DILEMMAS IN QUALITATIVE HEALTH RESEARCH

LUCY YARDLEY*

Department of Psychology, University of Southampton, UK

As the use of qualitative methods in health research proliferates, it becomes increasingly necessary to consider how the value of a piece of qualitative research should be assessed. This article discusses the problem posed by the novelty and diversity of qualitative approaches within health psychology and considers the question of what criteria are appropriate for assessing the validity of a qualitative analysis. In keeping with the ethos of much qualitative research, some open-ended, flexible principles are suggested as a guide to the quality of a qualitative study: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. Examples are given of the very different ways in which various forms of qualitative research can meet these criteria.

KEY WORDS: Qualitative methods, qualitative analysis, validity, evaluation.

The upsurge in enthusiasm for qualitative research in social psychology during the past decade is now beginning to have a substantial impact in the field of health psychology. Qualitative methodologies[1] (QMs) are perceived by their proponents as possessing a number of desirable characteristics which are not prominent features of quantitative health psychology research. The use of QMs typically involves detailed exploration of the interwoven aspects of the topics or processes studied, whereas quantitative studies more often employ a limited number of measures to summarise specific, isolated variables at one or two moments in time. While quantitative studies tend to focus on factors or relationships which are observed in large numbers of people, many QMs are explicitly concerned with the particular situations and experiences of the individuals participating in the study. In this respect some QMs can be viewed as akin to traditional clinical practice, and as in the clinician–client (or doctor–patient) relationship, central importance is often attached to the interaction between the investigator and the person who is being studied, and the personal and ethical issues arising from the potential for mutual influence. Finally, QMs have been associated in recent times with a renewed interest in culture and language. This has led to an intensive examination of the philosophical and socio-cultural foundations of concepts and procedures which have sometimes been employed in quantitative research with little explicit discussion of their origin, function and connotations.

Of course it is possible to carry out quantitative research which is exploratory and empathic, and pays close attention to process and unique variation, ethical and interpersonal issues, meaning, context and culture. However, QMs are especially well suited to these

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*Corresponding author. Tel.: (+44)(0)1703 594581; Fax: (+44)(0)1703 594597; E-mail: l.yardley@soton.ac.uk.
[1] The term "qualitative methodologies" is employed in order to note the plurality of qualitative methods, and to emphasise that they are not simply investigative techniques but represent a range of fundamentally different approaches to the production of knowledge.

particular objectives, just as the methods of quantitative research are most appropriate for answering questions about the stability or generality of phenomena, or for isolating, predicting and controlling specified variables. Hence QMs genuinely offer a complementary set of investigative approaches which can bring fresh insights into health and illness. Nevertheless, as increasing numbers of psychologists have sought to apply QMs to health problems, it has become apparent that there are many questions to be resolved regarding the conduct and interpretation of these new investigative approaches in the context of health psychology. While it is not possible (for reasons discussed below) to provide definitive answers to these questions, this paper will attempt to delineate some of the relevant issues and alternatives pertaining to the problem posed by the diversity of qualitative approaches, their relative novelty as a method of psychological research, and the difficult issue of quality control. These issues relate to the key question of how the value of QMs to health psychology can be determined. This is not a matter of merely academic interest, but has practical importance both for qualitative researchers *and* for the growing numbers of quantitative researchers who find themselves obliged to evaluate the worth of studies which employ QMs, whether in the form of a student project, article, or research proposal.

THE ISSUE OF NOVELTY AND DIVERSITY

To some extent, the problems surrounding the acceptability and evaluation of QMs arise simply because of their relative novelty as a psychological research tool, since the criteria for warranting and channels for disseminating qualitative psychological research are still in their infancy. For those conducting quantitative psychological research there is a set of well-established and widely acknowledged (albeit continuously evolving) conventions, methods, and terminology. Indeed, a thorough grounding in these, acquired through approved courses, is considered prerequisite for accreditation as a trained psychologist. The criteria for judging the excellence of quantitative empirical studies are relatively well-established; representative samples of adequate size, balanced design which minimises confounding variables, reliable measures, appropriate statistical analysis, etc. These standards are maintained and regulated by a hierarchical system of recognised expertise, embodied in research institutions, funding bodies, publication outlets, and individual researchers. In contrast, the conventions and standards for the conduct and evaluation of research using QMs are difficult to define (see following section on "Quality Control"), and do not yet form a significant part of the basic training of psychologists. Although certain individuals have achieved a reputation for excellence in the use of QMs, no hierarchy of widely acknowledged expertise yet exists. The journals most congenial to studies employing QMs are in disciplines other than psychology, or are too newly established to have acquired a solid reputation and extensive readership. The consequence is that those who seek to carry out and disseminate qualitative research within the context of mainstream health psychology constantly risk evaluation by criteria that are irrelevant to their particular approach, and by individuals who are unfamiliar with or even unsympathetic to the methods and rationale they have adopted (Stern, 1997).

   This situation is aggravated by the immense diversity of QMs. The term "qualitative" embraces such different methodologies and associated epistemologies that qualitative research tends to be semiotically defined simply by contrast with quantitative research (Potter, 1996), although this creates a sharp dichotomy which is many respects misleading and unhelpful. In fact, each of the different modes of qualitative research has quite different

traditions and procedures. For example, some QMs have their origin in linguistic analysis, some have developed from social theory, while some draw on poststructuralist or phenomenological philosophy. Moreover, each of these broad traditions of research itself encompasses numerous radically different approaches. This can be illustrated by the case of QMs which have their roots in phenomenology. Some researchers draw on the "transcendental phenomenology" of philosophers such as Husserl and seek to set aside the "natural attitude" of our ingrained assumptions and categories, in order to achieve a better intuitive comprehension of the phenomenon and our interpretations of it (Giorgi, 1990; Holstein and Gubrium, 1994). Others draw on later phenomenological philosophers such as Heidegger, Merleau-Ponty and Ricoeur, and explore the ways in which the meaning of all phenomena is created through interpretation and discussion, action and interaction (Kvale, 1983; Ray, 1994). Another approach emphasises the humanist aspect of phenomenology and the importance accorded to subjectivity, and uses QMs to attempt to understand and communicate the perspective and personal experiences of those who are studied (Morse *et al.*, 1994; Morse and Johnson, 1991). Moreover, some phenomenological researchers analyse the topic from introspection and reflection (e.g., Leder, 1990), others draw on personal experience (Toombs, 1990) or intensive interviews with a few individuals (Smith *et al.*, 1997), and yet others employ extensive and well-defined methods of observation and data collection, such as those developed for symbolic interaction and grounded theory research (Strauss and Corbin, 1990; Tesch, 1990). Similarly, within the scope of "discourse analysis" modes of inquiry range from examination of the structure and linguistic strategies that can be discerned in detailed transcriptions of conversation (Mishler, 1984; Potter and Wetherell, 1987) to the theoretical analysis of terms or concepts as a form of distributed knowledge (Leudar and Antaki, 1988), or as a means of perpetuating particular ideologies and power relations (Parker, 1990; van Dijk, 1997).

This diversity undoubtedly adds to the difficulty of demonstrating the value and intellectual integrity of QMs. The unwillingness of qualitative researchers to converge on a unitary set of methods, assumptions and objectives can lead to confusion and scepticism about the validity of their work. But a pluralistic ethos is central to the non-realist philosophical traditions underpinning most qualitative research. One of the primary reasons for adopting QMs is a recognition that our knowledge and experience of the world cannot consist of an objective appraisal of some external reality, but is profoundly shaped by our subjective and cultural perspective, and by our conversations and activities (Yardley, 1997a). Thus "truth", "knowledge" and "reality" are actively created by the communal construction and negotiation of meaning, both in our daily life and our academic endeavours. But if this is the case, there can be no fixed criteria for establishing truth and knowledge, since to limit the criteria for truth would mean restricting the possibilities for knowledge, and would also privilege the perspective of the cultural group whose criteria for truth was deemed "correct". Consequently, while qualitative researchers recognise the need to establish tentative agreement as to the validity and utility of a piece of research for a certain purpose, in a particular situation, and for a specific community of people, most reject the idea that there ever could or should be a universal code of practice for the use of QMs (Feldman, 1995; Greenhalgh and Taylor, 1997; Guba, 1992).

The lack of well-defined and universally agreed criteria for quality means that the development of qualitative research within health psychology remains vulnerable to a number of undesirable outcomes. One danger posed by this situation is that those QMs which appear most compatible with the criteria of traditional quantitative research will be accepted and assimilated (as has already occurred to some extent); i.e., those which endorse assumptions

and employ procedures which are consistent with those of quantitative research (e.g., coding frames with established inter-rater reliability, large and representative samples, realist interpretation of data). However, the more radical methodologies, which are hence potentially more important in terms of innovation and impact, may then be isolated and rejected, or may become exclusively aligned with other disciplines such as sociology and anthropology. Another trend which can already be discerned is the emergence of largely independent methodological traditions with quite separate conventions and criteria. This trend is fueled by the tendency of those who are new to qualitative research, and dismayed by the scope and complexity of the field, to adhere gratefully to any set of clear-cut procedures provided by proponents of a particular form of analysis, which appears to offer a methodological precedent which may guarantee academic acceptability. While the emergence of such methodological traditions could be viewed as the evolution of a healthy pluralism, the risk is that it might instead lead to fragmented, rigid, and even competitive research groupings, each with a small (and hence less influential) following of supporters who are ignorant or intolerant of other QMs. But these problems can be averted by explicitly embracing diversity, mutation, and openness to multiple viewpoints as central elements of qualitative research. There is therefore a need to agree (provisionally, of course!) upon equally open-ended and flexible ways of assessing quality, which are applicable to many different QMs. The question of how the quality of studies using QMs might be evaluated is considered further in the following section.

THE ISSUE OF QUALITY CONTROL

Before asking what standards *are* relevant to most QMs, it may be necessary to explain briefly why many traditional criteria are *not* applicable. Qualitative researchers are often criticised by quantitative researchers for failing to employ a representative sample, to develop reliable measures, or to yield objective findings or replicable outcomes. However, a sample size sufficiently large to be statistically representative cannot be analysed in depth (which consequently undermines the rationale for employing qualitative methods), since to do so would produce such vast quantities of data that the inter-relationships between the factors and processes observed become too complex to synthesise, and hopelessly "over-specified" in statistical terms. For qualitative research it is therefore often preferable to employ "theoretical" sampling of small numbers of people chosen for their special attributes; for example, those who are extreme or typical exemplars of the phenomena of interest, as well as those who appear discrepant or divergent (Charmaz, 1990; Hollway, 1989; Miller and Crabtree, 1994). Reliability and replicability may also be inappropriate criteria, if the purpose of the researcher is to offer just one of many possible interpretations of a phenomenon, or to study a situation which is in the process of changing, or a discourse which is itself inherently inconsistent (Bannister *et al.*, 1994; Potter and Wetherell, 1987; Swansea and Chapman, 1994). And for researchers who believe that knowledge cannot be objective, but is always shaped by the purposes, perspective and activities of those who create it, the use of "inter-rater reliability" as a check on the objectivity of a coding scheme is meaningless (Seidel and Kelle, 1995). Although it is certainly feasible to train two people to code a text the same way, this does not exclude the element of subjectivity in the interpretation of the data – it simply becomes an interpretation agreed by two people. Moreover, using pre-defined rules for coding limits the possibilities for subtle, imaginative, context-sensitive and elaborate interpretation (Manning and Cullum-Swan, 1994).

Table 1 Characteristics of good (qualitative) research. Essential qualities are shown in bold, with examples of the form each can take shown in italics.

Sensitivity to context
Theoretical; relevant literature; empirical data;
sociocultural setting; participants' perspectives; ethical issues.

Commitment and rigour
In-depth engagement with topic; methodological competence/skill;
thorough data collection; depth/breadth of analysis.

Transparency and coherence
Clarity and power of description/argument; transparent methods and
data presentation; fit between theory and method; reflexivity.

Impact and importance
Theoretical (enriching understanding); socio-cultural;
practical (for community, policy makers, health workers).

While traditional criteria for research quality are often inappropriate, and the ethos and plurality of many QMs is incompatible with fixed, universal procedures and standards, some way of evaluating the quality of research employing QMs is absolutely necessary, in both senses of the word – both imperative and unavoidable. All interpretations contain an implicit claim of authority (Lincoln and Denzin, 1994); it makes no sense to engage in a process of analysis and then deny that it has any validity! And if QMs are to have any practical use, claims that a piece of research is of high quality need to be legitimated by criteria which are meaningful to those people for whose benefit the research was intended, whether clients, patients, health policy makers or fellow health professionals. Some key dimensions on which studies using QMs can be assessed are therefore proposed in Table 1, and are discussed below.[2]

In keeping with the philosophy of many QMs, these suggested criteria are not in the form of rigid rules or prescriptions, but are themselves open to flexible interpretation. Moreover, the way in which a particular investigation will fulfil these criteria will vary widely, depending upon the approach employed (Secker, Wimbush, Watson and Milburn, 1995); the micro-analysis of a segment of dialogue demands entirely different forms of methodological rigour from those required to explore individual differences in the meaning attached to an experience of illness. It is clearly beyond the scope of this paper to illustrate in detail how the criteria can be applied to the vast array of different modes of qualitative inquiry, but the following sections provide some consideration and examples of different ways in which validity can be promoted within the framework of various QMs. In addition, the flexible applicability of the suggested criteria is demonstrated in Appendix A by showing specifically how they are met by two sound qualitative studies (Hartwell, 1998; Nijhof, 1998).

Sensitivity to Context

The context of a qualitative study comprises many facets, all of equal potential importance. Firstly there is the context of theory, and the understandings created by previous investigators

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[2]The sources from which these criteria have been garnered are too numerous to cite individually below, but more extended treatments of this issue which I have drawn upon include Potter (1996), Yardley (1997b), Stiles (1993), Lather (1993), and the proceedings from a workshop on "Qualitative Psychology: Criteria for Research Practice" organised by Ian Parker and Karen Henwood in Bolton in 1996.

who have employed similar methods or have analysed similar topics. Of course awareness of the relevant literature and previous related empirical work is essential for all investigations, whether qualitative or quantitative, but in much qualitative research the sophistication of the interpretation of the data is particularly crucial. Whereas quantitative studies typically rely on procedures such as standardised measurement and random sampling to ensure the "horizontal generalisation" of their findings across research settings, many qualitative researchers aspire instead to the theory-building work of "vertical generalisation", i.e., an endeavour to link the particular to the abstract and to the work of others (Johnson, 1997). Moreover, in QMs as diverse as critical discourse analysis and phenomenology, a central objective is to highlight and query the common-sense concepts and assumptions which shape our naive observations and explanations (Harding and Gantley, 1998). For these kinds of research it is therefore desirable to have a fairly extensive grounding in the philosophy of the approach adopted, and the intellectual history of the categories and distinctions that have been applied to the topic, since awareness of the different perspectives and complex arguments that can be brought to bear on the subject provides the researcher with the scholastic tools to develop a more profound and far-reaching analysis. For example, in order to derive new insights into the experience of living with HIV, Davies (1997) draws on Sartre's theory of the existential meaning of death as simultaneously the limit of individual freedom and hence the constituent of individual choice; thus she is able to show how the uncertain lifespan of those with HIV entails a loss of conventional orientations to the future (e.g., plans, responsibility) which can be petrifying but is also potentially liberating. But while theory can profoundly influence the interpretation, it is obviously integral to the rationale of empirical research that the analysis is manifestly sensitive to the data itself. This might be demonstrated by corroborating theoretical predictions or discriminations with compelling empirical evidence, or by ensuring that unexpected findings or observations which conflict with the investigator's understandings of the topic are not merely noted, but are actively sought, minutely examined, and satisfactorily accounted for.

Since language, social interaction and culture are understood by most qualitative researchers to be central to the meaning and function of all phenomena, awareness of the socio-cultural setting of the study is also important – for example, the normative, ideological, historical, linguistic and socioeconomic influences on the beliefs, objectives, expectations and talk of all participants (including those of the investigator – see discussion of "reflexivity" below). For instance, in one qualitative study of perceptions of stroke (Pound, Gompertz and Ebrahim, 1998), a sample of working class elderly people in the East End of London displayed a surprising degree of stoicism, stating typically that they had "got off lightly". Such assertions could be plausibly contextualised within the cultural imperative to demonstrate social competence; hence previous investigators have suggested that when the negative personal impact of health problems appears to be denied the speaker may be adopting a strategy of "normalising" the stigmatising disability in order to sustain an acceptable social identity (e.g., Kelleher, 1988). However, Pound and colleagues offer an alternative explanation, which makes sense of these stoical statements in terms of the age, socioeconomic circumstances and culture of their interviewees. They suggest that their responses are consistent with the East End tradition of cheerful endurance of adversity, and contextualise the statements by noting how stroke is narratively depicted as simply one more event in a lifetime of crisis and hardship, and just one more ailment among the many inevitable infirmities of old age.

The social context of the relationship between the investigators and the participants in the research can be crucial. Most qualitative approaches take speech not as a revelation of internal feelings, beliefs or opinions, but as an act of communication intended to have

specific meanings for and effects on particular listeners (Leudar and Antaki, 1996). Thus the listener contributes to what is said, not only by the moment-by-moment verbal and non-verbal input which prompts and completes the other's utterances, but also by actively or passively invoking the relative identities and shared understandings which provide the framework for speech (Mishler, 1986; Ochs, 1997; Pomerantz and Fehr, 1997). For this reason, in most QMs sensitivity to the linguistic and dialogic context of each utterance is crucial to interpreting its meaning and function. And since attempts to remain "neutral" when observing and interviewing are futile, and may result in highly unnatural interactions (Potter and Wetherell, 1995), the design of the study should incorporate consideration of the general and specific effects of the researchers' actions and characteristics (e.g., gender, status as health professional or fellow sufferer).

An important aspect of the behaviour and characteristics of the researchers concerns how these influence the balance of power in the process of investigation – an issue which clearly also has a crucial ethical dimension. The philosophies on which many QMs are founded promote a more active and powerful role for those participants who would formerly have been considered the "subjects" of research, as well as the consumers or end-users. To ensure sensitivity to the differing perspectives of all those involved, and the wider community to whom the study is relevant, some researchers therefore institute explicit procedures for eliciting and incorporating the opinions of those studied, or of colleagues (e.g., doctors, health promotion workers) who may have a contrasting approach to the topic. But the nature of participant involvement itself requires careful consideration at every stage of the design, analysis and reporting of the study, since more intimate relations with researchers increase the potential for exploitation, and can raise complications regarding the conventional preservation of anonymity and confidentiality of participants' views (Morse, 1998). And while it is vital to be open to the perspectives of all participants, it is difficult to overcome the inevitable imbalance in power relations between those who are selected for involvement in the study and the 'expert' whose role as an academic usually entails initiating, controlling and materially benefiting from the process of research. For instance, while Riessman (1993) advocates asking for participants' views on an interpretation offered by the analyst, she explicitly rejects the idea that the analyst's intellectual independence should be abdicated or eroded by taking participants' opinions as an authoritative judgement of the veracity or value of the interpretation.

Commitment, Rigour, Transparency and Coherence

These criteria are fairly straightforward, as they correspond to the usual expectations for thoroughness in data collection, analysis and reporting in any kind of research. The concept of commitment encompasses prolonged engagement with the topic (not necessarily just as a researcher, but also in the capacity of sufferer, carer, etc.), the development of competence and skill in the methods used, and immersion in the relevant data (whether theoretical or empirical). Rigour refers to the resulting completeness of the data collection and analysis. This depends partly on the adequacy of the sample – not in terms of size but in terms of its ability to supply all the information needed for a comprehensive analysis (in grounded theory terminology, "saturated data"). For instance, some analyses of discourse require only a few meticulously transcribed pieces of dialogue to illustrate the interactional processes of interest (although such "typical instances" are often taken from a much larger pool of representative interactions, e.g., Waitzkin and Britt, 1993), while phenomenological or narrative analyses often focus in depth on the case of a single individual (e.g., Toombs, 1992). But

rigour also includes the completeness of the interpretation, which should ideally address all of the variation and complexity observed, and may need to be undertaken at several levels of analysis. For example, in a phenomenological analysis commitment and rigour might be demonstrated by the effective use of prolonged contemplative and empathic exploration of the topic together with sophisticated theorising, in order to transcend superficial, "commonsense" understandings. In this type of research, the intuition and imagination of the analyst can be much more important than any formalised analytic procedures (Cooper and Stephenson, 1996). Alternatively, it may be desirable to employ "triangulation" of data collection or analysis in order to achieve a rounded, multilayered understanding of the research topic. This might involve gathering data from various sources (e.g., patients, doctors, nurses) or by different methods (e.g., observation, interviews, examination of records), so as to assess and analyse any divergence between, for example, publicly and privately expressed attitudes, or between behaviour and expressed intentions (Pope and Mays, 1995; Banister *et al.*, 1994). In addition, the limitations and idiosyncracies inherent in any single perspective on a topic can be both highlighted and partially circumvented by employing a combination of analytic approaches (Barbour, 1998).

At the level of presentation, the criteria of "transparency and coherence" relate to the clarity and cogency – and hence the rhetorical power or persuasiveness – of the description and argumentation. For many qualitative researchers, the function of any story, including the story of a research project, is not to describe but to *construct* a version of reality (Bruner, 1991; Freeman, 1993). Consequently, the quality of the narrative is an integral part of its productive value; a convincing account exerts its effect partly (or sometimes wholly) by (re)creating a reality which readers recognise as meaningful to them. For example, Anderson's (1986) analysis of how dentists discursively co-opt fearful and potentially antagonistic patients into allies is able to rely on illustrative expressions that most readers will be familiar with: e.g., "it can't really hurt that much", "let's just . . . shall we?" "that's a nice job". Coherence also describes the "fit" between the research question and the philosophical perspective adopted, and the method of investigation and analysis undertaken. For instance, if the aim of the research was to explore and give voice to the personal perspective of people suffering from a particular illness, a thorough phenomenological analysis of interviews with these sufferers could provide a consistent and complete description, whereas triangulation by seeking relatives' and health professionals' perspectives or by "deconstructing" the interviews would usually *not* be appropriate.

A convincing "transparency" in the presentation of the analysis and empirical data can be achieved by detailing every aspect of the data collection process and the rules used to code data, by presenting excerpts of the textual data in which the readers can themselves discern the patterns identified by the analysis, and/or by making detailed records of the data (e.g., audiotapes, transcripts) available to other analysts (Huberman and Miles, 1994; Peräkylä, 1997). In addition, transparency refers to the degree to which all relevant aspects of the research process are disclosed. In quantitative research, it is traditionally only considered necessary to detail concrete aspects of the investigative procedures; how participants were recruited or randomised, what equipment was used, or what order tests were administered in. But for researchers who believe that our experience of the world is profoundly influenced by our assumptions, intentions and actions, it is equally important to openly reflect on how such factors may have affected the product of the research investigation. This kind of disclosure, sometimes known as "reflexivity", might include discussion of the experiences or motivations which led the researcher to undertake a particular investigation, or consideration of how the work was influenced by external pressures or constraints (e.g., the

priorities of funding bodies, or the difficulty of involving certain people in the research process). For example, Wynne (1988) interweaves her analysis of accounts of multiple sclerosis with reflection on the way she is "diagnosing" the discursive practices in accounts of sufferers much as doctors diagnose their physiological processes – in both cases using claims to expertise to create new "facts".

Impact and Importance

The decisive criterion by which any piece of research must be judged is, arguably, its impact and utility. It is not sufficient to develop a sensitive, thorough and plausible analysis, if the ideas propounded by the researcher have no influence on the beliefs or actions of anyone else. However, there are many varieties of usefulness, and the ultimate value of a piece of research can only be assessed in relation to the objectives of the analysis, the applications it was intended for, and the community for whom the findings were deemed relevant.

As discussed in the section on "Sensitivity to context", theoretical worth is often of primary importance in qualitative research. Some analyses are important not because they present a complete and accurate explanation of a particular body of empirical data, but because they draw on empirical material to present a novel, challenging perspective, which opens up new ways of understanding a topic. Some pieces of scholarly work may be so esoteric that although the insights they offer are invaluable, they are appreciated by a relatively small number of people and may appear to have little practical import. Nonetheless, these ideas may eventually have a wider impact when applied to practical issues by other researchers. For example, Foucault's masterful but somewhat inaccessible analysis of how the body is socially regulated by the practice of medicine (Foucault, 1989) has strongly influenced current critiques of health promotion practices (Lupton, 1995).

In addition to the theoretical and practical impact of a study, many qualitative researchers are concerned with its socio-cultural impact. Whereas the aim of most quantitative investigators is to remain as scientifically "objective" as possible, many qualitative researchers consider research (like any other activity) to be inherently political, in the sense that *all* our speech and actions arise from a particular social context, serve some social purpose and have some social effects (Burman and Parker, 1993; van Dijk, 1997; Yardley, 1997a). It follows that since discourse, ideas and beliefs are an intrinsic part of our experience of health and illness, then this experience can be substantially altered by research which contributes to a change in the way we think or talk about health. For example, people with disabilities are currently campaigning for a change in both attitudes and the material manifestations of these attitudes (Oliver, 1990; Swain *et al.*, 1993). By means of qualitative theoretical and empirical analyses, these campaigners have highlighted the way in which the "medical/care" model of disability portrays those with disabilities as deficient rather than different, as in need of care and rehabilitation rather than having rights to basic amenities (Phillips, 1990; Ville *et al.*, 1994). Depiction of disabled people as damaged victims has a range of interlinked material and psychosocial implications; socio-economic prioritisation of medical prevention and "cure" (e.g., by genetic screening) rather than provision of aids and support; a paternalistic system of professional evaluation of needs for assistance rather than provision of opportunities for employment and participation; and a consequent culture of stigmatisation, low self-esteem and dependence. By means of such analyses, QMs can complement quantitative research by elucidating socio-cultural processes which explain effects documented by quantitative studies. For instance, analyses of the socio-political function of individualistic health promotion rhetoric can help to explain why the ideal that

it is possible to maintain health through personal endeavour remains popular despite evidence that individual behaviour has much less impact on health than factors such as socio-economic status (Blaxter, 1990; Lupton, 1993; Pollock, 1993). Similarly, qualitative analyses of the meaning and function of "risky" behaviour shed light on why people continue to engage in activities such as unsafe sex, smoking, or excessive drinking despite the provision of the information needed to make an apparently more "rational" decision (Ingham and Kirkland, 1997; Joffe, 1996; Lupton, 1995; Smith *et al.*, 1997).

One of the particular advantages of QMs for health research is that the emphasis on research-in-context should result in a close fit between research and practice (Swanson *et al.*, 1997). Indeed, the link between QMs and clinical practice may become so close that the two can be combined. Just as ideas and talk affect action, material experiences of health problems and health care can produce creative ideas and insights. The combination of these processes is sometimes known as "participatory" or "action research" (Bloor, 1997; Wuest and Merritt-Gray, 1997), and represents a step from interpretation to construction; from research which seeks to *explain* existing problems to research which *creates* new solutions. Participatory research offers an exciting alternative to quantitative intervention studies such as clinical trials, and represents an important development in QMs. Despite the relevance of talk, as outlined above, there is a real risk that the interview (or focus group discussion) could become the qualitative counterpart to the questionnaire – a convenient method of sampling opinion, but one that is divorced from the context of real-world action and interaction. This radical methodology poses the most extreme challenge to traditional criteria for validation, since the objective of such research is to produce emancipatory and positive change in all participants, and practical solutions to local problems, rather than to produce a transferable piece of knowledge which can be evaluated as an academic product (Oliver, 1992). Nevertheless, it is encouraging to note that it would appear quite feasible to evaluate a piece of participatory action research using the criteria suggested above: i.e., sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Concluding Comments

As qualitative researchers begin to arrive at tentative solutions to the question of how the worth of research employing QMs can be evaluated, the final obstacle that remains is the problem of communicating these criteria to those with whom they work, including quantitative researchers and other health professionals. The growing insistence by research funding bodies on provision of training in qualitative methods and inclusion of QMs in research proposals is both an encouraging sign that the value of QMs is beginning to be acknowledged, and is also itself a catalyst for more widespread interest in qualitative approaches. However, it is vital that the diversity and mutability which are central to these approaches is preserved despite the difficulties this may create for the process of communicating the nature and merits of different QMs, and developing procedures for verifying the excellence and integrity of research employing QMs. Rather than a simplistic and premature definition of what constitutes good qualitative research, what is needed therefore is a wider appreciation of the inherent complexities and ambiguities associated with evaluating qualitative studies.

Acknowledgements

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APPENDIX A: APPLIED EXAMPLES

The two studies with which the flexible application of the suggested criteria for validity will be implemented were selected to exemplify the heterogeneity in approach which characterises even studies which might appear, superficially, to employ a similar methodology. Both studies were published in the same issue of the international, interdisciplinary journal *Qualitative Health Research*. Both employ interviews to elicit the autobiographies or "life histories" of their participants. Yet the aim and epistemological grounding of each is entirely different, and calls for a quite different approach to validation.

Hartwell's study has a very pragmatic objective: to determine why, *from their perspective*, chronic recidivists from substance abuse programmes repeatedly re-enter such programmes. There is virtually no explicit consideration of theory, and the literature reviewed relates mainly to the prevalence of recidivism, and hence the scope of the problem. But although the treatment of interviewees' statements appears theoretically unsophisticated, taking descriptions of their lives more or less at face value, it is consistent with the practical approach adopted, and with the implicitly phenomenological aim of elucidating the perspective of the interviewees, and hence meets the criterion of "coherence". In contrast, Nijhof's study is theoretically driven, and therefore commences appropriately with a detailed critique of the way in which previous research has conceptualised and investigated epilepsy as if it was a unitary phenomenon. He also demonstrates coherence between theory and method, as the methodological design of his study was informed by a similarly well-elaborated theory of the methodological investigation and narrative significance of "life stories", and was explicitly designed to facilitate the exploration of heterogeneity in the meanings of epilepsy for sufferers.

Both studies meet the requirements for commitment, rigour and transparency. The sampling decisions are well justified and the numbers interviewed sufficient to yield a diverse (Nijhof; $N = 20$) or broadly representative (Hartwell; $N = 30$) sample of individuals from the target populations. In both cases the interviews were tape-recorded and fully transcribed, the interview content and coding procedures are clearly described, and ample interview material is presented to the reader to support analytic findings. Hartwell's commitment is demonstrated by her 100% success rate in following up a very elusive group of people a year after their initial interview, while Nijhof displays an in-depth awareness of relevant socio-linguistic theory and methodological issues.

Hartwell's study is manifestly sensitive to the empirical findings, as the study adopts an inductive approach to data analysis, offering no predictions or preconceptions as to what the interviewees' perceived reasons for recidivism might be. Although Nijhof predicts heterogeneity in the meanings of epilepsy, he is also inductive in the sense that the demonstration of heterogeneity entails discovery of variations in terminology surrounding epilepsy that can only emerge when a definition is not imposed by the researchers. Consequently, sensitivity to the dialogic and linguistic context is shown in his commitment to avoiding any specific questions which might prematurely define epilepsy (asking only "Would you mind telling me about your life?"). Hartwell also displays sensitivity to the social context of the interaction – for example, reflexively considering the influence her status as a white

woman interviewing predominantly black men may have had on their responses, and the possible effect of the interviewees' (principally financial) motivations for agreeing to be interviewed. These issues also have ethical implications for the relationship between the participants, and both authors display sensitivity to the power imbalance (for example, by choosing a setting familiar to the interviewee) and the need to actively elicit the interviewees' opinions. Hartwell carried out her interviews at locations and times convenient to her interviewees (for example, in snack bars late at night) and explains that in the course of her longitudinal research she developed a relationship of trust with her interviewees. Similarly, Nijhof conducted the interviews in the homes of interviewees, and sought to impress on them that it was *their* interpretation of epilepsy that was interesting and important.

Both studies have a clear potential for significant theoretical, practical and socio-cultural impact. Hartwell notes that her findings challenge normative conceptions of substance abuse treatment programmes as functioning as an end-point to substance use, showing how recidivists perceive them instead as a *part* of the cycle of substance use, serving functions such as placating family members and providing shelter in emergencies. She draws out the practical and policy implications explicitly, observing that there is a need to relate her findings to further research into the goals and expectations of those who pay for substance abuse treatment, as well as the perceptions of those who do not repeatedly access treatment programmes. Nijhof's study addresses principally theoretical and socio-cultural issues; his significant contribution to knowledge is to show that people with diagnosed epilepsy are not engaged in a straightforward contest against unequivocally stigmatising labels, but instead have to manage multiple meanings of their condition (e.g., medical, personal, others') and engage in a subtle struggle with ambiguous, unarticulated perceptions of them as obscurely "abnormal". However, Nijhof himself highlights the practical import of his analysis, noting that "For the successful development of a health service in which aid is geared towards the patients' own meanings, it is of importance to gain public knowledge of these interpretations" (Nijhof, 1998, p. 104).