
Article

**Using Focus Groups to Research Sensitive Issues:
Insights from Group Interviews on Nursing
in the Northern Ireland “Troubles”**

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Abstract

In this article the authors discuss the usefulness of focus groups for researching sensitive issues using evidence from a study examining the experiences of nurses providing care in the context of the Northern Ireland Troubles. They conducted three group interviews with

nurses during which they asked about the issues the nurses face(d) in providing nursing care amid enduring social division. Through a discursive analysis of within-group interaction, they demonstrate how participants employ a range of interpretive resources, the effect of which is to prioritize particular knowledge concerning the nature of nursing care. The identification of such patterned activity highlights the ethnographic value of focus groups to reveal social conventions guiding the production of accounts but also suggests that accounts cannot be divorced from the circumstances of their production. Consequently, the authors argue that focus groups should be considered most useful for illuminating locally sanctioned ways of talking about sensitive issues.

Keywords: focus groups, sensitive research, social division, conflict, Northern Ireland

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Introduction

The issue of the appropriateness of focus groups for researching sensitive issues has received some attention, albeit limited, since the early 1990s (see, e.g., Kitzinger, 1995; Lee, 1993; Renzetti & Lee, 1993; Wellings, Branigan, & Mitchell, 2000). In this paper we discuss the use of focus groups for such research using evidence from a study looking at the experiences of nurses providing care in the context of the Northern Ireland "Troubles." The recording and analysis of these experiences form part of a wider project, the objective of which is to produce information that can be used to create a range of education, training, and support services for health professionals. Such services, historically, have been absent in Northern Ireland (Smyth, Morrissey, & Hamilton, 2002), and despite a more recent trend toward acknowledging the potentially detrimental effects of working in situations of ongoing conflict (Healey, Blaney, & Harrison, 2005), they remain largely absent.

When considering an appropriate research design, we were conscious that discussions of nurses' experiences of caring might require participants to describe difficult and/or emotionally upsetting events and feelings. We therefore consulted extant literature on researching this type of subject matter as a precursor to decision making, particularly in relation to the type of interviews to conduct. In the following two sections we discuss this literature and our consequent decision making.

The issue of sensitivity

Definitions of the concept of "sensitive" research highlight the inherent threat to those involved, stemming from the private or personal nature of the issues under investigation as well as the potential for embarrassment, offence and/or social censure on disclosure of associated attitudes and/or behaviors (Lee, 1993). In relation to researching the issue of nursing in the context of the Troubles, all of these threats are implicated. As a result of living and working in Northern Ireland, the nurses who participated in our research are wholly involved in a society characterized by division and conflict. Typically, this division is understood in terms of a religious dichotomy (Harris, 1986) between Protestants and Roman Catholics, intensified by conflicting political ideals. Although the most extreme manifestations of this division have been evidenced throughout the extended period of the Troubles (Fay, Morrissey, & Smyth, 1999), it has also been shown to maintain a pervasive influence on day-to-day social life in Northern Ireland, with interaction,

particularly between strangers, characterized by caution and circumspection with regard to issues associated with religion and politics (Burton, 1978; Finlay, 2001; Hargie & Dickson, 2003).¹

The research required participants to talk about their experiences of providing care in the context of the Troubles, including in relation to sectarianism, a shorthand expression capturing prejudice, intolerance, discrimination, violence, and murder on the basis of (presumed) religious and community affiliation (Brewer, 1992; Higgins & Brewer, 2003). For example, participants were asked about their provision of care to individuals they regarded as either “perpetrators” or “victims” of conflict as well as about prejudice and discrimination they face(d) in the workplace. In answering these questions, participants were required to locate themselves in terms of the religious/political dichotomy outlined above and to discuss the issues they faced based on their location. Furthermore, participants were required to discuss their behavior and emotions over an extended period in the context of their professional code of practice, a cornerstone of nursing care in the United Kingdom (UK), which explicitly binds nurses to equality in the provision of care (Nursing and Midwifery Council, 2004). Consequently, the research could be considered sensitive on two counts. First, it referenced a deeply entrenched and enduring social “fault line,” spawning a whole raft of issues about which individuals were likely to hold irreconcilable, possibly mutually offensive views. Second, it concerned a core value underpinning nursing practice, the repudiation of which carried the threat of personal discomfort and/or social censure.

How to research sensitive issues?

The literature regarding appropriate methods for researching sensitive issues is ambivalent. Although Tonkiss (2004) stated that individual as opposed to focus groups are appropriate, she maintained that the degree of openness with which people will be prepared to speak “will depend on the nature of the topic, the research design and the make-up of the groups” (p. 197). Both Kitzinger (2000) and Wilkinson (2004) have challenged the common misconception that focus groups are inappropriate for researching sensitive issues, instead stressing that interpersonal dynamics within the group might enable participants to gain mutual comfort and reassurance. In terms of facilitating such discussion, Bloor, Frankland, Thomas, and Robson (2001) have pointed out that small groups have been used successfully in studies of sensitive behavior. Finally, in terms of group composition, Finch and Lewis (2003) have cautioned that the fact that “everyone [is] in the same boat” (p. 190) is particularly important to facilitate disclosure and discussion. They concluded that “the ideal is therefore usually a point of balance between the two extremes of heterogeneity and homogeneity, with as much diversity as the group can take and no more” (p. 190).

The tendency within nursing research on sensitive topics has been to use one-to-one interviews in the absence of any explicit discussion of their merits relative to those of focus groups. On the rare occasions that focus groups have been employed, the orthodoxy of using one-to-one interviews has been challenged on grounds similar to those highlighted within the social scientific literature more generally. These grounds include the potential for focus groups to provide a mutually supportive, sometimes empowering environment (Hellman & Baker, 1996; Owen, 2001); that group dynamics can encourage rather than stifle disclosure as participants enter into extended discussion and debate (Culley, Hudson, & Rapport, 2007; Seymour, Bellamy, Gott, Ahmedzai, & Clark, 2002); that focus groups promote a more egalitarian form of discussion as the controlling influence of the group moderator is diluted through group interaction (Hyde, Howlett, Brady, & Drennan, 2005; Owen, 2001); and that focus groups are particularly helpful in identifying issues of relevance within diverse linguistic and cultural environments (Culley et al., 2007; Murdaugh, Russell, & Sowell, 2000).

Methodology informing the research

Given the ambivalence regarding how best to research sensitive topics (Green & Thorogood, 2004), we sought to investigate which format was the most conducive to discussion of nursing in the context of the Troubles. We were unable to test the full range of possible interview configurations on methodological grounds; that is, to have created adequately constituted, religiously homogenous focus groups would have meant informing participants of the details (including rationale) of group homogeneity. The provision of such information would have alerted and possibly biased participants in relation to the significance of religious/community affiliation. Consequently, we conducted both one-to-one and mixed religious/community group discussions. In this article we report on evidence derived from group discussions; where appropriate, evidence from one-to-one interviews is also discussed.

In all, three focus groups (FG) were convened; the first (FG1) included 6 participants, the second group (FG2) included 4 participants, and the third group (FG3) involved only 2 participants. All figures exclude the group moderator, a female non-nurse unknown to all participants. Cognizant of the methodological literature advising the convening of smaller groups when researching sensitive issues (Ritchie & Lewis, 2003), we deliberately invited 6 participants only to each of the three focus groups and secured a verbal commitment from each that they would attend. Apart from FG1, the figures quoted are the result of nonattendance on the day. In the absence of any forewarning of nonattendance, there was no opportunity to invite substitutes. The fact that FG3 involved only 2 participants leaves it vulnerable to being discounted as a group interview (see Bloor et al., 2001). However, we have included an analysis of this “group” discussion for the important methodological insights afforded.

All participants were members of teaching staff from a large department of nursing and midwifery; some, but not all, of whom were known to one another. The majority were female; one man took part in FG3. Initially convenience sampling was used to recruit participants, as members of the research team approached individuals they knew to have worked as clinical nursing staff at some stage during the 30-plus years of the Troubles. However, to avoid the biases inherent in relying on convenience sampling alone (Ritchie & Lewis, 2003), we also undertook snowball sampling using recruited participants and advertised the study across the entire teaching school via e-mail.

Purposive sampling was embedded within this general sampling strategy as we tried to include a diverse range of participants based on, for example, their religious/community affiliation (where known), gender, and length of time spent working as a nurse as well as the historical timing of their work. This meant that some participants had many years of experience of clinical nursing, including during what are considered to be the most violent years of the Troubles during the 1970s (Fay et al., 1999), whereas others had only a few years’ experience during the late 1990s and early 2000s, a period generally seen as much less brutal in terms of both the nature and extent of violence.

In accordance with research governance arrangements of the time, the study was reviewed and granted full ethical approval by a university ethics committee. Participants were given detailed information about the research both verbally in the run-up to their decision making regarding participation as well as in the form of a written information sheet. A consent form was signed and retained by both the research team and the participants. Tape recordings of the focus groups were held centrally by one of the research team (JJ) in a locked drawer; no names were attached to either the tapes or subsequent transcripts. Transcription was undertaken by a team of two transcribers, who were made aware of the highly confidential nature of the research and asked to

sign a letter of contract confirming that they would respect this confidentiality. Transcripts were distributed across the research team for analysis; throughout this entire process they were either stored electronically on password-protected computers or held as printed copies in locked drawers to which only the research team had access. Participants were invited to review their individual transcript and to remove anything contained therein that they no longer wished to be used.

The analysis of talking about nursing in the Troubles

Throughout the following, analytic attention is focused on the content of talk and, simultaneously, on the form of this talk. The rationale for this dual analytic focus comes from the work of Holstein and Gubrium (2004), who have argued that paying attention to both the “hows” (narrative procedures) and the “whats” (narrative content) enables a more inclusive understanding of the dynamics of interaction. This is important because, as a way of analyzing interview data, it prioritizes content (what is conveyed), a dimension of data that has tended to be overlooked in other discursively oriented analyses, which have focused on the technicalities of talk to the detriment of substance.

In Holstein and Gubrium’s (1997, 2004) view of the active interview, participants are endowed with “interpretive resources” (2004, p. 150) of two types: first, those related to the issues that are the focus of the interview, essentially “substantive resources” such as “common cultural link[s],” “traditional cultural opposition[s],” or “institutionalised ways of dealing” (p. 150) drawn on by participants during the course of discussion; and, second, those relating to interaction, essentially “communicative resources” (p. 151) employed in the course of attending to interactive contingencies occurring throughout the interview. The objective then becomes both to describe the situated production of talk and to show how what is being said relates to encompassing experiences and knowledge of those engaged in this talk.

Although Holstein and Gubrium (2004) wrote about one-to-one interviews, their recommendations for analysis are, in our view, equally pertinent to focus group data on the grounds that both settings involve participants who collectively produce meaning in and through interaction. Taking onboard these insights means that in what follows, the statements made by participants, and the sequences of discussion of which they are a part, are analyzed for what they reveal about the articulation and circulation of shared or collective knowledge as this is drawn on and made to count in the course of interaction. On this analytical footing we offer some conclusions regarding not only what and how knowledge is produced, but why it is produced in these ways and the consequences of this for researching sensitive issues.

Talking about nursing in the “Troubles”: An emphasis on impartiality in nursing care

During all three focus groups participants were asked to describe their overriding memories of working as nurses throughout the Troubles.

Extract 1: Sequence of discussion in FG2

Participant [P]1: You gave equal care to everyone but . . . some of the patients in the main ward who . . . would have maybe condoned the perpetrators of the injuries that the soldiers received were shouting at us nursing students if we spent too long in the side-room bed-bathing say a soldier. . . . it was embarrassing but you just covered it up, . . . you didn’t make any difference with any of the patients but you were a bit offended that they thought you

were giving preferential treatment to a soldier in a side-room because obviously you weren't. They were very ill, they needed a lot of bed-bathing, a lot of support but the fact that they even noticed that and would consider shouting at you was . . . [shared laughter] . . .

Focus Group Moderator [FGM]: So from when you started training then, you were used to security on wards?

P1: Yes, I think so. [general murmurs of agreement] In the [place where participant trained] . . . definitely. Which, you didn't think of it . . . it would be amazing now!

. . .
P2: . . . we would have got people in with, most frequently, probably with punishment shootings. . . . I don't remember ever . . . having a particular problem with that and I wouldn't have had any experience of that sort of thing before. . . . but you, sort of, just . . . got on with it very much. I remember communication being a problem with these people because . . . the consensus seemed to be that they were nearly an inconvenience in those days. . . . they had in some way brought it on themselves.

. . .
FGM: [participant's name], have you any experiences that stand out?

P3: . . . you were very conscious of . . . the consequences of the Troubles, you know, the security services . . . arriving in . . . with civilians even, perhaps, with their ears hanging off with the . . . the . . . [somebody says "plastic bullets"] . . . yes, the plastic rubber bullets and their ears would be hanging off them or the police would have had maybe a leg blown off . . . it would have been mayhem . . . it seemed so strange that this was all happening and probably the fact that I had actually came from a background where I probably led quite a sheltered life . . . and there I come to live and work in the city [beginnings of shared laughter] and I probably wasn't really prepared [lots of shared laughter] and I sometimes wonder how I did cope!

In terms of content, participants establish two related "facts" about nursing in the Troubles. The first is that nursing care, including that which they personally gave, was equitably delivered. Second, the provision of such care was achieved in the most challenging and "abnormal" of circumstances. Thus, considerable detail is provided, establishing the pressures that might be expected to lead to a breakdown of impartial caregiving. In important respects, by depicting nurses as not being affected by the exceptional circumstances brought about by the Troubles, participants focus even more attention on the significance of their continuing provision of impartial nursing care.

In terms of organization, participants coordinate their talk in ways that achieve (at least) two important ends. First, they work collectively toward an avoidance of overt and/or extended articulation of experience relating to discrimination in nursing care. For example, the account given by P2 in which she² suggests that a consensus was shared among nursing staff regarding the "culpability" of some patients in relation to their injuries fails to provoke a challenge from co-participants. Given that accounts of nursing care given by these same co-participants elsewhere (both in the extract and throughout the group discussion) endorse the idea of impartiality, P2's representation of "more" and "less" deserving patients might be expected to arouse some form of dissent. However it does not, and both P1 and P3 remain silent. In this regard, it is also significant that although P2 raises the possibility of bias in the provision of nursing care, she subsequently retreats from such a position to focus on how nurses tended just to "get on with it." Thus, a

potentially controversial and divisive issue is left essentially unarticulated, both by the original speaker and by her co-discussants.

Second, at strategic points in the discussion, participants use humor to couch their descriptions as well as respond to descriptions offered by others. Thus, not only are some potentially disturbing accounts made more lighthearted by the way in which they are presented, but the response of other participants, typically laughter, serves to reinforce this sense of levity. In so doing, participants are, again, working toward the promotion of successful interaction, one in which certain aspects, namely the horror and emotional trauma of the events in which they were caught up, are downplayed. Of course, the telling of such traumatic events could be interactionally problematic because of the potential to reference issues and events about which participants will hold divergent, possibly conflicting views.

A similar emphasis, in terms of both the content and the organization of talk, is evidenced in the following sequence of discussion.

Extract 2: Sequence of discussion in FG1

P4: I suppose, also, you were aware that you couldn't be seen to be friendly either because of how that would be perceived, you know, from your patients' perspective. So there was an aspect where that . . . the whole aspect of being caught in the middle. . . .

P5: . . . And then sometimes you would have had patients who were very very rude and very very disrespectful to nurses and . . . ah . . . that was difficult sometimes, trying to be kind and caring and compassionate, to be absolutely abused in many ways. You know, I can remember one fella who . . . used to stand up and urinate on the floor and just expect the nurses just to come and clean it up. But that was the kind of guys, not too many of them now, but you . . . had to . . . stand back and take it. It was difficult.

FGM: Would there ever have been any issues of, like, sectarianism in terms of a patient and a nurse, seeing your name badges or any patient that, kind of, kicked up, refusing to be cared by a nurse because of . . .

P4: Part of my responsibility at one stage was . . . the secure unit and the patients were residents of Her Majesty's Prison. [some laughter] And . . . that was quite interesting as you can imagine and the patients were patients, you know, for us . . . But I can remember this fella who had been in with us for months, you know, he had had either blast or gunshot injuries to his legs . . . And then he was eventually discharged to be readmitted a couple of days later to have his appendix out. And I says "Oh, you didn't stay away too long." "Aye" he says "It's great isn't it," he says, "I'm escaping bit by bit"!!

[Lots of shared laughter]

P5: . . . you know, you had your ordinary decent criminals who were in for robbery and violence and all sorts of things! [laughter] But your . . . political or your terrorist . . . prisoners as well . . . they'd be, sort of, going round saying "Oh that car of yours could do with a good wash," you know, "Why don't you get it washed?" and they were just reminding you that they knew [general murmurs of agreement] "Do you find the traffic heavy going to [place where participant resides]?", you know, that sort of thing, just to remind that they knew where you lived and they had your number and they knew what your car was. [General murmurs of agreement] And that was fair

enough, it didn't, you know, I never really felt, at any stage, under threat but they were just letting you know.

In terms of content, although P4 initially acknowledges difficulties in providing impartial care in a politically charged environment, the maintenance of such care is not, in the end, called into question. In response, P5 continues an emphasis on impartiality from a different tack, as she describes the care she gave even to patients who could be considered undeserving of such care (because of their extreme rudeness). The focus group moderator further explores the theme of difficult patients by asking about those who might have displayed sectarian-based prejudice toward nurses. Failing to engage directly with the question, P4 once again responds with a story that underscores the notion of "ordinary" (equitable) nursing care being given in the most extraordinary of circumstances. Although P5's subsequent description of patients applying subtle sectarian-based pressures is endorsed by co-participants (as murmurs of agreements are uttered), even this relatively benevolent portrayal is qualified by her characterization of such behavior as acceptable. Of course, to have recounted experiences of sectarianism from patients would have been to establish the grounds for patient-nurse conflict and thus for discriminatory caregiving.

In terms of the conduct of talk throughout Extract 2, two features are noteworthy. First, P4's account of the circumstances in which nursing care was given emphasizes their bizarre, even farcical nature and, in so doing, tends to minimize their gravity. Insofar as co-participants respond to her story with laughter, they collectively promote a sense of levity within group interaction. Second, although P5 provides an account of an extremely discourteous patient, in the course of which she goes some way toward establishing the moral grounds for discrimination in caregiving, she can be seen to retreat from such a position through her use of the summary expression "But that was the kind of guys" Similar to the use of formulaic expressions such as idioms, proverbs, or clichés identified within a discourse analytic tradition (Wilkinson & Kitzinger, 2000), her use of such a perfunctory and vague phrase serves to draw a rhetorical line under her previous hints at the grounds for discriminatory practice, thereby moving the conversation away from a potentially difficult topic (Edwards & Potter, 1992; Sacks, 1995).

Throughout all three focus groups, the idea of impartiality as a feature of nursing care was directly challenged by the moderator when she asked how participants "coped" with having to provide care to patients they considered to be either victims or perpetrators of violence. The following exchange typifies the kind of discussion that such questioning prompted.

Extract 3: Sequence of discussion in FG 2

FGM: I mean, the idea, and you all touched on it, about, you know, in terms of nursing, it is about equal care, regardless of who people is. But . . . did it ever bother you, the rights and wrongs, the . . . reasons why, you know, when you've seen victims and maybe perpetrators coming in together and . . . ?

P1: I think you tried not to, I suppose.

P3: I think you tried to shut that out of your mind, you know, it was at the background, you know what I mean . . . you would have thought this is the job in hand at the moment and you get on with it and you hope for the best and you're here to preserve life. And yet there's other people trying to take it away, you know. Those who you were trying to preserve their life were the ones maybe who were trying to take it away and you're, sort of, trying to think to yourself, you know, isn't it crazy but you get on with it and you do your best and then it, it used to, sort of, sometimes, what I would have maybe have thought, would have been, you know it would have been, at the end of

the day these people were given priority within casualty because they were brought in as an emergency and yet there would have been a backlog of other patients sitting out in the wing, in the areas, a queue of people waiting to be seen, you know what I mean.

P1: So you thought about the ethics of that?

P3: Maybe a gentleman coming in with chest pain or someone as a result of a road traffic accident or whatever and you thought to yourself, how do you prioritise all of this, you know.

P1: So you would have got angry?

P3: I was a student and a junior staff nurse at those stages so, ehm, I was, you know, taking what was dedicated to me and got on with it but you sometimes wondered about it all.

FGM: Absolutely, I imagine that is difficult.

P3: In situations like that and, ehm, but as I say, you sometimes wonder how you did cope with it, don't you, when you look back on it?!

P1: I'm glad you didn't think too deeply about it!

FGM: Maybe that's right. [murmurs of agreement]

P1: I think it's good that we didn't.

In terms of content, and in line with previous extracts, the above sequence develops the idea of “(extra)ordinary nursing” and so underscores the potential for, but not the realization of, prejudice and discrimination. This is apparent in two ways. First, participants emphasize their capacity to undertake routine or “normal” care in the most exceptional of circumstances, in this case by not thinking about the rights and wrongs of the actions of individuals to whom they were administering care. Second, P3 makes muted appeals to the idea of “injustice” arising in a situation in which the perpetrators of violence were cared for alongside or ahead of other patients. In so doing, she establishes the notion of more and less “deserving” patients; however, at no point does she make either of these positions explicit. In this context, her use of the cliché “you know what I mean” is telling for the way in which it closes, in a nonspecific and nonconfrontational way, what she has just been saying (Edwards & Potter, 1992). Furthermore, shortly afterward she quite abruptly steers the discussion entirely away from the topic of (im)partiality in care by returning to the issue of “coping” in traumatic times (“but, as I say . . .”), a topic markedly less controversial in terms of what it suggests to have been her personal experiences of caring and its potential impact on group interaction.

In terms of the organization of interaction, throughout Extract 3 P1's support of P3 in her extended “muted” portrayal of injustice and the consequent justification of discrimination in care is noticeable in two ways. First, the manner in which she asks questions of P3, in particular the use of the word “so” (“So you thought about the ethics of that?”; “So you would have got angry?”), rhetorically suggests her understanding of and concordance with P3's emotional dilemmas. Second, by the end of the exchange, not only is P1 helping P3 in her endeavor to change the focus of conversation onto less socially divisive issues, she has shifted the onus of responsibility for “difficult” emotional responses onto everybody in the group (“I think it's good that we didn't”), thereby helping to engender a sense of shared experience and group cohesiveness.

It is noteworthy that throughout the sequence of discussion in Extract 3, P2 makes no contribution whatsoever. Kitzinger (1995) identified such absences from discussion as a disadvantage of focus groups, seeing them as evidence of a silencing of dissent. According to Hyams (2004), such an approach tends to normatively equate silences with absence conceived in terms of, for example, submission or oppression. From a discourse analytic perspective Hyams offered an alternative

conceptualization in which silences are opened up for analysis. Looking at the detail of interaction, P2 is effectively prevented from participation as P1 and P3 enter into a question and answer dialogue. Thereafter, the conversation is opened up by the moderator, facilitating P2's participation; however, she still does not become involved. Following Hyams (2004), it is possible to see this extended lack of involvement not as an absence from the discussion but, rather, as a form of presence (Hyams, 2004) that takes the form of active disengagement from talk. Although the reason for such disengagement might be a matter of analytical conjecture, one such might be P2's intentional silencing of contradictory personal experience of nursing care as a means of avoiding disruption to ongoing group interaction. The fact that P2's lack of involvement extends for another 1½ pages of text lends credence to this explanation. In the process a narrative of nursing care as impartial is sustained.

Bucking the trend: an emphasis on discrimination in nursing care

In terms of content, the idea of impartiality in nursing care holds constant throughout FG1 and FG2. However, during discussions that took place during the third focus group (FG3), a narrative of impartiality becomes fractured so that although the notion of nondiscriminatory personal caregiving is maintained, discrimination in the care given by other nurses is highlighted.

Extract 4: Exchange in FG3

FGM: You know the practice that you provide care on an equal basis regardless of who or what people are, in practice . . . is that the case or is it more difficult when you were dealing with perpetrators? . . . I mean, it takes a lot of work to keep that out, I'm sure?

P1: Well personally . . . I have never refused to look after anybody, but I have worked with people, including staff nurses, who have refused to work with people because they knew they were of the opposite persuasion or whatever. . . . Take psychiatry, for example, the [name of hospitals] . . . I've seen on the 12th July where the nurses refused to take patients up to the town to see the parades because they . . . were Catholic and wouldn't do it. I've also seen Catholics and Protestants, I'm not going to get at any particular side . . . refusing to take patients to the church or chapel on a Sunday because that's not mine and I'm not going to go . . . but personally I have not ever, to my knowledge, ever refused to look after any particular person that I was asked to.

FGM: But have you found it difficult?

P1: I might have been apprehensive initially being asked to look after somebody known what they had done perhaps, if they . . . had the opposite view . . . to myself perhaps. . . . but once you got to know the person it's, as I said, you generally find the people are absolutely no problem . . . now I'm going to use now an analogy here but it's the easier way for me to put it, to hate the sin, but love the sinner, does that make sense, you don't have to know what the person does, but you have to care for them. You don't have to agree with what they've done, you just have to care for them, so in a sense that's the way I put it, you know, I don't have to agree with what they have done but I do have to look after them, you know.

FGM: [directs gaze towards P2] But then there may have been . . . where if you were having difficulties or you were having issues that you were having to deal with, the ability to go somewhere or to know that there was somewhere you could go . . .

P2: No, well I don't think it did, and I'll tell you another culture, sorry if I could just relate, there was also it seemed that if anyone did seek help was almost seen like a weakness, and I do know one or two other colleagues . . . they were more senior to me, they were . . . senior staff nurses, and I remember one particular guy who did seem as if he was having problems, eh, and I remember asking him to go to counseling and I remember . . . his answer to me was, but if I go there that automatically will bar me from any promotion . . . it was almost seen like a weakness that if you did go for help, then it will be on your record, therefore you'll be seen as weak, psychologically weak, you know what I mean.³

In the above sequence P1 invokes a body of knowledge that prioritizes her experience of prejudicial nursing care. The recounting of such experience makes relevant to group interaction the idea that sectarianism adversely affected the quality of nursing care provided during the Troubles. In providing such an account, P1 departs, quite drastically, from the accounts given by participants in FG1 and FG2, all of which stressed a lack of prejudice in nursing care per se. In one important respect, however, P1's account mirrors these others, namely, the description of personal caregiving as devoid of prejudice, and this despite the leading question posed by the group moderator ("I mean it takes a lot of work to keep that out, I'm sure"). The substantive resources (Holstein & Gubrium, 2004) used by P1 in the course of establishing her impartiality, thus, both parallel and diverge from those used by participants in FG1 and FG2. She describes the potential for but not the realization of personal prejudice, thereby rehearsing the theme of (extra)ordinary nursing evident in other group discussions. On the other hand, she fails to apply this (extra)ordinariness to nursing per se, as P1 draws an explicit contrast between her own and others' nursing care.

In terms of the content of P2's narrative, she does not talk at all about the impartiality, or otherwise, of nursing care she either witnessed or gave, either during the sequence of discussion set out above or at any other time during FG3. Instead, in the above extract she invokes an entirely different body of knowledge, namely that relating to the need for and difficulties of accessing support services. Thus, P2 describes her experience of a "culture of silence" that discouraged nurses from giving voice to the pressures they faced in the course of their work. Although not made explicit in any of the extracts from FG1 or FG2 included in this paper, her account of such pressures parallels those given by participants in these other focus groups as well as by her co-participant elsewhere in FG3. In focusing on issues only tangentially related to discrimination in nursing care, P2 moves the conversation away from a potentially divisive issue onto more "mundane" matters. In this she is facilitated by the question posed by the moderator, which is sufficiently nonspecific to enable a number of responses.

Although P2 might not explicitly address the issue of discrimination raised by the moderator's question and sustained by P1's response to it, this does not mean that she has not engaged with it. In making this analytical claim, we return to the concept of silence (Hyams, 2004) outlined earlier, which enables an identification of active engagement on the part of P2, manifested as avoidance. Her apparent nonresponse leaves P1's account of discrimination essentially intact but means that extended discussion of a contentious issue is avoided. Highlighting an issue that emphasizes unity between nurses but division between them and others means that the content of P2's talk is markedly less controversial both in terms of what it says about nursing and in terms of what it might do for the interaction pertaining within the group. P2 can be seen to be somewhat diffident about instigating this change of direction in the way in which she apologizes for so doing ("sorry, if I could just relate"). One way in which this "sorry" can be read is as an

acknowledgement of her failure to respond to, in turn, the account offered by P1 and the question posed by the focus group moderator.

In summary, the net effect of the use of a range of interpretive resources (Holstein & Gubrium, 2004) in the focus groups convened was, first, the promotion of a relative silence concerning the incidence and implications of discrimination as a feature of nursing care, and, second, the maintenance of group accord. In terms of organization, these resources included maintaining a silence, endorsing the accounts given by co-participants, not mounting any overt challenges to accounts given by co-participants, couching descriptions of harrowing experiences in humorous terms, and moving the discussion on and away from particular issues. In terms of the content, participants' overwhelmingly use of a narrative stressing impartiality in nursing care emphasized equivalence and cooperation as, significantly, it, too, contributed to successful group interaction.

Discussion

Methodological issues

Recruitment

Earlier we highlighted the problematic status of Focus Group 3, in that it involved only two participants. As this was the result of unforewarned nonattendance, we were unable to rectify the situation on the day. Although the discrepancy between promised and actual attendance is a perennial challenge for focus group researchers, our numbers are likely to have been increased had we either overrecruited (a figure of around 25% is recommended) (Green & Thorogood, 2004) and/or contacted participants with a reminder about the focus group (for example, by phone call, text, and/or e-mail) either the day before or on the morning of the scheduled meeting. The fact that all focus group participants were recruited from within the same school of nursing and midwifery might have negatively affected recruitment, including in relation to nonattendance. First, those staff who knew one another might have felt uneasy about having to discuss personal issues in front of one another. Similarly, even those staff relatively unknown to one another might have been aware of the potential for future working relations to be compromised as a result of such discussions.

The ethics of conducting research on sensitive issues

The issues at the heart of this study have been the subject of very limited research, which, when undertaken, has highlighted unmet need often in the context of considerable emotional trauma (Smyth et al., 2002). Consequently, although we were convinced of the necessity for further research, we were conscious also of the potential burden we were placing on participants to talk about issues that are both contentious and upsetting. Therefore, at the end of every interview, we sought to debrief participants by, for example, thanking them for their contribution to the research, asking if they had any issues they wished to raise or comments to make, and providing them with information concerning opportunities for counseling should participation have engendered emotions or thoughts they wished to discuss further. Although not a definitive assessment, it is significant that any comments made about participation in the research were universally positive. Not only did nurses talk about their enjoyment of the discussions, but they highlighted the sense of personal "worth" the research promoted. In this context, comments on never having been given the opportunity to talk about their experiences before are significant. Consequently, from a research ethics standpoint, and so long as due care and attention is paid to research design, we are inclined to endorse the view that participation in research addressing sensitive issues can be beneficial (Cutcliffe & Ramcharan, 2002; Dyregov, 2004).

Accounting for differences in the content of talk

In terms of difference across focus groups, one issue stands out. Why should a narrative of universal nondiscriminatory nursing care emerge from FG1 and FG2 but not from FG3? One reason might be found by looking at the context in which these different narratives emerge. Although both occur within group discussions, the composition of these groups and the interaction they consequently facilitate are markedly different. In the case of FG3, only 2 participants took part, and in terms of the proportion of talk occupied, at least, P1 dominated. Overwhelmingly, the transcript of FG3 reads like a dialogue between P1 and the group moderator, with infrequent contributions from P2 and these typically only after direct prompting. Such features mimic the dialogic circumstances of one-to-one interviewing, suggesting that this more “intimate” forum of discussion encourages the production of other forms of knowledge. To explore this possibility further, it is worth reviewing the data generated in the one-to-one interviews that were conducted alongside the focus groups as part of our preliminary research.

In all, 9 face-to-face interviews were conducted, involving a range of male and female nurses working in the same large department of nursing and midwifery as the focus group participants as well as nurses (working and retired) from local hospitals/community services across the greater Belfast area. In the extended discussions of their experiences of working during the Troubles, these nurses provided very similar accounts to those given by focus group participants. One nurse described the emotional trauma she underwent with regard to caring for individuals she considered to be perpetrators but, notwithstanding, stressed the impartiality of her nursing care. Furthermore, the nurses who participated in one-to-one interviews were more inclined to provide accounts that highlighted discrimination against themselves as a feature of professional working relations. However, no one acknowledged discrimination as a feature of the care that they or any other nurse gave. Instead, similar to focus group participants, although their accounts might have acknowledged the underlying difficulties of maintaining strict impartiality, in the end the provision of equitable nursing care was affirmed.⁴

If the differences in accounts between FG1 and FG2, on the one hand, and FG3, on the other, cannot be explained on the grounds of interview format, what other factor(s) might be at play? One such is evident by looking at the other dimensions of knowledge invoked by P1 throughout FG3. Thus, she makes repeated references to her experiences as an “outsider” (born and raised outside of NI) as well as her ability to “tell it like it is” based on this marginal social position. The very fact that P1 discursively embeds her experience of prejudice in nursing care in that of her marginal social position suggests her awareness of the likely controversial nature of her account and the need to contextualize it appropriately. Furthermore, this awareness is shared with other group participants; not only does P1 recognize her marginal social position as the discursive grounds for launching a contentious claim, but her co-participants are equally aware. For the purposes of talking about her experiences of nursing care in the Troubles, P1 is an outsider who can tell it like it is.

This claim resonates strongly with those inherent in Holstein and Gubrium’s (1997, 2004) approach. Their fundamental argument was that the experiential knowledge conveyed by participants in an interview is intrinsically related to locally available, culturally relevant ways of thinking and doing. As they have stated,

Meaning is not constantly formulated anew, but reflects relatively enduring local contingencies and conditions of possibility . . . such as the research topics presented by interviewers, participants’ biographical particulars, local ways of orienting to those topics, institutionalised ways of understanding and talking

about things, and other accountable features of “what everyone knows” about a topic. (2004, pp. 150-151)

The ways in which the account provided by P1 in FG3 originates out of normative possibilities have been made explicit immediately above. The patterned content and organization of accounts provided by the other focus group participants reflects a similar normative orientation, only this time the particular possibilities of understanding and talking actively discourage an acknowledgement of discrimination as a feature of nursing care. In this regard, it is significant that no matter what the particular content of discussion, in all of the focus groups the same organizational imperative for silencing discrimination in nursing care emerged. For example, in FG1 and FG2 the accounts given by participants overwhelmingly endorsed the idea of impartiality, and the few challenges that occurred were only ever partially elaborated on. In FG3 when P1 characterized nursing care as frequently discriminatory, P2 responded in precisely the same way as participants in FG1 and FG2 responded to an entirely contrary characterization; that is, she failed to mount an explicit challenge.

Implications for the use of focus groups to research sensitive topics

What focus groups should not be used for . . .

The consistency in accounts provided by all nurses irrespective of interview format challenges some of the assumptions and recommendations to be found in both the nursing and more general social scientific literature. As indicated in the review undertaken at the start of this paper, there is a lack of consensus on how best to conduct research on sensitive issues. Contemporary nursing studies are characterized by a duality of approach, with some researchers advocating the use of one-to-one interviews based on their relative intimacy, confidentiality and lack of perceived peer pressure and others championing the use of focus groups based on the mutual support provided by participants as well as greater equity in the circumstances of discussion as the group moderator is encouraged to “take a back seat.” Although these recommendations differ in specific content, they share the same epistemological underpinnings; that is, they both treat the talk generated in interviews in essentialist terms as either more or less accurate accounts of what people “really” think and/or do.

It is on the basis of these assumptions that arguments are made concerning which interview format is better at facilitating the provision of “truthful” accounts. Such arguments ignore the locally situated and contingent nature of accounts provided in both one-to-one and focus group interviews. Certainly, all interviews enable access to legitimate knowledge but knowledge tied to the immediate, and observable, circumstances of its production. Consequently, it is epistemologically naïve to assume that the knowledge generated in focus groups can be taken as a proxy for beliefs and behaviors pertinent elsewhere.

What focus groups should be used for . . .

In the absence of being able to confirm the religious/political convictions of co-participants, focus group members had the precarious task of having to talk about the very issues that previous research suggests would otherwise be avoided in such public arenas (Burton, 1978; Finlay, 2001; Hargie & Dickson, 2003; Harris, 1986).⁵

In the end they managed this difficult interactional work quite adeptly by, first, “acknowledging” the existence of discrimination in nursing care as an abstraction, for example, in terms of its potential but not its realization and, second, by otherwise actively working toward the

maintenance of intragroup consensus. Thus, the substantive and communicative resources employed by participants tended to underplay discrimination as they simultaneously accentuated the likelihood of avoiding interactional disruption. The use of these two resources is strategic, based on an awareness of ways of talking appropriate to the immediate circumstances. The content of talk, as it revealed participants' thinking and experience of providing nursing care, revealed "real" knowledge but knowledge concerning culturally appropriate ways of thinking and talking about this issue in a public arena.

In that the accounts collectively produced by participants are the result of their interpretation of ongoing interaction, they are local accomplishments. However, crucially, this does not mean that they are relevant only to the context in which they are produced. Rather, they are oriented to other circumstances of experience because of their grounding in the knowledge participants brought with them to the focus group and made meaningful in specific ways during that interaction. Consequently, the accounts do not appear from nowhere, so to speak; they are creatively fashioned using interpretive resources available to participants. Certainly they are engaged in highly situated interactional work, but even this requires something to work with, and this is where the approach toward analyzing interview data advocated by Holstein and Gubrium (2004) is particularly useful. Because the focus is just as much on content as on organization, the analysis is able to account for knowledge production not only in terms that relate to internal focus group process but also to encompassing cultural reasoning and expectations.

In adopting this analytic position, we have been interested in how participants draw on particular aspects of the "cultural universe and its content of moral assumptions" (Silverman, 2001, p. 113). Wilkinson and Kitzinger's (2000) study of the way in which people talk about "positive thinking" in relation to coping with cancer demonstrates the utility of seeing such statements as presentations of a cultural norm that "strongly endorses positive thinking" (p. 805). Similarly, the accounts given by participants might be seen as orienting to a cultural norm that endorses talking about Troubles related issues in particular ways. Taken overall, our analysis has highlighted how, in recounting experiences to each other, participants effectively produce "morally adequate" accounts (Silverman, 2001, p. 106). It is precisely because participants emphasized impartiality in nursing care that evidence of its significance as a culturally appropriate way of thinking and talking is demonstrated. In this context, the point made by Wilkinson (2004) concerning the way in which a discursive approach enables insight to be gained into participants' understanding of the interaction in which they are involved, as displayed directly through their talk, is relevant.

Conclusion

In the brief literature review set out at the beginning of this paper, we outlined a number of issues addressed by different authors when considering the value of focus groups for researching sensitive issues. Implicit in these assessments is the assumption that, given the right conditions, focus groups can facilitate the gathering of accurate information about individual cognition and/or behavior. Nothing in the analysis set out in this paper invalidates this claim as long as it is recognized that the phenomena being illuminated have to do with knowledge and experience concerning culturally acceptable ways of thinking and talking about the issues under discussion. Where focus groups have been convened to discuss sensitive issues around which particular conventions concerning appropriate ways of talking exist, then the discussion will afford an excellent insight into these conventions. In the case of our research into nursing during the Troubles, we were thus afforded an understanding of how participants routinely think and talk about such issues in a public or group context; what we found was that, as a way of talking, these issues are routinely silenced.

It is on this basis that the usefulness of focus groups for researching sensitive issues should be gauged. Participants' talk will certainly be drawn from their knowledge and experience of the sensitive issue(s) of interest; therefore, the knowledge generated in a focus group is entirely valid (or "true"), but it will be knowledge that is quite specific to the context in which it is constituted; that is, it will illuminate locally culturally appropriate ways of thinking and talking about the sensitive issue(s) in that context as distinct from knowledge concerning what participants might have otherwise "done," "thought about," "said" or "had happen" to them in relation to them. Consequently, although focus groups can certainly generate useful research knowledge concerning sensitive issues, they cannot be taken as delivering data on experience of these issues in any other way except as they are directly relevant to the context in which they are generated, that is, the focus group itself. This is not to point out a shortcoming of focus groups; rather, it is to highlight the opportunities afforded by them.

Notes

1. Considerations of space prevent a more extensive historical summary of the Troubles. However, a wide-ranging literature exists, much of which is written from a particular political stance. An excellent place to start is the Fay et al. (1999) book as well as other publications arising out of The Cost of the Troubles Study, which may be accessed at <http://cain.ulst.ac.uk/cts/>.
2. Because there was only one male respondent, to help preserve anonymity, we have referred to all participants as "she" or "her."
3. Although not the explicit focus of this paper, the lack of organizational support permeated the discussions occurring in all three focus groups. For a detailed consideration of the issue of support structures for health and social care workers in Northern Ireland throughout the extended period of the Troubles, including the role of managers and administrators, please see Smyth et al. (2002).
4. A detailed discussion of the ethical challenges associated with nursing care, including that of providing care to patients considered "undeserving," falls outside the remit of this paper. Useful discussions can be found in Cassell (2004), Liaschenko (1994), Varcoe, Rodney, and McCormick (2003), and Wolf and Zuzelo (2006).
5. As described, participants' accounts can be seen as orienting to the "culture of silence" identified by a wide range of empirical studies. For example, Burton (1978) referred to a process of telling, whereby local people use various indicators (e.g., a person's name or their speech idiom) as clues to a stranger's identity as either Protestant or Catholic. According to Burton, it is only when the process of telling can be completed and a stranger is unambiguously identified as "same" that people will embark on talk that references Troubles-related issues. Conversely, in situations in which such identification is not possible or the person is identified as "other," any such talk is avoided.

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