e.g., Eatough & Smith 2008).
- A dialogue between the researchers and the data about what it might mean for participants to have these concerns in this context (e.g., Larkin et al. 2006; Smith 2004), which leads to the development of a more interpretative account.

In developing our ideas for working with these focus group data, we started out from these principles and extended them whenever we accounted a problem which appeared to require a new solution. The eight steps of the protocol that we subsequently developed are outlined in Table 1.
Table 1
Summary of protocol for using IPA with focus group data

1. Objects of Concern and Experiential Claims
   a. Pick out experiential claims and concerns as they appear in the transcript.
   b. Summarise these, and sort into emergent patterns.

2. Positionality
   a. Explore the role played by facilitators, keeping track of questions, permissions, encouragements, redirections, etc. (What is their perspective, stance, position?)
   b. Explore the function of statements made by respondents. (What is their perspective, stance?)

3. Roles & Relationships
   a. Examine references to other people: What roles and relationships are described? What sorts of meanings and expectations are attributed to these relationships?
   b. What are understood to be the consequences of these?

4. Organisations & Systems
   a. Examine references to organisations and systems: How are they described? What sorts of meanings and expectations are attributed to these?
   b. What are understood to be the consequences of these?

5. Stories
   Examine the stories told by participants: look at the structure; genre; imagery and tone. What does each story achieve? How do participants support or impede each other to share their experiences? What temporal referents exist?

6. Language
   Throughout stages 1–5, monitor language use, paying particular attention to use of metaphor, euphemism, idiom, etc. Consider:
   a. Patterns
      Repetition, jargon, stand-out words and phrases, turn-taking, prompting – are these identified in individuals or the whole group?
   b. Context
      Impact on language used; descriptions of feelings/emotive language; jargon and explanation of technical terms; impact of facilitator.
   c. Function
      How/why is certain language being used? (e.g. to emphasise/back-up a point, to shock, to provoke dis/agreement, to amuse/lighten the tone?)

7. Adaptation of Emergent Themes
   Return to the emergent themes from step 1b. and adapt them according to the work done subsequently. Answering the following questions will help:
   a. What experiences are being shared?
   b. What are individuals doing by sharing their experiences?
   c. How are they making those things meaningful to one another?
   d. What are they doing as a group?
   e. What are the consensus issues?
   f. Where is there conflict? How is this being managed/resolved?
Approach to Focus Group Data

8. Integration of Multiple Cases
Where more than one focus group has taken place, integrate work done with each to build up an overall analysis of the topic under investigation. Data should be checked to ensure sufficient homogeneity between focus groups to allow for successful integration. To draw the analysis to completion:

a. Pick out commonalities and stand-out differences between groups drawing out superordinate themes.

b. Frequently revisit the transcripts to check themes in relation to original claims made to help ensure accuracy.

c. Consider the analysis in the wider context of existing relevant theories, models and explanations.

Note that these steps evolved from engagement with these data. They may not be useful to other researchers if they are simply taken as a recipe “applied” to another data set. Instead, the steps in our process account are likely to be much more helpful if they are taken as prompts for reflecting upon those aspects of the data which require either more focused, or less obviously phenomenological, analytic work.

First, we explored our participants’ experiential claims and concerns. Alongside this, we began to develop a parallel commentary on the co-constructive qualities of these claims in the context of the group discussion. The emerging accounts (i.e., the main claims and how they had been made) were then contextualised, initially by focusing on the role of the facilitator (i.e., the immediate “research” context) and then by exploring participants’ relationships to various professionals and structural systems (i.e., the wider “professional and institutional” context). Aware that the groups had often used narrative as a vehicle for their claims, we also described the structures of the main stories that were told and examined the use of language within these stories. We then returned to the principal claims and concerns identified in step 1 and reframed them in accordance with the subsequent work. The final step was to integrate the themes identified across the different groups.

Each step will now be discussed in more detail using examples to demonstrate the process of analysis.

Step 1. What are Participants’ Main Objects of Concern?
What Experiential Claims Do They Make About Them?

To begin, we applied “standard” IPA practices. Here we aimed to identify the participants’ experiential claims and concerns. This means that we first set out to identify “objects of concern,” that is, anything that was important to the participants. We then explored the claims made about these objects. This is typical of the first order descriptive coding carried out in IPA studies using interview data. Thus we aimed to stay close to the participant’s own language, wherever we could, in both identifying objects and the meanings through which they were revealed. The claims and concerns were tracked systematically throughout the transcript and organised into a table for each transcript. At this stage we also began to note potential emergent themes. The example in Table 2 gives an indication of how the coded material was organised. The example, where two carers discuss inpatient staff, is based on the following short extract:

Table 1 (Continued)
Table 2
Step 1: Keeping track of experiential claims and identifying emergent themes

<table>
<thead>
<tr>
<th>Line</th>
<th>Object</th>
<th>Experiential Claims</th>
<th>Emerging theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>261*</td>
<td>Communication (N.B not ‘talk’)</td>
<td>“They won’t communicate ... they’ll talk between themselves but won’t communicate ... it’s ridiculous” - staff not talking to carers or service users</td>
<td>Lack of communication (LoC) with users and families: ridiculous</td>
</tr>
<tr>
<td>263</td>
<td>Communication</td>
<td>“If someone is sitting in the room, in a corner, sitting there twiddling their thumbs ... they will talk between themselves”</td>
<td>LoC: disrespectful</td>
</tr>
<tr>
<td>266</td>
<td>Communication</td>
<td>“This person is frightened because they’re ill” - service user being frightened because they are ill</td>
<td>LoC: frightening</td>
</tr>
<tr>
<td>267</td>
<td>Well-being</td>
<td>“It’s going to make that person worse” – lack of communication having a negative impact on their well-being</td>
<td>Well-being: Consequence of LoC: toxic</td>
</tr>
</tbody>
</table>

P1: They won’t communicate. They’ll talk, they’ll talk between themselves but they won’t communicate ... it’s absolutely ridiculous, they’ve got to communicate. I mean if someone is sitting in the room, in a corner, sitting there twiddling their thumbs, which they do, and they will talk between themselves

P2: And this person is frightened because they’re ill

P1: It’s going to make that person worse. It’s alright them sitting there talking about it rather than talking at or talking to . . .

P2: They sit outside the door at night, clicking pens.

(Extract from Region 2 Carers’ Support Group)

Here we can see that communication was an important object of concern for the carers. Its importance was made visible through the carers’ experiences of the absence of effective communication — in this case, between inpatient staff and service users. The meaning of this absence is at once ridiculous (implying that trained staff, in mental health services, of all people, should know better), frightening (for the service user who is left alone and excluded in the scenario they describe), and even actively toxic (to the well-being of the service user).

We can also see, quite simply but very clearly, the added complexity of focus group data. The scenario and its “ridiculousness” is established by Participant 1. In an interview, this might be as far as the participant would take this story, or it might be that from here it would be directed elsewhere, either drawing on that speaker’s own experiences or in response to an invitation or prompt from the interviewer. Here, however, Participant 2 picks up the thread and makes a significant shift from “ridiculous” to “frightening.” Participant 1 then draws the conclusion that “it’s going to make the person worse.”
It is evident then, that there are clearly additional interational aspects to focus group data, which require analytic strategies additional to ‘standard’ IPA. Yet something even more complex is occurring here, perhaps based on common experiences or the prior sharing of different experiences. In the co-constitution of this account, there is a powerful sense of experiential recognition between the two speakers: an intersubjectively consonant perspective on the scenario as they describe it. This is evoked in the collaboratively-developed detail of the account and most strikingly in the observation that the staff “sit outside the door at night, clicking pens.” The apparently familiar and shared nature of many participants’ experiences, in exchanges like this one, suggested to us that persistence with an experiential focus was justified.

**Step 2. What are Participants’ and Facilitators’ Positionalities?**

To sustain and protect the experiential content of the data, we had to contextualise them. We began to do this by turning our attention to the interactional stance of the various speakers. This involved a move away from standard IPA. Employing the concept of ‘positionality’ (see Box 1) which has been used to capture the phenomenological concept of orientation to and involvement in the lived world (de Monticelli 2007), we worked through the transcripts again, this time asking ourselves: “What are the facilitators’ and participants’ positionalities?” Answering this question involved keeping track of the perspectives which participants took in relation to the phenomenon at hand. For example, we might imagine that the phenomenon at hand (“relationships between inpatient staff and inpatients”) is a three-dimensional object. Imagine also that participants are turning this object over in their hands, passing it back and forth, and that as they do this they are describing what they see, how the object feels, or what it seems to do. As they do so, they each offer us a different experiential perspective on the topic in hand, through their own particular, positional relationship to it. Similarly, in the data extract above, we might note that Participant 1’s opening stance was indignant (“it’s absolutely ridiculous”) and oriented toward staff. In response, Participant 2 initiated a shift of focus toward clients and offered a more sympathetic perspective on the phenomenon (“this person is frightened”). Combining these two perspectives paved the way for a prediction of the consequences (“it’s going to make that person worse”), which would not have been possible without the two previous positions having been explored.

We also brought a functional perspective to some of our questions on positionality, and this did bring us to closer to what would be recognised by discourse analysts as engagement with positioning theory. We began this process by exploring the role played by facilitators because we were immediately aware of some differences in the way that the groups appeared to have been run. This aspect is likely to be an important avenue of analysis in any study of researcher-led discussion data. We worked through our transcripts, keeping track of the facilitators’ contributions, and noting questions, permissions, encouragements, and redirections.

The facilitators varied considerably in their personal style and approach to data collection. One example of this was in the balance struck between “information giving” and “information receiving.” Some groups’ accounts were clearly driven much more actively by the facilitators than others’. The facilitator in Region 1 did very little talking (averaging only two to three lines of text at a time in the transcript) and adhered closely to the preagreed prompts, offering clarifying information only where requested. In contrast, the facilitator in Region 2 took a more active role, at some points offering much explanatory/descriptive detail (up to 20 lines of text) about the way in which services were designed and delivered. Within all this talk, this facilitator appeared to take up a
Positionality is offered here as a concept which we might find useful for practical, analytic purposes in qualitative phenomenological analyses. It is a composite concept. It is partly “new” in that it offers a way of distilling our analytic attention down toward some specific aspect of participants’ accounts. It is also partly derived, owing something to both “intentionality” (de Monticelli 2007) and “positioning” (Hollway 1984).

**Intentionality** is important for phenomenological understandings of meaning making—because it draws our attention toward the “directedness,” “relatedness,” and “involved” nature of our being-in-the-world. The concept is problematic for qualitative analysis itself, however, because of its disputed epistemological/ontological qualities and its wider involvement in fundamental questions of “being” and “consciousness” (Moran 2000). It is difficult to **apply** intentionality **per se** to the task of qualitative analysis because the concept encompasses so much more than a person’s meaning making. “Positionality” is thus offered as an attempt to apply one crucial aspect of intentionality (the sense of “relatedness”) in qualitative analysis.

**Positioning** is important for qualitative psychology (and discursive psychology in particular) but carries with it an epistemological focus which is not usually consistent with the primary aims of phenomenological researchers. Positioning theory (Harré & Van Langenhove 1999) refers to subject positions as they are made manifest in language and interaction. Positions are stances in talk, and they need bear no relation to any sort of experiential account. Thus, when one describes an act of positioning, one describes what a person has **done** with the cultural resources which are available to them (or what has been done to them), in terms of their stake and identity, in a particular narrative or conversation. This can provide a powerful counterpoint or complement to experiential analysis, but obviously, and by its own terms, positioning theory has other purposes and is not intended to produce an experiential account.

**Positionality** on the other hand refers not to a linguistic stance or action but rather to the experiential **meaning** of one’s stance in relation to a given phenomena. This will be dynamic and subject to change of course (we are not describing **character**), but it may also be sustained over some time or across certain contexts. Positionality is thus what we describe when we try to capture a participant’s relationship to, or involvement in, a given matter of concern. Note that, interestingly, it is broadly “descriptive” in its intention but very clearly “interpretative” in its execution, requiring as it often does, a degree of analogical-metaphorical thinking from the analyst.

Position as an advocate for, or defender of, good practices in mental health. Participants in both regions offered critical perspectives on the services they had received. However, one consequence of Facilitator 2’s style and positionality may have been a shift in the target of the group’s criticism. It was notable that carers in the Region 2 discussion were particularly explicit with regard to the underfunding of mental health services rather than the intentions or competence of individuals. In drawing these observations together, we also reflected upon the facilitators’ demographic characteristics (and how these compared to participants) and professional background (training, clinical, and research experience).
In exploring the perspective and function of statements made by respondents, we also began to build up a picture of the interactional dynamic, asking ourselves what respondents achieved by articulating their various claims and concerns. Again, there are some clear connections to the interests of discursive analysts. For example, in any given statement, it may be that participants were affirming their qualifications as members of a given group (i.e., stake management), validating their own or other’s experiences or advancing their own personal and/or group agenda (e.g., to effect change in mental health services).

As we worked with the data, moving through this stage of questioning, we began to develop an understanding of how the groups were working together and of how particular participants enabled or constrained each other in offering perspectives on their experiences. It is at this point that one begins to see both what is gained and lost through the use of focus groups as opposed to individual interviews; while it is more difficult to draw out patterns in individual experience, it is possible instead to draw out some sense of the intersubjective patterns. Moreover, with an overview of the work so far, we were able now to move between parallel accounts of what had been claimed (from stage 1) and how it had emerged (from stage 2).

**Step 3. What Roles and Relationships are Described, and What do They Mean to Participants?**

With this balance in mind, we reviewed what we had collated so far and decided that more focused coding was required in order to better understand the various aspects of the participants’ lived worlds. This was akin to the more interpretative coding used in standard IPA in that it involved asking further questions of the data, focusing on key features of the accounts, but it was distinctive insofar as we made a conscious decision to use these strategies to contextualise the carers’ accounts.

With data from a one-to-one interview and a little background knowledge about one’s interviewee, one can contextualise a respondent’s account. Here, we had a much larger number of participants, no prior knowledge of them, no experience of interviewing them, and a set of complex social interactions. From the data, we had determined that relationships with professionals and organisations were especially important for understanding carers’ experiences. As a result, steps 3 and 4 describe our attempts to situate our participants in the systemic contexts which were important to them, first at an interpersonal-professional level and then at an organisational-health level. We believe that it would be useful to consider something like this when dealing with other focus group data from an IPA perspective, but note that the levels of context that are most salient for a given group of participants may well differ. For example, in another study, with another focus, we may find that interpersonal-familial or interpersonal-romantic are more important than interpersonal-professional.

For step 3 then, we examined participants’ references to other people. Participants made barely any references to the same people (i.e., if they had mutual acquaintances with professionals, they tended not to discuss them). Instead they described people in terms of their professional roles and viewed these roles as meaningful. We worked through the data again, asking what roles and relationships are described, what sorts of meanings and expectations were attributed to these people, and what is understood to be the consequences of these.

Participants frequently described encounters with professionals or reflected on the roles of, and their relationships with, mental health staff. Once all of the relevant professional and associated roles had been identified (e.g., psychiatrist, psychologist, nurse,
outreach team, carer), we tracked them through the transcripts, examining the claims made about them and their narrative contexts, to try to build up a picture of both individual participants’ views and of the group’s overall perception, of each role. For example, the following extracts illustrate experiences and perceptions of psychiatrists:

“My daughter went to a psychiatrist with depression, and he wanted to know why she looked so miserable [laughter] . . . I worked that one out.” (Carer, Region 1)

“So, I was trying to speak on her behalf . . . been doing it for 30 odd bloody years. But no, ‘You keep out of it.’ So I said, ‘Well if you like I’ll go outside,’ I said, ‘But before you give her a prescription or anything at all, will you please tell me what you’ve done. Because I’ve got to live with what you’re doing.’” (Carer describing a consultation with his daughter’s psychiatrist, Region 1)

Narrative extracts like these can tell the researcher something about the participants’ experiences and understandings of psychiatrists, the expectations they have of them, and the attributes they think they should have. In the first example, the carer used a common but diagnostic term to describe his daughter’s mood (“depression”). The psychiatrist’s response was presented as inappropriate (“miserable” does not confer the professional recognition “depression” does), appeared to have been experienced as insensitive, and was certainly interpreted as self-evident. For the participant, it was obvious that depression is the cause of looking miserable. Of course, it may be that the psychiatrist in this narrative had an idea of causality which was somewhat less circular than this, and that the question was not so self-evident. From our point of view, what is important is that the observation “I worked that one out” implies that the carer expected that a psychiatrist should offer a deeper insight into her daughter’s problems than this. Here we have learned something about the psychiatrist role as it is understood by this participant.

In the second extract, the carer spoke about an appointment he attended with his daughter (a service user). Here the carer’s narrative illuminated something of the perceived inequities in the relationship between psychiatrist, service user and carer. The carer was told to “keep out of it,” despite that he was there to help his daughter (who has difficulties retaining information) and that the psychiatrist’s actions would affect his life. Here we have learned something about the respondent’s relationship to psychiatry.

These examples were typical of the carers’ sense of their interactions with and relationship to psychiatrists. The respondents understood their negative experiences both in terms of the personal characteristics of those in the psychiatrist role (controlling, condescending, lacking empathy and interpersonal skills) and the organisational issues that affect this role (training, time available to see clients).

**Step 4. What Organisations and Systems are Described, and What do They Mean to Participants?**

Stage 4 was a direct development from stage 3. Here we examined participants’ orientation toward various organisations and systems. Working through the data, we asked how they are described, the sorts of meanings and expectations attributed to them, and their consequences. Where organisations and systems were identified, the process of recording these
was much the same as for roles and relationships. The types of organisations and systems discussed in this study included management, meetings, training, and “the system” (perceived NHS [National Health Service] organisational culture). The following examples give a flavour of the one group’s experience and perceptions of mental health services:

“He’s back in [inpatient care] again now and this has been going on for 20 years. Which is costing the system an awful lot and is not helping him.”
(Carer, Region 3)

“It seems like there is a huge variance, isn’t there, within the system? . . . There is a tremendous range from those who really don’t bother, don’t upset the system . . . Then on the other hand, within the system, the clinicians, some are extremely good at dealing with you, and there are some that are extremely bad.” (Carer, Region 3)

The first extract highlights the carer’s beliefs about the negative impact that frequent discharge and re-admittance to inpatient units is having on both her son and the system. The second extract illustrates one carer’s perception of a commonly described problem, that is, a lack of consistency within the system. Throughout the transcript, the carers referred to the system in relation to what they believe to be accepted ways of doing things within mental health services. Each carer had developed their own understanding of how the system works based on both their own experiences and those shared within the group. Many of these experiences appeared to be quite negative, describing an ongoing struggle, which added to the carers’ sense of frustration. The second extract is also a good example of how links can be made between organisations and systems (step 4), and roles and relationships (identified in step 3) with the carer talking about clinicians operating within the system.

**Step 5. What Kinds of Stories do Participants tell?**

We were aware that a great deal of the most powerful experiential detail in the participants’ accounts was nested in the narratives. For step 5, we decided to examine in more detail the stories told by the participants. Drawing on work from the more experiential strain of narrative psychology (e.g., Bruner 1990; Crossley 2000; Polkinghorne 1991) and the recent narrative turn in phenomenological psychology (e.g., Langdridge 2007; Shaw 2004), we focused on describing the structure, genre, imagery, and tone of each significant narrative. Here we discuss some of these features in relation to one of the data extracts we have already seen:

“I sat on a car park one night, three o’clock in the morning, on my own, in tears, with my mobile phone, and I left him — ’cause he was on the drive — I drove off and he was chasing me down the road. I couldn’t cope with him. He was absolutely out of control and I thought, ‘What am I going to do? What am I going to do?’ Anyway, I phoned [my husband] and he said, ‘He’s gone now, I don’t know where he’s gone.’ We woke up in the morning and do you know where he was? He was by the bin in the back garden sleeping, and he just lay on the concrete and I felt so cruel. I mean, we didn’t know he was there, we thought he’d gone off.”

(Female carer, Region 1, talking about her son)
The carer begins the account by setting herself in a specific location at a specific time. She establishes that she is upset and alone, away from her home, and thus creates a sense of her vulnerability and isolation. We are also informed that she has a mobile phone with her. She then describes a desperate scene. Note the repetition of “What am I going to do?” and how this emphasises her feelings of despair. Then, reminding us of the mobile phone, she describes calling her husband. At the end of the story, the narrator describes finding her son asleep outside the following morning. His proximity to home (when she thought “he’d gone off”) is in direct juxtaposition to his obvious discomfort. She might have said that he was found “in the garden” or “the yard,” but instead she locates him in relation to “the concrete” and “the bin.”

The early signposting of the mobile phone may indicate that this story is familiar or rehearsed: certainly it anticipates that a listener will need to know that the phone is in the car. It may have been told before, to others or to herself. The carer describes feeling “cruel” when she discovers her son by the bin but probably does not anticipate a genuine moral judgment against her: she has already evoked a sympathetic response from her listeners, through describing the circumstances of her desperation. It is significant then that this story is offered to an audience familiar with such dilemmas. The telling of the story says something about the context in which it is told (the data collection taking place in a carers’ support group) and that the carer feels secure in that context. Through telling the story, the carer is able to share an experience about a time when she had difficulty coping. Through telling it in this way, and especially through successful use of pathos (her son is “lost” while nearby, sleeping rough outside his own home), she communicates something of the emotional meaning of her role and the difficulties of caring for someone with mental health problems.

While this step may look like a remove from standard IPA, there is strong affinity between IPA and the various forms of narrative analysis, not least because of a shared interest in meaning making and in how narrative shapes our experience of the world (Eatough & Smith 2008; Shaw 2004). Perhaps what is most striking about the account described above is that the salience and insight of the experiential elements seem to transcend or exceed any provisos which we might place on it in light of its structural and interactional qualities. The elements which a reader is most likely to take from it are the narrator’s pursuit and escape, the lonely car park and tearful phone call, and the son sleeping by the bin:

“... people telling the stories of their lives are doing more than drawing on a stock of culturally-available meanings. Such stories may achieve a whole host of things — such as face-saving, persuasion, rationalisation, identity claims — but there is almost always more at stake. Often, important aspects of the stories we tell about ourselves will transcend the demands and constraints of a given interaction.” (Smith, Flowers & Larkin 2009)

**Step 6. How is Language Used in the Development of Participants’ Accounts?**

As with standard IPA, we also monitored language use throughout the preceding stages, with attention being paid to the use of metaphor, euphemism, idiom, and so forth. Where these occurred we found it useful to cluster similar cases together in order to explore the patterns further, both within and between groups. This helped us to contextualise and understand the key semantic choices made by participants. We then examined the ways that specific language mapped onto emergent themes. For example, the following examples
are related to the theme of “conflict between carers and mental health services” (emphases added):

“You have to scream and shout . . . Nobody’s screamed and shouted louder than me.” (Carer, Region 1)

“We’re treated like the enemy, aren’t we?” (Carer, Region 1)

“Basically we’re kept at arm’s length . . . Shut out. You always feel as if you’re shut out.” (Carer, Region 1)

The carers in this group used quite emotive language to describe experiences of conflict between themselves and mental health services. They used physical metaphors to describe their attempts at interaction with services. In the first extract, a second-person imperative (“You have to.”) indicates that this carer views screaming and shouting as accepted practice, continuing to describe how much personal effort she has had to put into being heard. A feeling of us and them with regard to carers and mental health service providers begins to emerge and is backed up by one carer expressing a group feeling of being treated like “the enemy” (note the collective voice – “we’re treated. . . aren’t we?”).

**Step 7. What are the Patterns and Variations in the Experiences Shared? Adaptation of Emergent Themes**

By this stage, we felt we had a comprehensive account, incorporating the main experiential claims and concerns, the interactive context in which these concerns had emerged, the relational and systemic context in which the experiences took place, and the main narratives that had been woven into the group discussions — all of this underpinned with a close attention to language use.

As a consequence, we began to adapt the emergent experiential themes (from step 1) in light of the work done in subsequent steps. Working with one group at a time, we reviewed all of the coding stages and asked what experiences are being shared, what individuals doing by sharing their experiences, and how they are making those things meaningful to one another. For each group, we also asked ‘where the consensus and conflict in the group are, how this conflict plays out, and if anyone’s account is being marginalised.’

The following example (Table 3) illustrates how links between the steps of the protocol are made in order to turn the emergent themes into something more concrete. At this stage we began to build an overview of what was happening within each group. For example, the emergent theme of lack of communication appeared to be an important issue for the carers in Region 1. They linked communication skills to training issues and the more personal attributes of the mental health workers they met. They also linked lack of communication with poor service delivery and management. There was discussion about lack of communication not simply being a local issue but also part of the wider NHS mental health system. In telling their stories the carers describe how lack of communication had adversely affected service users’ experiences and well-being. Where carers refer to a lack of communication, their language was typically informal and jargon free. However, the use of particularly emotive words such as ‘frightening’ and ‘torture’ was noted, indicating that the impact of this theme was quite strongly negative and felt on a very personal level.
Step 7: Adapting emergent themes, linking the steps together

1. **Emergent Theme:** Lack of Communication (Region 1) Frustrating, excluding, frightening for carers; toxic for service users.

2. **Positionality**—Dissatisfaction: exasperated; Broadly critical of services; High levels of conflict between carers and services expressed; Efforts to engage with services often described in physical terms (e.g., screaming and shouting, make noise, kept at arm’s length, hysterical). Pursuing change through shared experience (“you know you’re not on your own”); Empowered through group membership (“. . .now we’ve got a group and headed notepaper . . . they [services] might listen to us now”)

   *Facilitator role* Little input; sticking closely to prompts, clarifying questions where requested; offering little information about professional background — relevant information given to encourage trust and imply shared understanding (i.e., background in mental health nursing and family/carers’ issues).

   *Statement functions* Encouraging each other to share experiences; narrating own life stories; specific events — some familiar or rehearsed; validating own experiences — not alone; power — strength in numbers; agenda — wanting to effect changes in mental health service delivery.

3. **Roles & Relationships**
4. **Organisations & Systems**
5. **Stories**
6. **Language**

| Negative perceptions of many individual staff & professional roles | Poor service delivery | Detrimental impact of care on service user’s well-being | Emotive – ‘frightening’ ‘torture’ |
| Negative experiences of relating to specific staff [personal attributes] | Bad management | Carers having difficulty | Typically informal |
| Negative experiences of some staff’s interpersonal skills | | Carers wanting to be listened to | |
| Inappropriate professional skills & training | Awareness of local and national issues | |

**Step 8. How do Insights from Different Groups Relate to Each Other?**

*Integration of Multiple Cases*

This step will only be relevant where more than one focus group has taken place, as it concerns integrating insights from across different focus groups to develop a bigger picture of the overall research topic. The process is analogous to that of bringing together analyses of several interviews within a data set in standard IPA. It is important to note that if one is aiming to integrate work conducted with multiple groups, then the degree of homogeneity,
both within and between groups, will require some consideration (just as would be the case when recruiting participants for a more typical IPA study). Members of a group are likely to be selected because they share an experience and can offer an informative perspective on it. A certain degree of variability can be managed within any IPA study, and the same is true here — but where analyses are likely to be integrated (rather than, say, reported in parallel) it is important that the participants share certain characteristics.

In this case, for example, all focus groups consisted of a similar number of male and female participants, and all participants were currently caring for somebody experiencing mental health difficulties. The participants recruited for this study also shared the commonality of membership of a local carers’ support group. While this helped to create a certain degree of homogeneity between groups, the use of natural (i.e., pre-existing) groups may have resulted in different data being collected than would have been the case using constructed groups. The carers in this study clearly demonstrated that they knew of each other’s experiences throughout the focus groups. They actively encouraged each other to speak up and share their thoughts and often set their own stories against the context of other group members’ experiences.

The first step was to identify commonalities between groups with a view to further clustering the themes from each focus group into larger, superordinate themes. However, it was important to go back frequently to the transcripts to check these in relation to the original claims made by participants to help ensure accuracy. An example of how the researcher might begin to create a summary of this information is provided in Table 4.

At this stage, the researcher should map the participants’ stories onto the main themes that have been identified. In our study, the themes of “not being heard” and “wanting to be listened to” were central to many of the stories told. In Table 4, however, one clear difference is seen between the Region 1 group (whose dissatisfaction was directed toward particular individuals or particular professions) and the Region 2 group (whose dissatisfaction was directed toward the organisations themselves).

Here it is obviously useful to draw upon the information gathered in step 2 to assess the extent to which variations and patterns may be related to the role of the researcher in data collection. In this study, both groups shared a set of commonalities around difficult experiences of caring, not being listened to, and dissatisfaction with services. However, the different foci of carers’ dissatisfaction may have been a function of differences in the style of the facilitators.

**Discussion**

Where IPA research using focus group data has been undertaken previously, its authors have tended to highlight the benefits of doing so while at the same time urging caution with this type of analysis (e.g., Dunne & Quale 2001; Flowers et al. 2001; Green et al. 2003). For example, Flowers et al. (2001) noted that their focus on shared understandings led to a neglect of idiosyncratic experiences. de Visser and Smith (2007) attempted to avoid this problem by applying the IPA process of analysis to a linked series of individual interviews and group discussions and then combining these insights so as to develop an understanding of subjective experiences and broader contextual factors. What we have reported here is an attempt to develop a modified IPA which allows analysis of focus group data to examine personal experiences, shared understandings, and contextual factors.

Previous applications of IPA to focus group data have focused more on the content of the data than on the process of working with them, and they offer little in terms of how such an analysis might be best approached to recognise and account for the synergy associated
### Table 4
Step 8: Integrating data from multiple focus groups

<table>
<thead>
<tr>
<th>Region 1</th>
<th>Region 2</th>
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<tbody>
<tr>
<td><strong>Steps 1 &amp; 7 Emergent Themes</strong>&lt;br&gt;• Individual staff at fault&lt;br&gt;• Carers ignored/treated badly&lt;br&gt;• Time (focus on waste and waiting, e.g., for appointments, for improvements to be made to services)</td>
<td><strong>Organisations/systems at fault</strong>&lt;br&gt;• Carers ignored/treated badly&lt;br&gt;• Time (focus on length of time spent involved with services and lack of change for the better)</td>
</tr>
<tr>
<td><strong>Step 2 Positionality,</strong>&lt;br&gt;<strong>Facilitator Role &amp; Statement Function</strong>&lt;br&gt;• Dissatisfaction: critical, pursuing change (frustrated)&lt;br&gt;• FR: Little talking (average 2–3 lines of text in transcript)&lt;br&gt;• FR: Sticking closely to pre-agreed prompts but clarifying questions where requested</td>
<td><strong>Dissatisfaction: critical, pursuing change (hopeful)</strong>&lt;br&gt;• FR: Talkative (average up to 20 lines of text in transcript)&lt;br&gt;• FR: Going beyond pre-agreed prompts into descriptive detail re. service design and delivery</td>
</tr>
<tr>
<td><strong>Step 3 Roles &amp; Relationships</strong>&lt;br&gt;• Carers/family (references made to I, we, us. Some conflict between personal identity and the term 'carer')&lt;br&gt;• Psychiatrists (generally negative comments, particularly focusing on role expectations and individual personality traits) Outreach Team (a new service in the region, generally positive comments)&lt;br&gt;• Crisis Team (expectations in conflict with what is offered)&lt;br&gt;• Police (often involved as a result of a perceived poor response from mental health services)</td>
<td><strong>Carers/family (references made to I, we, us. Acceptance of the term ‘carer’ as applying to themselves)</strong>&lt;br&gt;• Doctors (ambiguity, e.g., psychiatrists, general practitioners, psychologists — it is the context more than specific language in relation to role that identifies what type of doctor)&lt;br&gt;• Outreach team (very positive comments)&lt;br&gt;• Managers (poor management linked to poor service delivery)&lt;br&gt;• Police (often involved as a result of a perceived poor response from mental health services)</td>
</tr>
<tr>
<td><strong>Step 4 Organisations &amp; Systems</strong>&lt;br&gt;• Individuals (focus on individual personality traits)&lt;br&gt;• Management (perceived as powerful yet reluctant to make changes to improve services)&lt;br&gt;• Meetings (focus on time-wasting and lack of impact)</td>
<td><strong>Groups of individuals (focus on role expectations)</strong>&lt;br&gt;• Management (bad experiences linked to poor management of staff/services)&lt;br&gt;• Training &amp; Development (lack of resources available for this)</td>
</tr>
<tr>
<td><strong>Step 5 Stories</strong>&lt;br&gt;• Wanting to be listened to&lt;br&gt;• Having difficulty coping&lt;br&gt;• Inpatient discharge as problematic&lt;br&gt;• Support from services as lacking-being offered too late</td>
<td><strong>Wanting to be listened to</strong>&lt;br&gt;• Service resources/funding as lacking&lt;br&gt;• Security/safety (expectations in conflict with what is delivered)</td>
</tr>
<tr>
<td><strong>Step 6 Language</strong>&lt;br&gt;• Feelings/Emotions - high&lt;br&gt;• Stories set years ago&lt;br&gt;• Jargon — professional&lt;br&gt;• Language of conflict/protest and frustration</td>
<td><strong>Feelings/Emotions - moderate</strong>&lt;br&gt;• Stories set in recent past&lt;br&gt;• Jargon – professional&lt;br&gt;• Language of conflict/protest but hopeful for the future</td>
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with using focus groups. In this article we have described the development of a process for engaging with focus group data in IPA. While this obviously does not guarantee a complete or successful analysis, we hope that other researchers will find our guiding questions helpful in deciding how to structure analyses of group data in such a way as to balance a deeper understanding of personal lived experience with the context of its expression.

The eight steps (illustrated in Table 1) describe a process applied to a particular set of focus group interviews. The questions posed at each stage are thus offered to researchers as a set of general prompts for thinking about the likely challenges and requirements of drawing phenomenological inferences from interactional data. We hope they will prove useful in this capacity but would reiterate our caution about simply applying the steps to a different set of data.

It is not the intention of this discussion to outline the various advantages and disadvantages associated with using focus groups to collect data in general (for useful summaries, see Lehoux et al. 2006; Thomas et al. 1995; Wilkinson 2003). However, an important issue to consider when considering applying this protocol to focus group data might be the type of group task that was carried out. Certainly, Smith suggests that the nature of the data is likely to be a deciding factor:

“If the researcher is convinced that participants are able to discuss their own personal experiences in sufficient detail and intimacy, despite the presence of the group, then the data may be suitable for IPA.” (Smith 2004, p. 51)

It certainly seemed to us that our data withstood this test, although, having been through this process (with some of us as “focus group sceptics”), we might now question that phrase “despite the presence of the group.” What has been striking about working with these data is that certain insights appeared to arise not in spite of, but because of, the shared experiences and understandings of the group. As we have already noted, these intersubjective qualities are consistent with a hermeneutic phenomenological approach. The group environment appeared to allow group members to co-constitute narratives and multiperspective accounts that would probably not have emerged in single interviews. Therefore, there would seem to be an advantage to working with pre-existing groups, in particular.

Interestingly, Leask et al. (2001) provide a counterpoint to this observation on the effects of focus group composition, comparing natural (pre-existing) groups with groups constructed solely for the sake of the research. They reported that discussions within constructed groups were more animated and enthusiastic and resulted in more divergent views being expressed than in natural groups. However, it is worth noting that in their study, Leask et al. (2001) asked participants to discuss a topic that had relevance to but was not the sole purpose or existence for the natural group. In the present study, the topic under investigation was directly related to membership of the natural groups from which data were collected. Participants had already taken the decision to become members of local carers’ support groups and were therefore self-selecting in terms of the potential research population. In our study, the use of natural groups appeared to have a positive effect on participants’ engagement. Certainly, researchers should think carefully about the topic under investigation in relation to the target research population when deciding how to recruit participants. Furthermore, facilitators must manage group dynamics so as to permit all participants to express their opinions and to prevent them from being silenced by other group members or pressured to conform to a consensus position.

IPA with individual interviews requires the collection of data from a relatively homogeneous group of participants. The same requirement applies to IPA with focus group
Unless the design is explicitly “multiperspectival” (e.g., reporting two different sets of perspectives on the same phenomenon), it is likely to be important that the composition within each group is comparable, at least to the degree that it permits integration of multiple cases (step 8). Ideally, too, the same facilitators should work throughout the data collection process. In addition to the type of group and facilitator used, the researcher should consider the location at which the focus groups will be held. In this study, we approached carers’ support groups and held discussions within their regular meetings. This may well have helped to create a safe, supportive environment, where the participants felt comfortable sharing their experiences with each other. Had we invited the carers to talk about services at a local NHS site instead, we might well have seen different experiences being shared from those that were revealed in the familiar surroundings of their regular meeting venue.

In summary, when adapting and applying this protocol to focus group data, it is worth bearing the following points in mind:

- The data collection must permit the generation of data which clearly suggest a phenomenological analysis by way of a strong, detailed experiential content.
- Exploration of positionality is likely to be important in ensuring that the analysis is suitably attuned to interactional factors. This may include more explicit reflection on the researcher’s role than has been typical in IPA (for more on this, see Finlay 2002, 2008).
- When exploring organisations and systems, it may be useful for the researcher to include references to those that are clearly established (e.g. NHS) but also to go beyond these, to explore the specific structures that are meaningful to the participants (e.g., local groups, internet communities, participant’s employing organisation).
- As with any IPA study, the stories that participants tell about their lives, and the language that they use, are central to the analysis.
- Where only one focus group has occurred, steps 1 to 7 may provide useful starting points for much of the data analysis, allowing the researcher to draw out the superordinate themes, to check these back with the original claims made, and to consider the data in the context of all levels of the analysis.
- A degree of homogeneity within each group is likely to be important. For studies which aim to integrate findings across groups, a further level of homogeneity between groups will also be required.

We do not assume that some kind of direct, unproblematic, or “true” account is accessed in interviews any more than it is in focus groups. Whatever the data collection method, IPA researchers set out with a commitment to understanding respondents’ perspectives and to taking their claims and concerns seriously. Obviously, we must situate these claims and concerns within the dynamic of a particular research interaction and contextualise each research interaction within the lived world of our respondents. It has been our intention in this article to describe some data-derived strategies for achieving this.

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